

The Moral Experiences of Undergraduate Nursing Students During Clinical Placements:
A Constructivist Grounded Theory

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Abstract

Moral experiences are experiences where there are values at stake. All people live moral experiences, from the mundane to the extraordinary. Undergraduate nursing students [UNS] have moral experiences during their clinical placements yet little is known about these experiences. Research that acknowledges and accounts for the range of moral experiences that UNSs have when providing patient care better reflects the diversity of these experiences, from the good to the bad, the right to the wrong, and the just to the unjust. Understanding their moral experiences can foster a greater awareness of UNSs as moral beings who live meaningful experiences that affect them as learners and future professionals.

The purpose of this research study was to examine clinical placement-related moral experiences of UNSs and the ways in which these moral experiences shape them as learners. The research questions were 1) What are the moral experiences of undergraduate nursing students in the context of clinical placements?; 2) What are the relational dimensions of undergraduate nursing students' moral experiences in the context of clinical placements?; and 3) How do undergraduate nursing students incorporate their moral experiences into their learning process?

This study is a constructivist grounded theory as articulated by Charmaz. Twenty-three semi-structured interviews with UNS participants were conducted and retained for analysis. All participants were recruited from the Bachelor of Science in Nursing program at a bilingual university in Ontario, Canada. In keeping with constructivist grounded theory, the data analysis process was iterative and evolving to construct a theory that was grounded in the data. As a result of data analysis, three categories were developed: 1) having a moral experience; 2) learning in motion; and 3) navigating relational contexts. In brief, the first category, having a moral experience, represents the moral experiences described by the participants; these are the stories

participants shared that unfolded during or in relation to clinical placements. The second category, learning in motion, describes the participants' learning process. The third category, navigating relational contexts, represents the interconnected relationships that framed the participants' moral experiences. Overall, the findings of this study provide insights into the range of moral experiences that UNSs have during their clinical placements, the relational dimensions at play, and the learning process that UNSs experience as they navigate clinical placements as learners.

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Chapter 1: Introduction

1.1 Situating Myself

I begin this study by explaining how my story informed the development of this work. My pursuit of graduate studies started, not because I wanted to change the world or make a contribution to knowledge, but because I wanted a “better job” one day. I graduated in 2012 from the University of Ottawa with a Bachelor of Science in Nursing and worked several jobs as a bedside nurse in diverse places such as the small town of Carleton Place as well as the big city of Las Vegas. I knew that when I was ready to settle down, I wanted to have a Master’s degree so that I could apply for one of the “better jobs”, meaning one away from the bedside, and become a unit manager or clinical educator. I had no children, no mortgage, and a husband who supported me. I felt there was no better time to finish my Master’s so I could bolster my curriculum vitae. I had the drive and liked to learn enough to think that I could be successful. I started in the Master of Science in Nursing in the course-based stream, meaning that I had no thesis supervisor and most importantly, I would not have to write a thesis. I later switched into the thesis stream, but again admit that it was not done for any altruistic purposes but instead because I thought it might look better on my curriculum vitae. I also had not anticipated that the course-based stream involved nearly as much writing as the thesis-based stream. I spent time considering several different topics for my Master’s thesis, but there was no topic that piqued my interest enough that I wanted to spend a year thinking about it.

That changed when I read an article by W. Austin (2007) that forever changed my life’s trajectory and led me to embark on my PhD. In this article, I was introduced to the concept of moral distress. It was a term I had never heard of, yet it resonated deeply with my own experiences working as a bedside nurse. In its original form, moral distress is what happens

when one knows what they perceive to be the right course of action, but are constrained from acting in a way that aligns with their beliefs about what is right (Jameton, 1984).

Upon reflection, it was my own experience of moral distress that had persuaded me to travel 45 minutes outside of my home in downtown Ottawa to work in a small-town hospital where I felt a genuine sense of community and support, and that eventually motivated me to move away from the bedside. The moral distress I experienced as a nurse nearly drove me out of the profession. During my first year of practice, I worked on a busy medical unit where I considered myself a novice and was not as efficient as some of the other nurses. To compensate for this, I showed up early and left late nearly every shift, in addition to frequently missing my breaks. I wanted to know my patients, hit the ground running at the beginning of my shift, and make sure that I did not leave the evening shift nurses with my unfinished work. I did this because I wanted to be the kind of nurse that I would want if I were hospitalized: I wanted to be the kind of nurse that I could be proud of. My extra time was unpaid, and on the rare occasions I asked for overtime, there was no guarantee it would be approved.

After one year of practice under three different unit managers, I was asked to meet for a performance evaluation. The manager complimented me on my ability to connect with patients and staff on the unit but criticized my poor time management, noting that I frequently left late. Reflecting on those observations significantly changed the outlook on my practice going forward. The extra unpaid time that I spent to provide what I considered to be good patient care was being used not to celebrate my dedication to my patients but instead to show me how and why I was not good enough. To me, the message was clear; I was the problem, and not the institution that seemed to claim no responsibility in creating the working conditions where as a novice nurse I felt unsupported and overworked. Ultimately, I quit that job, feeling defeated.

Inspired by my own experiences, I made the decision to investigate the moral distress of nurses for my Master's work. I wanted other nurses to know that these challenging working environments should not make them feel that they were not good enough. I created a project proposal that felt meaningful to me and would do justice to the topic, although it ultimately proved too big for the scope of a Master's thesis. I had to decide between compromising the project that I had envisioned or carry out the project as I imagined as a doctoral dissertation. To me, there was little doubt, and the choice was clear: I was going to complete a PhD on the moral distress of nurses.

The idea of enlarging the scope of the study to include moral experiences more broadly came only later thanks to the Master's work of my colleague and friend, Kristina Ma, and her supervisor, Dr. David K. Wright. In her thesis with nurses engaged in ethically meaningful situations in end-of-life care, Ma (2018) made a compelling argument about the value of asking nurses what kinds of experiences were meaningful to them, from the ethically challenging to the ethically enriching. As a nurse, I lived that full range of experiences and emotions and for me, one of the most interesting parts of nursing is the gray zone that exists in nursing practice. The gray zone lies between black and white, between where right and wrong are clear and certainty is absolute. It was clear, if I was committed to understanding the experiences of nurses, I needed to create an understanding of these experiences on their terms. My experience of moral distress led me to believe that nursing practice is unsustainable in its current form, where nurses are continually asked to do more with less. But I wanted to be open to other narratives, to document the stories of nurses that were meaningful to them rather than the ones that I wanted to hear to support my preconceived ideas. As a result, I made the decision that this would be a doctoral study examining the moral experiences of nurses.

My specific interest in the experiences of undergraduate nursing students [UNS] came later and was inspired by my own experiences. As I read about moral distress, and then more broadly, about the moral experiences of nurses, I realized that the experiences of UNSs were largely absent in published literature. During my time as an UNS, I often felt as though my university experience was different from that of my peers who were enrolled in other programs. We had many common experiences, such as the stress of leaving home for the first time, learning to cook meals on hot plates, meeting academic deadlines, and deciding which electives to take to help bring up our faltering grade point averages. But for me, as an UNS, I felt some of my experiences were different, even if I had a hard time articulating why I felt that way. As part of the nursing program, I completed clinical placements where I found myself responsible for other individuals (i.e., my patients) in ways that were unfamiliar and sometimes downright scary to me. Nothing in my textbooks prepared me for some of the moral experiences I would encounter. I did not understand this concept at the time, and therefore did not define them as moral experiences, but what I believed was good or right was challenged at times. For example, I would feel conflicted when I provided care that did not align with what I believed to be in the best interest of the patient, or when I felt my patient's priorities or care timeframes were not in line with my clinical instructor's expectations. In contrast, there were times when I felt proud of the positive differences that I made in someone's life, when, for example, I had extra time to focus on developing a meaningful relationship with a terminally ill patient's spouse or to teach my patients about their prescribed medications in a way that empowered them to be active participants in their own care upon discharge. Years later, I can recognize that part of the challenge of clinical placements as an UNS was not only learning clinical skills, but also learning to navigate relationships with patients, clinical instructors, healthcare professionals, and multiple

clinical environments, and to understand the sociopolitical context in which these relationships are constructed. I now believe it was this clinical learning that created the dissonance between my university experience and the university experience of my peers.

The challenging and exhilarating experiences that I had as an UNS during clinical placements influenced my practice as a registered nurse as well as who I am as a person. The experiences of students or learners is important and worthy of study. Clinical placements represent a time where UNSs are exposed to patient care, interdisciplinary practice, and the healthcare system, often for the first time. Those initial experiences may have a lasting effect on nurses, and we have much to learn from UNSs. Their insights have the potential to provoke meaningful changes to nursing curricula and foster a greater awareness of UNSs as moral beings who live meaningful experiences that affect them as nurses and people.

1.2 Moral Experiences

All people live moral experiences, which range from the mundane to the extraordinary. Matthew Hunt and Franco Carnevale provide a framework of moral experiences that recognizes the contextual and subjective nature of these experiences. As Hunt and Carnevale (2011) proposed,

Moral experience encompasses a person's sense that values that he or she deems important are being realized or thwarted in everyday life. This includes a person's interpretations of a lived encounter, or a set of lived encounters, that fall on spectrums of right-wrong, good-bad or just-unjust (p. 659).

When thinking about moral experiences, both in general and in our own lives, we risk defaulting to the extraordinary. Experiences related to divisive ethical quandaries such as medical assistance in dying, the death penalty, or abortion, for example, could be considered

extraordinary because of the magnitude of their impact with life and death consequences. These represent contentious topics where opposing values collide, and proponents of each side may believe they are unequivocally right, meaning that the other is unequivocally wrong. Focusing on these extraordinary experiences is important; however, as researchers, it is also important to look beyond these extraordinary experiences to better understand how individuals live out the moral dimensions of their everyday lives (Hunt & Carnevale, 2011). People have moral experiences in the corners of their everyday lives that appear to hide in plain sight; these experiences are often overlooked and remain on the periphery of published literature in the field of ethics. For example, my experience as a novice nurse when I arrived early and left late most shifts to provide what I perceived to be “good” patient care, provides an example of an experience where values are at stake. My actions were guided by what I considered to be “good” or “right” despite the financial and personal consequences. How people decide what they perceive to be “right” (what matters most) is shaped by their own lived experiences and interpretations of those experiences (Kleinman & Benson, 2006). How people interpret and understand their experiences is influenced by cultural meaning, social knowledge, and subjectivity (how we see ourselves) (Kleinman & Benson, 2006). In other words, moral experiences are influenced by an individual’s lived experiences and the context in which these experiences occur. As a result, one’s interpretation of their moral experiences is dependent on several factors that are not static across time or place.

For example, in some clinical contexts, such as the disclosure of a terminal illness, healthcare providers used to withhold information from patients about their diagnosis and prognosis if they thought this information could cause harm to their patients (Tabak et al., 2012). Some healthcare providers still today uphold this practice, predominantly in non-western

countries (e.g. China) (Li et al. 2008, Kazdaglis et al. 2010). This approach has received intense criticism and the current prevailing consensus is that patients have a right to receive accurate information that respects their autonomy and decision-making capacity (Rassin et al., 2006). Today, information withheld from a patient may be problematic, whereas historically, this same practice was once considered to be in the best interest of the patient. One's interpretation of moral experiences are both contextual and subject to change over time.

1.2.1 Moral Distress of Nurses

Moral distress is an increasingly familiar and common moral experience that has gained significant and sustained attention over the last 40 years, particularly in the field of nursing (Ulrich & Grady, 2018). In 1984, Andrew Jameton, who is largely credited for having coined the term, defined moral distress as what “arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action” (Jameton, 1984, p. 6). Currently, a significant proportion of the literature about moral distress is in relation to in-hospital nurses; more specifically, critical care nurses (Huffman & Rittenmeyer, 2012). Situations or events that are frequently referenced as giving rise to moral distress include when nurses perceive a negative unit culture in their care setting, when they feel compelled to act in ways that they believe are not in the patient's best interest, particularly as it relates to futile care, and when a patient or family member acts aggressively towards them (DeKeyser Ganz & Berkovitz, 2012; Oh & Gastmans, 2015). Nurses' responses to moral distress include an array of emotions and feelings, such as anger, anxiety, depression, guilt, powerlessness, loss of confidence, as well as a range of physical symptoms including crying, loss of appetite, insomnia, headaches, heart palpitations, and vomiting (Wiegand & Funk, 2012). In light of this, moral distress is now generally accepted within the profession as a common and troubling phenomenon

experienced by nurses (Corley, 2002; McCarthy & Gastmans, 2015). Although moral distress has garnered significant attention in recent years, conceptually it is still evolving, and there have been slight variations of the use of the concept in the literature (Deschenes et al., 2020; Hameric, 2012; McCarthy & Gastmans, 2015). Despite the conceptual ambiguity, moral distress is generally associated with negative consequences for patients, nurses, and organizations (Corley, 2002).

There are many reasons for the significant and sustained interest in the concept of moral distress in nursing. For example, the current socio-political context of healthcare, which is underpinned by a business focus and efficiency models, is associated with an increase in the moral distress of health professionals (Doane & Varcoe, 2013; Varcoe et al., 2012). Beyond that, patient care is becoming increasingly complex, due in part to limited resources, technological advances, changing demographics, and competing demands (Ulrich & Grady, 2018; Walton, 2018). More recently, the onset of the COVID-19 pandemic in 2020, which continues to strain healthcare systems globally, exacerbated the moral distress of nurses practicing in clinical settings (Riedel et al., 2022). As patient care becomes increasingly complex and healthcare turns its focus to efficiency models of care, nurses are required to make decisions about which care they prioritize over others and, at times, compromise on what they perceive to be “good” patient care given these constraints.

A colleague provided an example from their training on Lean Management Principles (Bertagnolli, 2022) about how the focus on doing more with less has affected the prioritization of certain aspects of patient care over others. They described how the trainees were asked to imagine that a ball was a patient within the hospital and they were tasked with passing the ball around as quickly as possible with each one of them touching the ball and passing it on to the

next. They stood shoulder-to-shoulder in a circle and passed the ball from one person to another. They were asked to do it faster and faster and faster. Each time they got closer and closer together. The demonstration was intended to highlight that when working closely as a team, the team is more efficient, and the patient can move more quickly within the hospital. We were stuck by how this approach to patient care focused so heavily on efficiency at the expense of nurturing and developing relationships with patients. Beyond our own impression of this event, research has shown that, for nurses, caring is at times, incompatible with efficiency demands in providing health services (Simone, 2004).

The clinical arena is fraught with thorny ethical issues (Ulrich & Grady, 2018) and the prevalence of moral distress in the clinical environment has garnered significant interest from researchers. Further, there has been a significant and sustained interest in the moral distress of nurses in research because many nursing researchers, including myself, have experienced moral distress in clinical practice, making the decision to pursue research in this area deeply personal (e.g., Rodney, 2013). When reflecting on our clinical practice as nurses, we remember the experiences, good and bad, that changed us, not just as nurses but also as people. As nurses, we often remember the good experiences but are unable to let go of the bad experiences; these are the stories that haunt us (Rashotte, 2005) – this is moral distress.

1.2.2 Moral Distress of Undergraduate Nursing Students

Andrew Jameton (1984) first noticed what he coined “moral distress” among the UNSs he was teaching. However, research on moral distress in this population has not garnered the same attention (Sasso et al., 2016); even Jameton himself did not pursue this line of enquiry. His groundbreaking book, *Nursing Practice: The Ethical Issues* (1984), which first introduced the concept of moral distress in nursing practice, is focused on in-hospital staff nurses rather than the

UNSs from which he was inspired. Furthermore, a 2016 systematic review on the moral distress of UNSs sought to include all articles published on the topic between 2004 and 2014, yet the researchers located only four such studies (Sasso et al., 2016). In the last five years however, there has been a slight increase in the volume of published literature on this topic. These more recent studies predominantly used quantitative designs (Rabori et al., 2019) in contrast to the studies conducted greater than five years ago that were predominantly qualitative (Sasso et al., 2016).

1.2.2.1 Understanding the Concept of Moral Distress in Undergraduate Nursing Students. Identifying the body of literature about the moral distress of UNSs is challenging because of the conceptual ambiguity that persists on the concept of moral distress in general. Some researchers use frameworks through which the moral distress of UNSs is considered a stand-alone experience, while others include it as an outcome of an experience, the difference being that in the former, the experience itself was morally distressing and, in the latter, the experience caused moral distress as an outcome of an experience. When researchers consider moral distress to be an outcome, they use concepts such as professional dilemmas (e.g., Rees et al., 2015), ethical issues, and ethical challenges (e.g., Rabori et al., 2019) as antecedents to the experience of moral distress. Further, some authors do not use the term moral distress specifically, instead opting to use terms such as ethical problems, despite conceptual similarities (e.g., Erdil & Korkmaz, 2009). Research where the authors conceptualize the moral distress of UNSs as an experience in and of itself (e.g., Escolar Chua & Magpantay, 2019) are easier to identify because it is a central tenet of the article with the term moral distress located in the title of the article. When moral distress is viewed as a stand-alone experience, it is defined as an

experience where individuals feel constrained in some way and they are unable to act in ways that align with their values and beliefs (Duschenes et al., 2020).

The antecedents of moral distress in UNSs identified in the literature are diverse. Reasons include a disconnect between nursing education and nursing practice, feelings of powerlessness, witnessing or being a part of perceived unethical or unprofessional behaviours of healthcare professionals, deficiencies in health services, inadequate support, taking care of patients with health disparities, lack of attention to patient's rights, giving patients insufficient information, inappropriate communication with patients, breaching patient confidentiality, and perceived mistreatment by clinical instructors and nurses (Escolar & Chua, 2018; Escolar, Chua & Magpantay, 2019; Rabori et al., 2019; Reader, 2015; Rennó et al., 2018; Sasso et al., 2016). Further, when UNSs experience moral distress, they may have difficulty coping because of their limited clinical work experience, poor self-confidence, inadequate professional judgement, and limited ethical knowledge and training (Comrie, 2015).

Despite the relatively few studies on the moral distress of UNSs, conclusions drawn from them are remarkably similar, with UNSs particularly vulnerable to moral distress during clinical placements (Bickhoff et al., 2017; Reader, 2015; Sasso et al., 2016). The reasons that UNSs are particularly vulnerable to moral distress have not been largely explored. In one study, UNSs were found to be at a higher risk than all other health professional students to witness or be asked to participate in situations or events that put a patient's safety or dignity at risk (Monrouxe et al., 2014). Situations or events that put a patient's safety or dignity at risk may violate the UNSs' values; this puts them at risk of experiencing moral distress (Duschenes et al., 2020). Additionally, this vulnerability may be linked to their status as learners in the clinical environment. As learners, UNSs have multiple people and organizations to which they are

accountable. Conflicting relationships with these groups have been identified as a prominent source of moral distress in nurses (Huffman & Rittenmeyer, 2012; Källemark et al., 2004). Nurses may have multiple accountabilities: patients themselves, physicians, other healthcare practitioners, their manager, the organization, or their regulatory body (Huffman & Rittenmeyer, 2012; Lamiani et al., 2017). UNSs feel a particularly strong sense of accountability to their patients (Lindh et al., 2008; Reid-Searl et al., 2009), and they are aware of their status as “guests” in the clinical environment (O’Mara et al., 2014). Recognizing that what happens during a clinical placement may differ from what is taught in classrooms (Raso et al., 2019), UNSs might try to fit in and conform to practices that conflict with their own values (Bickhoff et al., 2017; Grealish & Trevitt, 2005). They may do this out of fear of being reprimanded or “blacklisted” by other clinical professionals (Reader, 2015). UNSs also count their clinical instructor and educational institution among the entities to which they are accountable, which creates further potential for conflict and rendering UNSs particularly vulnerable to moral distress (Rennó et al., 2018; Wojtowicz et al., 2014b). UNSs are aware that at the end of their clinical placements, they are graded as satisfactory or not satisfactory. Therefore, UNSs may be fearful of doing anything that could jeopardize their relationship with their clinical instructor because of the clinical instructor’s capacity to pass or fail them (Reid-Searl et al., 2009). These multiple and potentially conflicting relationships may make UNSs particularly vulnerable to experiencing moral distress during clinical placements.

1.2.3 Limitations of Research Focused on Moral Distress

Moral distress in nurses and UNSs in clinical settings represents a valuable and compelling area of research. To date, most research on the topic focuses on the negative consequences of moral distress. Researchers are beginning to recognize the narrowness of this

view, and are advocating for a more balanced approach to future work (McCarthy & Deady, 2008; Pauly et al., 2012; Rodney, 2017). A limited and negative focus on moral distress perpetuates narratives that unilaterally categorize nurses as oppressed or powerless to affect situations that contribute to their moral distress (McCarthy & Deady, 2008). Further, although Andrew Jameton (1993) has since updated his original definition of moral distress to include initial and reactive distress, many authors have used and continue to use his original definition of moral distress to underpin research done on this topic. As research on moral distress has grown, it has become apparent that Jameton's (1984) original definition of moral distress implies that what an individual believes to be right or wrong originates from an individual's values – however, the source of the individual's values is not made explicit in his writings (Thomas & McCullough, 2015). As a result of this, most writing on moral distress includes the assumption that the individual's values are only influenced by the individual and excludes any contextual influences, such as culture, gender, race, experience, and the larger environment. Understanding of moral distress without accounting for external influences is in line with a dominant discourse in bioethical literature of an autonomous individual. When individuals are considered to be autonomous, they are independent from the social world around them (Carnevale & Weinstock, 2011; Taylor, 1991).

Research on moral distress has frequently been taken up within the framework of individuals as autonomous beings, whether intentionally or not. As a result, most of this research has centered on the individual experience of moral distress, such as the sources of and the bio-psycho-social responses to nurses' moral distress. Interventions to prevent, reduce, or mitigate moral distress within this framework also focus on the individual, without accounting for the context. This is problematic because if moral distress is located solely within the individual, then

the experience of moral distress is strictly the result of character flaws (Varcoe et al., 2012). In this light, there is a perception that nurses may be constrained from acting in a way that aligns with their values and beliefs because they lack confidence, for example. Interventions would therefore seek to identify ways to increase the confidence of nurses. This view, however, does not consider the broader factors at play, such as inadequate human resources, that contribute to or affect moral distress.

1.3 Problem Statement

In order to overcome the aforementioned challenges of research about the moral distress of nurses and UNSs that is focused on the individual, I have opted to use a relational lens to understand the moral experiences of UNSs more broadly. The precedent for this approach has been established by a small number of researchers (e.g., Elmore et al., 2018; Hunt & Carnevale, 2011; Ma et al., 2020; Passos dos Santos et al., 2019) who similarly sought to better understand the diversity of experiences nurses live while challenging the discourse that nurses are powerless in clinical settings. A relational lens acknowledges and considers the context in which people live, moving beyond the individual as an autonomous agent. Attending to moral experiences, rather than strictly moral distress, in clinical practice provides the opportunity to explore a wider range of realities and better reflects the diversity of experiences that occur when providing patient care. Further, embracing the range of moral experiences acknowledges the moral distress of nurses, while simultaneously expanding inquiry to help shift nursing's disciplinary narrative from one of hopelessness to one of possibilities (Ma, 2018; Rushton, 2017). When reviewing existing literature, I did not identify any articles published on the moral experiences of UNSs during or outside of clinical placements. UNSs represent the future of nursing clinicians and yet

a significant gap exists in our understanding of their moral experiences during clinical placements.

1.4 Research Purpose

The purpose of this study was to examine clinical placement-related moral experiences of UNSs and the ways in which these moral experiences shape them as learners. By engaging with UNSs on the topic of moral experiences in clinical placements, I hope to highlight the processes at play that contribute to the complexities of clinical nursing education in such a way that accounts for the relational dimensions at play.

1.5 Research Questions

1. What are the moral experiences of undergraduate nursing students in the context of clinical placements?
2. What are the relational dimensions of undergraduate nursing students' moral experiences in the context of clinical placements?
3. How do undergraduate nursing students incorporate their moral experiences into their learning process?

1.6 Format and Outline of the Dissertation

This dissertation represents the consolidation of one doctoral research study. It is intended to be read like a monograph that presents an interpretation of the moral experiences the UNS participants generously shared with me. The components of the thesis comply with the University of Ottawa Academic Regulations. Chapter 1 is the introduction, chapter 2 presents a review of the literature, chapter 3 presents the research methodology, chapter 4 presents the results, and chapter 5 presents the discussion.

Chapter 2: Literature Review

A literature review looks broadly at concepts that provide a context for grounded theory. In this case, the contexts for looking at the moral experiences of UNSs are: registered nursing education, relational ethics, nursing as moral practice, and power. More specifically, registered nursing education represents the functional context, where I provide a historical overview of nursing education in Canada, as well as the current components of Canadian baccalaureate nursing programs. This history and current snapshot of the program format provides information for those seeking to understand the context in which this study took place. The remaining three components of this chapter – relational ethics, nursing as moral practice, and power – represent the sensitizing concepts. Charmaz (2014) describes sensitizing concepts as a starting point to help the researcher explain the conceptualization of their ideas and arguments. These sensitizing concepts are not intended to be tested, or imposed on the data, but instead give researchers initial ideas and directions to pursue, as a place to *start* inquiry, not to confine, commandeer, or end it (Charmaz, 2014). As a person, nurse, and researcher, the concepts of relational ethics, nursing as a moral practice, and power resonate both with me and my research. These are my sensitizing concepts that will provide a starting point for the ways in which I thought (and think) about the moral experiences of UNSs.

Therefore, this review will be divided into two parts. In the first half, I will describe registered nursing education in Canada. In the second I will present the literature available on relational ethics, nursing as a moral practice, and power, specifically focusing on literature that looks at the concept within the context of UNS education.

2.1 Registered Nursing Education

Currently, there are nursing designations in Canada other than registered nurse. These include licensed practical nurses/registered practical nurses, registered psychiatric nurses, and nurse practitioners. The background information presented here is focused specifically on registered nurses because the participants in this study were in a program that led to their licensure as registered nurses. It is important to describe the structure of nursing education to better understand the context in which UNSs are immersed during their learning. Nursing education has been shaped by historical events that affect the way nursing education is delivered today.

2.1.1 History of Nursing Education in Canada

The history of nursing education in Canada is often attributed to the development of the first nursing school in 1873 under Florence Nightingale's model of nursing education, as her model most closely reflects formalized nursing education as it exists today. Nursing education in Canada, however, predates European settlement in North America (Saarinen, 2008). In Canada, Indigenous healers and midwives provided care to members of their communities (Benoit & Carroll, 2005). As Europeans settled in Canada, they brought with them their ideologies of medicine and the people who provided healthcare. The provision of healthcare activities that we now think of as nursing activities were the responsibility of women because of the belief that caring for the health of others was innate to them; women were naturally caring and nurturing, therefore, they did not need to be educated to do "what comes naturally" (Saarinen, 2008, p. 17).

Formal nursing education in Canada was introduced in the 1600s by Roman Catholic nursing sisters who initially trained in France (Saarinen, 2008; Violette, 2005). Over the next 200-300 years Catholic nursing sisters developed and operated a large network of nurse-run

hospitals where they educated new nuns to provide nursing care (Paul, 2005). It was not until later in the 1860s that Florence Nightingale developed the first school of nursing at St. Thomas Hospital in London, England (McDonald, 2010). This was a year-long program that involved didactic teaching, as well as supervised clinical experiences, which helped solidify nursing as a respectable occupation for women (Almost, 2021; Okrainec, 1989). Despite the development of this nursing educational program, Florence Nightingale considered nursing to be a vocation one was born to do, with many of the skills thought to be innate to women (Butcher, 2013). It is important to note, however, that Nightingale's vision of nursing has been criticized from a colonial standpoint (D'Antonio, 2022). Nightingale's belief that nursing skills were innate to women did not extend to all women. Rather it was limited to middle-class white women, a belief that reflected the global, colonizing roots of healthcare that placed middle-class white women at the apex of a racialized hierarchy within the nursing profession (D'Antonio, 2022).

It was only a short while later, near the end of the 19th century, that formalized nursing education programs were introduced in Canada (Olfert, 2012). The first hospital-based diploma school in Canada was founded in 1873 by Dr. Theophilis Mack at the St. Catharines General and Marine Hospital in Ontario (Gibbon & Mathewson, 1947). This educational model rapidly spread across Canada, but, with such rapid growth and no regulatory oversight, the quality of education varied and admission standards declined (Bramadat & Chalmers, 1989; Kirkwood, 2005). These nursing programs used a hospital-based apprenticeship model where students worked in hospitals as part of the labour force while under the supervision of staff nurses (Saarinen, 2008).

The first nursing degree program offered in Canada was at the University of British Columbia in 1919 (Canadian Nurses Association (CNA), 1968). It was a five-year program that

incorporated both classroom and clinical components (CNA, 1968). Around that same time, the Canadian Association of Trained Nurses, a professional nursing association representing nurses that later became the Canadian Nurses Association, recommended that nursing education in Canada transfer from hospital schools into the educational system of each province because of growing concerns about the quality of nursing education (Mansell, 2004; Pijl-Zieber et al., 2014). This recommendation was met with resistance over the next few decades because of the fear that an increased focus on academic development would come at the expense of the practical skills needed to provide patient care (Mansell, 2004). In the 1960s there was an increase in the national accreditation of nursing educational programs. Around that same time, in 1960, Dr. Helen Mussalem, president of the CNA, commissioned a nationwide study that found only 16% of schools met the CNA's accreditation standards (Pijl-Zieber et al., 2014). Despite this research, which identified that many hospital-based nursing programs lacked quality education with students receiving inadequate instruction and working excessively long days, resistance to moving nursing programs into colleges and universities persisted (Mussalem, 1960). Beyond improving the quality of individual nursing programs, the move from hospital to school-based programs was also motivated by the belief that it would increase the social legitimacy of nursing and advance nursing's role and position in the healthcare system (Baumgart & Kirkwood, 1990; Kirkwood, 2005).

2.1.2 Becoming a Registered Nurse in Canada

Over time, nursing practice shifted from a religious vocation to a profession in the pursuit of professional legitimacy (Bates & Memel, 2021; Ruby, 1999). Similarly, nursing education has moved from being unregulated and unpredictable to regulated and organized (Ruby, 1999). Although initiated in 1957, it was not until 2007 that the baccalaureate degree as a requirement

for entry to practice was fully realized across Canada (Pijl-Zieber et al., 2014). In Ontario, the requirement to obtain a baccalaureate degree came into effect in 2005 (College of Nurses of Ontario, 2018a). Currently, to become a registered nurse in Canada, with the exception of the province of Quebec, individuals must complete an approved four-year baccalaureate nursing program. An approved program means that the program has met or exceeded the requirements set out by provincial regulatory bodies. In Quebec, there are three available options for nursing education; the first is a three-year college diploma, the second is a three-year university baccalaureate degree, and the third is a Master of Science (Applied) in Nursing. Further, graduates of accredited nursing programs must pass a licensing exam to become eligible to apply to the regulatory college of their respective province or territory to obtain their designation as a registered nurse. In all provinces, with the exception of Québec, new graduate nurses must pass the National Council Licensure Examination – Registered Nurse [NCLEX-RN] before they can apply to become registered nurses. The NCLEX-RN is a multiple-choice examination that is intended to test entry-to-practice competencies of prospective registered nurses (College of Nurses of Ontario, 2023). In Québec, nursing program graduates write the *Ordre des infirmières et infirmiers du Québec*'s professional examination to obtain their professional designation (Almost, 2021).

2.1.3 Becoming a Registered Nurse in Ontario

In Ontario, where this study took place, individuals seeking to become registered nurses must complete a baccalaureate nursing program, the Bachelor of Science in Nursing, at a college or university. Currently, the program needs to be approved through the College of Nurses of Ontario (CNO), the provincial governing body for registered nurses, registered practical nurses, and nurse practitioners. It has only been since 2020, in response to the shortage of registered

nurses in the province, that colleges have been allowed to develop and offer nursing programs independent of universities (Government of Ontario, 2020). Previously, colleges offered collaborative nursing programs that were affiliated with universities.

Beyond completing an approved nursing program and passing the NCLEX-RN, graduates must show evidence of recent nursing practice, pass the registered nurse Jurisprudence Examination, be proficient in English or French, be authorized to work in Ontario, pass a criminal record check, and declare any health conditions that would make them unfit to practice. Once these criteria are met and licensure is granted, the individual is a registered nurse (College of Nurses of Ontario, 2014).

2.1.4 Nursing Program Approval and Accreditation in Ontario

Provincial regulatory bodies, such as the College of Nurses of Ontario (CNO), have overarching entry-level competencies that graduates from nursing programs are expected to meet. Entry-level competencies refer to the knowledge, skills, judgement, and attributes new graduates need in order to practice safely and ethically (Canadian Council of Registered Nurse Regulators, 2018; Canadian Nurses Association, 2015). The CNO, as the provincial nursing regulatory body, has outlined 101 entry-to-practice competencies organized thematically under nine roles: clinician, professional, communicator, collaborator, coordinator, leader, advocate, educator, and scholar (CNO, 2020). The CNO evaluates entry-to-practice based on its program approval framework and standards that look at the curriculum, structure, and outcomes of the program (CNO, 2022). The CNO does not dictate how baccalaureate nursing programs are expected to meet those criteria. Therefore, there can be variation in the actual delivery of the programs across the province. The approval process by the CNO involves a comprehensive review of nursing education programs in Ontario at minimum once every seven years and

includes an annual monitoring process. A program is approved by the CNO when it meets a score of at least 75% and all mandatory indicators (CNO, 2019).

Currently in Ontario, UNSs need to graduate from a nursing program accredited by the CNO to be eligible to register to write the NCLEX-RN licensing examination. Prior to 2020, program accreditation responsibilities were held by the Canadian Association of Schools of Nursing (CASN). Therefore, at the time of data collection from November 2019 – February 2020, CASN rather than CNO accredited the nursing program and curriculum at the post-secondary institution where data collection occurred. Currently, Schools of Nursing may elect to be accredited by the CASN; however, this accreditation is now optional.

The CASN accreditation process consists of a review of both the educational unit delivering the nursing education program, as well as the nursing education program itself (CASN, 2020). There are three educational unit standards and three education program standards against which the educational unit and nursing program are evaluated (CASN, 2020). The three educational unit standards are 1) leadership, governance, and administration, 2) resources and environment, and 3) teaching, learning, and scholarship. The three educational program standards are 1) program framework and curriculum, 2) program outcomes, and 3) quality improvements.

2.1.5 Overview of the Nursing Program Components

This section provides an overview of the components that make up nursing education in Ontario. Bachelor of Science in Nursing programs in Ontario are made up of three components: clinical, simulation/laboratory, and classroom didactic components, which will be presented in terms of their general format since their implementation is not standardized throughout Ontario.

2.1.5.1 Clinical Practicums. Clinical practicums, also referred to as clinical placements, are a form of experiential learning where students gain direct, hands-on experiences in real world settings and opportunities to develop their professional skills, gain confidence, make links between theory and practice, as well as develop self-efficacy and self-awareness through critical thinking and reflection (Kolb, 1984). UNSs' clinical practicums occur in settings where nurses are often employed, such as hospital units, community centers, and long-term care facilities, among others. UNSs immerse themselves in these settings and learn by doing.

2.1.5.1.1 Benefits of Clinical Practicums. Clinical placements make up a significant portion of baccalaureate nursing programs with hundreds of hours dedicated to this learning modality. Research has shown that UNSs perceive clinical placements to be the most influential context in terms of acquiring relevant skills and knowledge; they report it is one of the most important parts of nursing education (Chan, 2001; Myrick et al., 2006). During clinical placements, UNSs apply knowledge, skills, and attitudes learned to unplanned situations as they arise with individuals across the lifespan (Canadian Association of Schools of Nursing, 2015). In addition to the practical skills that UNSs learn during clinical placements, they become socialized to nursing practice in a process called professional socialization – how one learns the implicit cultures, practices, and values of a profession by being immersed in the professional culture (Black, 2014; Salisu et al., 2019). In relation to nursing specifically, Dinmohammadi et al. (2013) defined professional socialization as “a dynamic, interactive process through which attitudes, knowledge, skills, values, norms and behaviors of the nursing profession are internalized and professional identity is developed” (p. 32). Clinical placements, where UNSs are immersed in nursing culture, are essential to the socialization process and a vital component of developing clinical competence (Salisu et al., 2019; Shin et al., 2014). Nurses who are not

adequately socialized to nursing culture may face challenges as they transition into the workforce (Kramer, 1974; Salisu et al., 2019).

2.1.5.1.2 Challenges of Clinical Practicums. Despite the benefits, clinical placements are not without challenges. First, they require significant human and financial resources, including clinical instructors and clinical coordinators. They also rely on the willingness of community partners to take UNSs into their practice setting. Notably, in recent years, nursing educators have faced a shortage of clinical placement availability, an increasing number of UNSs, and challenges related to recruiting and retaining clinical instructors (Larue et al., 2015; Murray et al., 2008). Additionally, education in the clinical environment is dependent on the patient or client cases available at the time UNSs are on site. UNSs may, therefore, not have the opportunity to encounter important types of clinical scenarios (Eyikara & Baykara, 2017). In this sense, the clinical environment is unpredictable and there are many factors that cannot be controlled, such as staff members, unit environment, equipment and supplies, as well as patients and family members (Tiwaken et al., 2015). The unpredictable nature of clinical placements, however, allows UNSs to learn to respond to unplanned situations, an essential part of their preparation for practice (Canadian Association of Schools of Nursing, 2015). Finally, research has shown that clinical placements can be a significant source of stress and anxiety for UNSs, much of which is attributed to the fear of making a mistake while they have someone's life in their hands (Fadana & Vember, 2021; Tiwaken et al., 2015).

2.1.5.1.3 Operationalization of Clinical Practicums in Canada. In Canada, there is no set standard as to the timing, duration, and location of clinical placements (Garrett & MacPhee, 2014; Smith et al., 2013). As a result, the structure of clinical placements in baccalaureate programs varies across the country in terms of the location, duration, and semester/year in which

clinical placements occur (Canadian Association of Schools of Nursing, 2015). Clinical placements are typically made up of a small group of UNSs who work under supervision to ensure patient safety (College of Nurses of Ontario, 2019). Clinical coordinators are often responsible for overseeing multiple clinical groups and ensuring that clinical placements are organized with each UNS getting a placement (Smith et al., 2013). Unlike some experiential learning opportunities, such as cooperative education, UNSs are not paid for their time spent in clinical placements (Grant-Smith & de Zwaan, 2019). Finally, in order to participate in clinical placements, UNSs at some institutions, including the post-secondary institution where data collection occurred, must demonstrate that they have met specific health requirements, such as proof of mandatory vaccinations, and pass a vulnerable sector police record check that identifies any past criminal convictions (Institutional document, n.d).

2.1.5.2 Simulations and Laboratories. Simulation is an interactive teaching method that is widely used in baccalaureate nursing education in Canada and internationally, as well as in other practice-based professions or sectors, such as medicine and aviation (Garrett et al., 2011; Johnson & Patterson, 2006). Like clinical placements, simulation is based on experiential learning where students learn by doing (Bland et al., 2011; Kolb, 1984); simulation allows UNSs to link theory with practice (Eyikara & Baykara, 2017). Variation exists in proposed definitions of simulation; however, they all center on the act of simulating real or hypothetical conditions that happened or could happen in real life (Bland et al., 2011; INACSL Standards Committee et al., 2021a). Simulation is considered a learner-centered, active learning strategy where students develop cognitive and psychomotor skills in a controlled setting (Alinier et al., 2004; Jeffries, 2005). Bland et al. (2011) identified five attributes in their concept analysis that make up simulation as a learning strategy in undergraduate nursing education: creating a hypothetical

opportunity, authentic representation, active participation, integration, as well as repetition, evaluation, and reflection. Learning outcomes of simulations are dependent on the educational needs identified and should be structured into the development of the clinical scenario (INACSL Standards Committee et al., 2021b).

2.1.5.2.1 Operationalization of Simulations. Simulation education is delivered in nursing education through simulated scenarios of people who are acting in specific roles, simulations with the use of mannequins, or virtual simulations (Eyikara & Baykara, 2017).

In simulations with real people, also referred to as standardized patients, UNSs, educators, or other people including paid members of the community act out roles of patients, physicians or family members (Oh et al., 2015). The actors respond in real time based on their developed characters.

Simulations with the use of mannequins have been used in educational settings since the first modern simulator, Sim One, was developed for medical students in the late 1960s (Bland et al., 2011). Today, most mannequins used in nursing education are life-sized and have the technology to simulate many bodily functions. For example, the popular SimMan mannequins have a long list of features and complications they are capable of simulating. To name a few, their chest can rise and fall, they can simulate bleeding, bowel sounds, seizures, and urine output. Additionally, they have many feedback features where UNSs can get measurements such as blood pressure, pulse, and electrocardiogram (ECG) readings. Some mannequins are even capable of simulating childbirth.

Finally, simulations can be done using virtual reality. There are many different products and technologies used to create virtual learning environments, but it is often in relation to computers (Foronda et al., 2020). Virtual simulation is used to give UNSs the opportunity to

work through realistic experiences from diagnosis to treatment on virtually created patients (Padilha et al., 2018).

2.1.5.2.2 Operationalization of Laboratories. Many schools of nursing, including the one at the post-secondary institution where data collection occurred, offer UNSs learning in nursing laboratory settings (Lavoie & Clarke, 2017). In these laboratories, UNSs practice various non-invasive nursing skills such as checking vital signs and doing physical assessments on one another. In these instances, UNSs have the opportunity to hone specific techniques in a controlled environment where they get real life readings and feedback. It also challenges UNSs to work with different bodies of varying shapes and sizes. UNS have Further, UNSs have the opportunity to manipulate and practice using equipment that may be found in the clinical environment, such as intravenous lines, vital sign machines, and stethoscopes.

2.1.5.2.3 Challenges and Benefits of Simulation and Laboratory Delivery Methods. Simulation and laboratories in nursing education has gained popularity in the last few decades because it allows educators to meet specific learning needs in controlled environments. They also provide UNSs assurance that they can make mistakes without fear of harming a real patient.

Research on the use of standardized patients and mannequins specifically has shown that they have a positive impact on improving performance skills and metacognitions (Shin et al., 2019). They are, however, cost and resource intensive when compared to virtual simulation often limiting their use (Shaikh et al., 2017). Virtual simulation is attractive because it does not require the same physical space and human resources (Padilha et al., 2018; Shaikh et al., 2017). The downside to the use of virtual simulation is that while UNSs work through clinical situations, there is no hands-on experiential component (Park et al., 2022; Seropian et al., 2004). Simulations that use real people have a higher degree of fidelity. Fidelity, meaning the accuracy

or degree of realism, can be affected by the scenario, environment, and people/simulators involved (Hayden, 2010; Seropian et al., 2004). The higher the fidelity, the closer the simulation reflects reality. The challenge of practicing with people, however, is that more invasive skills, such as inserting a urinary catheter, cannot be performed because of their invasive nature. Additionally, mannequins have the ability to adjust bodily functions, such as breath sounds, which is not possible with people. Both laboratories and simulations have challenges and benefits. They offer UNSs the opportunity to practice clinical skills and develop their critical thinking in a controlled environment.

2.1.5.3 Didactic Lectures. Didactic teaching has traditionally been a central pillar of educational institutions and is commonly found in classrooms (Graham & Wong, 1993). Didactic lectures are a model of education where an educator actively transmits knowledge in a classroom setting to students who are passive recipients of this knowledge (Merriman et al., 2014). Didactic lectures are commonplace in post-secondary institutions, including nursing programs, where there is one educator delivering course content to a group of students. There are various strategies and techniques that can be used in didactic teaching. In nursing, for example, this can include patient centeredness, intertwining theory and practice, as well as incorporating technology, games, narratives, reflection, and art (Berry, 2009; Crookes et al., 2013; Westin et al., 2015).

2.1.5.3.1 Benefits of Didactic Lectures. Didactic lectures in post-secondary institutions continue to be an attractive approach to education. Lectures are cost-effective and can accommodate large numbers of students at a time (Saunders & Gale 2012). At the post-secondary institution where data collection occurred, for example, the largest lecture hall can accommodate 420 students. This is in contrast to the clinical placements, simulations, and

laboratories described above which require significantly more resources to coordinate and deliver because they have a lower UNS to educator ratio.

2.1.5.3.2 Challenges of Didactic Lectures. Despite their longstanding use in education, didactic teaching has come under scrutiny in recent years. Didactic lectures provide UNSs with theoretical knowledge without hands-on learning that are central features of clinical practicums, laboratories, and simulations. Theory alone is insufficient to prepare UNSs to practice in clinical settings upon graduation (Tiwaken et al., 2015). The gap between theory and nursing practice is well documented, where what is learned in theory is inconsistent with the realities of clinical practice (EL Hussein & Osuji, 2017). As a result, nursing educators are challenged to bridge the gap to help UNSs develop the knowledge, skills, and ethics needed for nursing practice (Benner et al., 2010). Academic ideals learned in the classroom will likely continue to be disconnected from the realities of nursing practice where resources are finite, and the human nature of practice defies the application of universal truths (EL Hussein & Osuji, 2017).

2.2 Relational Ethics

Relational ethics provides a means for thinking about the moral experiences of UNSs as interconnected experiences within a socio-political world (Bergum, 2013; Carnevale, 2013). In this section I explain the origin of this concept, the elements of relational ethics, and how relational ethics is used thus far to understand the moral experiences of nurses and UNSs.

Relational ethics originates from a team of researchers, led by Vangie Bergum and John Dossetor at the John Dossetor Health Ethics Centre, University of Alberta, who sought to identify the ethical aspects of everyday healthcare (Austin et al., 2003). According to Bergum (2013), relational ethics is an ethical framework that focuses on the nature and quality of relationships in all professional practices. It assumes that a moral dimension exists in these

relational spaces in every situation and encounter where one human being relates to another (Bergum, 2013). Ethical practice is more than achieving a desired outcome or resolution based on practice standards, policies and procedures, codes of conduct, and other organizational documents that guide ethical action (Austin et al., 2003). Rather, ethical practice in clinical practice encompasses nurses' commitment to uphold the quality of relationships with each patient, family member, other healthcare professionals, or with administrators and politicians (Bergum, 2013; Levine, 1977). Nursing work is inherently relational in nature because nurses interact with patients, families, healthcare professionals, and others within organizational environments. Relational ethics provides a framework to explore the morality that exists in all relationships and considers how the context shapes and is shaped by these relationships.

Relational ethics emerged in response to the individualistic focus in mainstream healthcare ethics, which is often considered the pinnacle of healthcare ethics (Hawthorne & Yurkovich, 1995; Wright & Bratjman, 2011). This individualist focus illustrates how individuals are autonomous and independent from the social world around them (Carnevale & Weinstock, 2011; Taylor, 1991), but some scholars believe this focus is too narrow to provide an adequate framework to account for the complexity of nursing practice and moral life (Taylor, 1991; Wright & Bratjman, 2011). Relational ethics instead builds on the idea that an individual is autonomous and then reframes healthcare ethics as an interdependent notion (Taylor, 1991; Wright & Bratjman, 2011). From this perspective, individuals are relationally embedded in a socio-political world, as well as in a network of meaningful relationships (Carnevale, 2013).

Relational ethics is an action ethic where human beings act with the intent that actions will lead to goodness and recognize that actions originate from a subjective position (Bergum, 2013). From this subjective position "there is no clear high mountain vantage point from which

to view the situation with complete objectivity. Nor is there clear certainty found in the valley of subjective experiences” (Bergum, 2013, p. 127). In other words, the way we act is bound to the knowledge we have, the experiences we carry, the relationships we hold, and the socio-political world that surrounds us. Austin et al. (2003) make the distinction that an action ethic is less about solving an ethical “problem” and more about appreciating the uncertainty of living and opening dialogue between and among individuals by asking ethical questions. Sometimes, the ethical action is just “being there” with and for oneself and another (Austin et al., 2003, p.46).

There are four themes in relational ethics: environment, embodiment, mutual respect, and engagement (Bergum, 2013). The environment exists both outside and within us, because as Bergum (2013) states, “we are the healthcare system; we are the environment” (p. 129). As nurses and others within the healthcare system respond to care needs, each action affects the system itself. In this light, the healthcare system is an interdependent and complex environment that is akin to an ecological system made up of an interconnected matrix of living things (Peacock, 1999). Embodiment refers to the intersection of the “body as object” and the “body as lived” – the intersection of objectivity and subjectivity, as well as thinking and feeling (Austin et al., 2003; Bergum, 2013, p. 132). To truly know and respect the other, it is important to consider the intersection of the mind and body of their experience (Austin et al., 2003). The third theme, mutual respect, includes respecting both oneself and others (Dillon, 1992). True mutual respect is reciprocal and interactive in nature (Bergum, 2013), as well as universally held irrespective of differences in power, knowledge, beliefs and values, experiences, and attitudes (Bergum, 2013). Engagement, the fourth theme, is about intentionally being sensitive to and vulnerable with another person in order to engage with them in a way that promotes genuine connection (Austin et al., 2003). We can engage with others by being willing to empathize with them and by trying

to understand the world from their vantage point (Austin et al., 2003). Without engagement, nurses may be reduced to disengaged technicians who mechanically perform their daily tasks (Bergum, 2013).

While relational ethics is relatively new, researchers have long acknowledged the importance of relationships in nurses' work (e.g., Gastmans et al., 1998). More recently, relational ethics has been used as a framework for nursing research to open new ways of thinking, inquiring, and addressing the challenges that nurses face in their work (Kunyk & Austin, 2012). For example, a relational ethics framework is used to understand various aspects of nursing practice such as work engagement in nurses (Keyko, 2014), moral distress in nurses (Deschenes & Kunyk, 2020), and nurse leaders' role in medical assistance in dying (Thiele & Dunsford, 2017), among others. Relational ethics is also relevant to the topic of the moral experiences of UNSs during clinical placements, but there is currently no literature that applies this framework to them. During clinical placements, UNSs are not passive nor neutral observers; instead, they become part of the healthcare ecological system as they move within it. In this environment, they engage in relationships whenever they provide care. Relational ethics provides a framework to explore the morality that exists in all relationships and to consider how they shape and are shaped by the environment in which they occur. A relational framework is not only appropriate but necessary to understanding the complex web of relationships that UNSs navigate in their everyday practice.

2.3 Nursing as a Moral Practice

To consider nurses as having moral experiences, it is important to position nursing as a moral practice. In this section I describe what makes nursing a moral practice and what is known about the moral experiences both of nurses and of UNSs.

Drawing on the work of earlier European philosophers and anthropologists, Gastmans et al. (1998) laid the foundation for understanding nursing as a moral practice. In nursing practice, nurses enter a relational space with an individual or a group of individuals who are situated in a specific time and place (Gastmans et al., 1998). Within this space, nurses are asked to make decisions to achieve as much good as possible, where “good” care encompasses not only the skillful execution of clinical tasks but also accounts for the physical, relational, social, psychological, moral, and spiritual aspects of a person’s being (Gastmans et al., 1998).

Gastmans et al. (1998) describe two important characteristics of nursing as a moral practice. The first is that nursing is not based on general truths that are constant across individuals but is instead based on a particular caring context where all individuals and groups of individuals are distinct (Gastmans et al., 1998). The application of nursing knowledge, also referred to as the art of nursing, uses both nursing knowledge and personal insights to make decisions about what “good” care is in a particular context (Johnson, 1991). The art of nursing challenges the myth that the caring process is a neutral practice; instead, nurses use their judgement in each care situation based on multiple sources of knowledge to achieve as much good as possible (Gastmans et al., 1998). The second characteristic of nursing as a moral practice is that nurses are not disengaged technicians whose practice can be evaluated merely by the value of its efficiency, but rather on the good sought (Gastmans et al., 1998). Nursing practice cannot be reduced to its instrumental context; instead, it is characterized by the ability to make moral choices that aim to achieve as much good as possible in each care situation (Gastmans et al., 1998). Therefore, the quality of nursing care needs to consider the relationship between the nurse and patient that is situated in time and space (Gastmans et al., 1998).

The caring relationship between nurse and patient/client is the foundation upon which nursing as a moral practice can be understood (Gastmans et al., 1998). As nurses enter a relational space with their patients who are situated in a specific time and space, nurses come to know their patients. Through a process of choice and deliberation, nurses make moral judgements about care practices based on their understanding of each relationship. In this sense, nursing is a morally loaded undertaking founded on the reciprocal relationship between individuals.

2.3.1 Moral Experience of Nurses

Gastmans et al. (1998) published their article *Nursing Considered as Moral Practice: A Philosophical-Ethical Interpretation of Nursing* approximately 25 years ago. Since then, it has been cited over 200 times. Most research on the moral experiences of nurses has sought to understand a specific moral experience within a particular clinical context or in relation to a specific clinical scenario. For example, the moral distress of nurses in critical care units has received much attention in published literature (e.g., Forozeiya et al., 2019; Henrich et al., 2017; McAndrew et al., 2018). It would be both unfeasible and undesirable to provide a summary of existing literature on specific moral experiences across all clinical environments and scenarios. Merging these findings together would imply a degree of consistency across all moral experiences and all settings and situations. It would be counterproductive to attempt to identify universal truths and does not align with my philosophical perspective of the world and how it can be known. Moral experiences are dependent on relationships and the context in which they occur. For example, the moral experiences of nurses working in critical care settings may be different than those working in community settings. Similarly, they might also be different depending on the situation even if the context is the same. Nurses' experiences, for instance, of

working on a birthing unit might differ when caring for a mother delivering a baby who is born with a life-limiting illness compared to another who became pregnant after years of infertility. Below, I describe research about the moral experiences of nurses more broadly. This will help identify what contexts and settings have been looked at through a lens of moral experiences and will highlight gaps in our understanding of them.

I searched CINAHL, PubMed (medline), EMBASE, and PsycINFO (OVID) databases and located six articles and two theses about the moral experiences of nurses in specific settings or situations (Cooper, 1990; Elmore et al., 2018; Ma et al., 2020; O'Connor, 1991; Pang, 1998; Passos dos Santos et al., 2019; Rashotte et al., 2011; Wright et al., 2015). I did not set any date limitations but restricted my search to English and French articles. Based on my knowledge of existing literature, I identified one additional thesis (Wong, 2018). Although Wong (2018) did publish their thesis results in a peer-reviewed journal (Wong et al., 2020), the concept of “moral experiences” was absent; therefore, the thesis was retained while the article was excluded. In addition to these, I found two articles that were relevant; however, based on the presentation of results, the experiences of nurses could not be distinguished from those of other healthcare professionals and were therefore not retained (Fernández Basanta et al., 2022; Hunt, 2009). In total, I identified nine studies: three theses, five primary studies, and one meta-synthesis. Two of the primary studies were based on graduate study theses, in these cases, where both publications (article and thesis) were available, only the published articles were retained and the theses were not included (Ma et al., 2020; Wright et al., 2015). The meta-synthesis of qualitative research by Elmore et al. (2018) focused on nurses’ moral experiences of assisted death. Although the authors retained 14 studies for their meta-synthesis, none of these were included in the 9 articles/theses identified above because they focused on the experiences of nurses rather than the

moral experiences of nurses. The authors of the meta synthesis then interpreted the data with the assumption that “nurses experiences are moral experiences” (Elmore et al., 2018, p.958). I did not locate any associated publications in peer-reviewed journals for the three included theses. The dates of publication ranged from 1990 to 2020, all were in English, and the studies were conducted in Canada, the USA, and China. Notably, of the nine studies and theses identified, six of them include researchers who have or have had direct links with the University of Ottawa. There was a significant amount of overlap in the care context in which moral experiences were explored, with five of the nine studies focusing on assisted death, palliative care, and end of life care (Elmore et al., 2018; Ma et al., 2020; Rashotte et al., 2011; Wong, 2018; Wright et al., 2015). Within these five studies, there was a range of situations and clinical environments explored that included a pediatric unit, a hospice, and a community hospital, with the two remaining studies not limited to one specific unit. Outside of the care contexts, however, there was little overlap between the studies. The remaining four studies looked at the experiences of pediatric nurses (Passos dos Santos et al., 2019), oncology nurses (O’Connor, 1991), critical care nurses (Cooper, 1990), and experiences of nurses as it related to information disclosure (Pang, 1998). Given the heterogeneity in the care context, environment, and situations, even among the studies exploring care at end of life, more research is needed to better understand the moral experiences of nurses in other settings.

2.3.2 Moral Experiences of Undergraduate Nursing Students

With only nine studies identified, there is little published research aimed at understanding the moral experiences of nurses broadly in the clinical environment. A search of the same databases, CINAHL, PubMed (medline), EMBASE, and PsycINFO (OVID), identified no articles or theses on the moral experiences of UNSs. Similar to the research on nurses, however,

research about specific types of moral experiences, such as moral distress, moral courage, and moral resilience within the UNS population exists. Some examples include research on the moral distress of UNSs in mental health settings (Wojowicz et al., 2014b) and the moral courage of UNSs who complete advance directives with homeless persons (Nash et al., 2016).

There are relational aspects of clinical practice that affect the experiences of UNSs, including the multiple and at times competing demands on them, their strong sense of accountability to their patients, and their status as guests in the clinical environment. As a result, the moral experiences of UNSs may be different from those of practicing nurses and yet no research has been done in this population. At present there is a gap in our understanding of their moral experiences during clinical placements.

2.4 Power

Power is an important concept to consider when exploring moral experiences of UNSs because UNSs navigate multiple relationships where power is exercised in the context of clinical placements. Late French philosopher Michel Foucault is well known for his work on power, breaking from traditional conceptualizations that position power as a negative and repressive force held by those in a position of authority that evokes ideas of prohibition, punishment, and the imposition and enforcement of laws (Holmes & Gastaldo, 2002; Perron et al., 2005). Foucault instead offers a (somewhat) radical perspective, describing the concept as a productive force (Foucault, 1990; McHoul & Grace, 1993). Foucault's reconceptualization of power breaks from tradition because power:

Neither belongs to a privileged class of wealthy individuals who exercise it on classes of lower socioeconomic status [such as proposed by] (Marx), nor does it belong to people in

positions of legitimate authority at the heart of organizations who impose their decisions upon others [such as proposed by] (Weber)” (Perron et al., 2005, p. 537).

Instead, “Power is employed and exercised through a net-like organization; it is not the property of someone or a group. Power acts upon individuals as they, in turn, act upon others. Therefore, power is relational” (Holmes & Gastaldo, 2002, p. 559). It is precisely the relational aspect of power that is of interest for this study because it helps conceptualize the experiences of UNSs as a product of multiple power relations.

Power is related to knowledge: as Foucault explains, “There is no power relation without a correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations” (Foucault, 1995, p. 26). In this way, power is essential to the production of knowledge and knowledge is essential to the exercise of power – both function to justify and legitimize the other (Foucault, 1980; Holmes & Murray, 2011). This particular emphasis on the relationship between power and knowledge is equally important to understanding the relational dimension of power. It helps us understand how we come to value and legitimize certain forms of knowledge over others, prioritize practices, or define what is right or wrong, among others.

2.4.1 Bio-Power

As the world population grew over the 17th and 18th century, new forms of power emerged to “regulate life, to manage it in its most intricate forms” (Perron et al., 2005, p. 537). Foucault defines these new forms of power under a single, multipronged concept: *bio-power*. As Smart (2002) eloquently puts it, “the emergence of bio-power designated the moment at which the complex phenomena of human existence were submitted to the calculation and order of knowledge and power” (p. 103). Foucault describes bio-power as having two complimentary

poles: *anatomo-politics* and *bio-politics* (Foucault, 2003; Perron et al., 2005). *Anatomo-politics* is about the exercise of power over individual bodies, while *bio-politics* is about the exercise of power over populations (Smart, 2002). For purposes of this research project on UNSs, only the anatomo-political pole is discussed below because of its link to disciplines (e.g., nursing) and the institutions in which power circulates (e.g., hospitals).

2.4.1.1 Anatomo-Politics: Disciplinary Power. According to Foucault (1995), anatomo-politics is the dimension of bio-power that is concerned with power over the life of the body, and which has as a goal the optimization and realization of its capacities (Smart, 2002). In other words, bio-power looks at power as a productive force that “made possible the meticulous control of operations of the body, which assures the constant subjection of its forces and imposed upon them a relation of docility–utility” (Foucault, 1995, p. 137). This imposition of order is manifested through disciplinary power. The technologies through which disciplinary power is achieved are hierarchical observation, normalizing judgement, and examination (Foucault, 1995).

Training of bodies through disciplinary technologies is what produces the intricate docility-utility relation (Foucault, 1995). This relation symbolizes the “creation of submissive, yet skillful, docile bodies” so that the body operates in a productive and desired way (Perron et al., 2005, p. 538). The first, hierarchical observation, denotes the link between visibility and power, where architectural/spatial/interpersonal configurations are designed to allow for the constant surveillance of subjects by an authority (Perron et al., 2005; Smart, 2002). Configuring a space so that all subjects can be “seen”, permits the observer to “know” them while also imposing on them a form of self-regulation, a result of *believing* they are being observed (Holmes & Murray, 2011; Smart, 2002). The second disciplinary technology is normalizing

judgement, where a system of micro-penalties is exercised to enforce normative behaviours by rewarding/punishing conformity/non-conformity (Smart, 2002). In the military, for instance, subordination is rewarded (e.g., by rank advancement) and insubordination is penalized (e.g., loss of rank). The final disciplinary technology is examination, which combines hierarchical observation and normalizing judgement, so that individuals can be classified and judged (Smart, 2002). Through the examination of individuals' abilities and knowledge, the examiner seeks to "know" the individual and ensure conformity (Perron et al., 2005). An example of the use of examinations is in the school system where students' knowledge is tested at regular intervals based on a set of expectations. Students are awarded a grade to establish their performance against their peers. When students are not successful, they may be asked to meet with the teacher and are expected to change their behaviour and establish learning plans in order to improve their performance.

2.4.1.2 Disciplinary Power and Undergraduate Nursing Students. According to Ball (2019), Foucault's work has been extensively taken up in the field of education. Primarily, his work is used to understand the mechanics of schooling as a disciplinary technology (Deacon, 2006). Educational institutions are described as "sites for training bodies to behave in socially sanctioned ways" (Cooks & Warren, 2011, p. 211). In other words, schools are institutions of social control that are relatively unchallenged in modern society (Hope, 2016). Despite the known relevance of disciplinary power in the context of nurses and students generally (Ball, 2019; Perron et al., 2004), its application in nursing education research is more limited.

The most relevant published literature I identified on the use of disciplinary technologies in nursing education is a 2001 nursing doctoral study conducted in the USA. Coverston (2001) undertook an exploratory, qualitative, and critical study, underpinned by feminist methodology,

to uncover issues of power in the experiences of UNSs. In total, the author conducted semi-structured interviews with 20 UNSs. Despite being published over 20 years ago, the findings are still relevant given that the structure of nursing education remains relatively unchanged. In this section I will describe what is known about the use of disciplinary technologies in nursing education in the clinical setting based on the findings of this study.

In terms of hierarchical observation, Coverston (2001) described the clinical environment as the context in which UNSs are the most visible throughout their education since they are identified through the use of name tags, specific uniforms, or other mechanisms. As a result, others in the clinical setting (physicians, nurses, allied health professionals, their clinical educator, patients, families, and others) know that they are learners and not registered nurses. According to their findings, regardless of whether or not the UNSs were being observed, they believed that they were. The constant belief of being observed felt by the participants in Coverston's study is linked to Foucault's (1995) discussion of Jeremy Bentham's concept of the panopticon. Coverston (2001) found that several of the study participants acted in an enlightened way because they believed they were being observed (panoptic observation) and based their actions on a fear of the potential punishment or reward, rather than on their own beliefs.

From a normalizing judgement standpoint, the participants rotated through various clinical placements, transitioning from one clinical instructor to another and thus constantly navigating what was expected of them by others. When the participants did not meet expectations, they were subjected to micro-penalties to improve their conformity with expected outcomes, which included being asked to leave the clinical setting, given an unsatisfactory grade on part of their clinical evolution, or being threatened with failing the clinical placement altogether (Coverston, 2001).

Finally, from an examination standpoint, Coverston (2001) found that their participants expected to be evaluated as part of the nursing program but a surprising number were unaware that the school of nursing used their clinical evaluations to track their achievements and failures. These evaluations made up what was known about each UNS so that they could be classified and judged, and ultimately, trained into nurses.

2.4.2 The Knowledge/Power Dyad

In today's world where infinite ways of being are possible, Foucault sees the materialization of the knowledge-power dyad through the concept of discourses that come to govern our ways of knowing and being in the world (McKenna & Wellard, 2004). To state this more simply, discourses exist in relationship to their socio-political context (Creek & Porter, 1997). Discourses are more than the language used to speak about the world; they also create the frame that constrains the infinite possibilities of thinking and acting that serve to structure realities (Drewery, 1998; McKenna & Wellard, 2004). In a Foucauldian sense, dominant discourses that constrain our ways of thinking and acting are a product of relations between knowledge and power; they serve to create both hierarchies of knowledge and groups (Cheek & Porter, 1997; Rudge et al., 2011).

2.4.2.1 Knowledge, Power, and Nurses. Foucault's work highlights the distinct relationship between the accumulation of knowledge about people, and how this knowledge is used to better control them (i.e., their conduct or thoughts). From a structural (discursive) perspective, knowledge stemming from dominant discourses greatly influences people's everyday experiences. According to Peter et al., (2004), several authors have written about nursing as a female dominated profession, where nurses individually and collectively embody passivity, submission, and obedience. This focus on nurses as powerless is due, in part, to the

profession's historical relegation to a subservient role within healthcare organizational structures (Keddy et al., 1986; Ruby, 1999). As such, nurses have long been subject to healthcare hierarchical constraints that continue to permeate the workplace (Russell, 2012). These hierarchical structures, where nurses find themselves feeling powerless and their knowledge devalued (Davis & Fowler, 2018), create normative expectations that are internalized by nurses. In this way, nurses may become complicit in accepting their subservient role within these hierarchies and less likely to resist the exercise of power (Peter & Liaschenko, 2013). A salient example of this is the power dynamics between nurse and physicians, which has been described as the "doctor-nurse game", that continues to define this relationship (Darbyshire & Thompson, 2018; Holyoake, 2011). Nurses preserve the "omnipotence" of physicians by abiding by the norms of niceness and silence (Darbyshire & Thompson, 2018, p. 1). Alternatively, and in response to the powerless narrative in nursing research, some authors have published on nurses' capacity to exercise power (Peter et al., 2004). Often from a Foucauldian perspective (Holmes & Murray, 2011; Perron et al., 2005), this conceptualization helps to understand the complex relations at play in thinking about nurses' work and what they experience.

2.4.2.2 Knowledge, Power, and Undergraduate Nursing Students. The concepts of knowledge and power are relevant for understanding the moral experiences of UNSs, but the relationship between them in the UNS context is not well understood (McKenna & Wellard, 2004). Nevertheless, there are a limited number of studies that make implicit links to the knowledge-power relationship in the UNS population.

UNS are often socialized to believe that nurses are respected members of the healthcare team (Peter & Liaschenko, 2013). They come into nursing school with a set of expectations about their role, and their education furthers the belief that nurses are valued, trusted, and

respected. However, when UNSs begin clinical placements, they are exposed to what is coined a “hidden curriculum”, one that is not taught during lectures, but possesses tremendous power to shape the behaviour of learners (Hafferty, 1998, p. 403). The hidden curriculum refers to the learning that occurs during interactions with patients, faculty, healthcare professionals, and other individuals who are influenced by the organizational, structural, and cultural environments embedded in the clinical area (Gaufberg et al., 2010). Through this hidden curriculum, UNSs become socialized to the realities of everyday practice where different discourses come to constrain the way they see themselves and the world around them. Expectations of efficiency, performance, and professionalism, among others, create tensions between what is taught in class and what is learned during clinical practicums (Bickhoff et al., 2017; Cantrell et al., 2005; Steven et al., 2014). According to Kramer (1974), UNSs subjected to this paradox come to the difficult realization that professional ideals and values often go unfulfilled and unrewarded in clinical practice. Further, UNSs report how, within healthcare hierarchies, they “stand powerless beside the powerless” (Zerwekh, 1990, p. 23). Although this quote is from over 30 years ago (around the time Jameton defined moral distress in nursing), recent research indicates that not much has changed in the UNS narrative (Bickhoff et al., 2017). UNSs continue to perceive their role within hierarchies in the clinical environment as being that of *just* a (nursing) student (Bickhoff et al. 2017; Reader, 2015).

Much like the general literature on power in nursing, a few authors have written about the power that UNSs exercise; it is often referred to in terms of empowerment (e.g., Bradbury-Jones et al., 2010; Bradbury-Jones et al., 2007; Mailloux, 2006). This body of evidence is useful for understanding what this concept means for UNSs and how empowerment is fostered. Empowerment is defined as “a social process of recognizing, promoting and enhancing people’s

abilities to meet their own needs, solve their own problems and mobilize the necessary resources in order to feel in control of their own lives” (Gibson, 1991, p. 359). Empowerment, however, has only indirect applicability to understanding the power that UNSs exercise in the context of clinical placements because the social process of empowerment is in relationship to oneself, rather than in relationship to others. The only direct reference to power within a relationship in the clinical context I found, as it relates to UNSs, was in an article written by Bickhoff et al. (2017). They found that UNSs were aware that they exercised power in relationship to patients and how their actions had the potential to cause psychological and physical harm to them (Bickhoff et al., 2017). The authors also identified instances where UNSs demonstrated moral courage, the capacity to overcome fear, and action based on one’s values and beliefs despite the associated risks (Bickhoff et al., 2017). The knowledge of what the UNSs considered to be “good” practice helped them to see when patient care deviated from acceptable standards, compromising patient safety (Bickhoff et al., 2017). UNSs used this knowledge to fuel their ability to exercise power and speak up against – or refuse to participate in – poor practices (Bickhoff et al., 2017). Notably, the consequences of speaking up or refusing to participate in poor practices were not always positive and included being ostracized and/or experiencing horizontal violence, although some UNSs used strategies to attempt to mitigate these negative consequences (Bickhoff et al., 2017).

As evidenced by literature on the topic, UNSs are both subjects and objects of power. They are subjects of power to the extent that they use knowledge to govern the conduct of their patients. They are objects of power in that they are subject to disciplinary technologies and their practice is constrained by formal and informal norms and discourses of the university and the organizations in which they have clinical placements.

2.4.3 Power in the Context of Moral Experiences

The concept of power is central (albeit implicitly) in the literature on the specific moral experiences of UNSs (e.g., moral distress, moral courage, moral resilience). More precisely, while the term “power” is infrequently used by authors or UNSs themselves, the findings of these studies reflect my understanding of the concept. For example, in a recent literature review on the moral courage of UNSs (Bickhoff et al., 2017), the power differential between registered nurses and UNSs was the most common theme identified by the authors, despite the limited explicit use of the term in the included studies (Bickhoff et al., 2017). Similarly, Lindh et al. (2008) found that UNSs’ roles as patient advocates within the clinical environment equally fostered experiences where they felt empowered (Lindh et al., 2008). This seemingly conflicting positionality speaks to various dimensions of power, where UNSs are both objects and subjects of power.

Current literature on the specific moral experiences of UNSs challenges readers to consider the interplay and effects of power in the context of relationships (Peter et al., 2004). This is in part because differences of power in relationships have direct or indirect ethical implications for patients, healthcare professionals, and the community (Peter et al., 2004). UNSs are new to the clinical environment and are trying to find their way, their place, and their voice – all while trying to conform to what is expected of them to pass their courses. Navigating these relationships where they are both subjects and objects of power is challenging for UNSs and worthy of exploration.

2.4.4 Relational Ethics and Power

The sensitizing concepts for this study are relational ethics and power. Specifically, I rely on Bergum’s (2013) articulation of relational ethics and Foucault’s (1995) work on power to

frame my understanding of these concepts. These were purposefully chosen to inform a conceptualization of the moral experiences of UNSs that accounts for the relativist nature of reality embedded within a socio-political world.

A relational ethic assumes that individuals are relationally embedded in a socio-political world, a network of meaningful relationships (Bergum, 2013; Carnevale, 2013). As a result, the ways in which people exist in the world are influenced by their relationships and the social context in which these relationships are embedded (Mackenzie & Stoljar, 2000). It is important to consider the ways in which these relationships empower and constrain action and the kinds of choices individuals make (or can make) (Rodney et al., 2013; Sewell, 1992).

A postmodern stance on power, such as the work by Foucault, similarly considers that all things exist in a state of relativism (Wilkinson, 1999) and can help to articulate the ways in which relationships empower and constrain action. Foucault's (1995) work on the knowledge and power dyad is relevant to understand how knowledge is produced through relations of power in the context of UNSs during clinical placements. In light of this, the knowledge individuals acquire, including UNSs, is constrained by dominant discourses that favour forms of knowledge while others are marginalized (Phillips et al., 2021). Knowledge acquisition is not a neutral activity whereby UNSs accumulate knowledge in an upwards trajectory. Instead, UNSs' knowledge is shaped by the relationships and the quality of these relationships that exist in the clinical environment. Further, Foucault's (1995) work on biopower, which looks at power as a productive force using disciplinary technologies, helps us to consider the mechanisms and social structures that shape the experiences of UNSs as learners.

I posit that relational ethics and power complement one another, rather than one being in service of the other. Relational ethics according to Bergum (2013) and power according to

Foucault (1995) are both relational in nature. While relational ethics is not directly concerned with power, power is exercised in all relationships. A relational understanding of power informs the ways in which power is exercised in these relationships and how these relationships are influenced by structures of power. When looking at the moral experiences of UNSs, this understanding allows us to better understand the ways in which power influences how UNSs relate to themselves, to others, and to institutions.

Chapter 3: Methodology

3.1 Qualitative Research Design

I used a qualitative design to explore the moral experiences of UNSs during clinical placements. Qualitative research is vital to the advancement of health knowledge; it provides an important contribution to the development of policy and practice changes because it can enrich our understanding of clinical phenomena and stimulate discussions that account for multiple views of the same phenomena (Macdonald & Carnevale, 2008). In the context of this study, qualitative research offers a means to better understand the moral experiences of UNSs during clinical placements. Additionally, my philosophical beliefs about the world and how it can be known align with the ontological and epistemological assumptions of qualitative research. These assumptions are discussed below in the section titled *Constructivist Grounded Theory* where I describe these philosophical assumptions in relation to constructivist grounded theory, the methodology used for this study.

3.2 Grounded Theory

Grounded theory is a widely used qualitative research methodology and is a significant source of scientific knowledge in nursing (Benoliel, 1996; Mills et al., 2006b). Since it was first introduced in 1967 by Barney G. Glaser and Anselm L. Strauss, the proverbial fathers of grounded theory and creators of what is now called classic grounded theory, the methodology has been approached from a variety of ontological and epistemological positions (Mills et al., 2006a). Two salient reformulations, one by Corbin and Strauss, called Straussian grounded theory, and the other by Charmaz, called constructivist grounded theory, have since been offered as alternatives to classic grounded theory. Grounded theory in its simplest form is the discovery, development, or construction of a theoretical understanding about issues, processes, or

phenomena that are important in individuals' lives (Charmaz, 2014; Corbin & Strauss, 2015; Glaser & Strauss, 1967). As a qualitative methodology, grounded theory is particularly useful when exploring new areas of research by challenging existing knowledge of what is known and expanding and generating new ideas (Charmaz, 2014).

3.2.1 Theoretical Underpinnings of Grounded Theory: Symbolic Interactionism

Grounded theory is a research methodology rooted in the symbolic interactionist theoretical perspective that was developed to study social phenomena (Charmaz, 2014; Eaves, 2001). Symbolic interactionism and grounded theory methodology complement each other to create an open-ended theoretical perspective; they work together to create a cohesive whole (Charmaz, 2014). Symbolic interactionism was originally coined by sociologist Hubert Blumer (1969); it is a theoretical perspective about human behaviour where human actions construct the self, situation, and society (Charmaz, 2014; Chenitz & Swanson, 1986). It focuses on the meaning that events have for people, as well as the language and symbols used to convey the meaning of those events (Baker et al., 1992). Symbolic interactionism assumes that to construct meaning, individuals have a self-concept and can communicate with their "self"; this allows them to act in response to their interpretation of a situation (Blumer, 1969; Charmaz, 2014). There are three basic premises of symbolic interactionism according to Blumer. The first is that "human beings act toward things on the basis of the meanings that things have for them" (Blumer, 1969, p. 2). The second premise is that "the meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows" (Blumer, 1969, p. 2). The third premise is that "meanings are handled in, and modified through an interpretative process used by the person in dealing with the things he [sic] encounters" (Blumer, 1969, p. 2). Symbolic

interactionism is a dynamic theoretical perspective, a way of knowing that inspires theoretically driven research; grounded theory provides the tools to drive this research (Charmaz, 2014).

3.2.2 Constructivist Grounded Theory

I considered constructivist grounded theory, as proposed by Charmaz (2014), to be the most appropriate methodology to answer the research questions for this study. Constructivist grounded theory is underpinned by a relativist ontology and a subjectivist epistemology (Mills et al., 2006a). A relativist ontology, as articulated in constructivist grounded theory, assumes a belief in multiple realities that are constructed; realities are social constructions of the minds and as such, there can be as many constructions of reality as there are individuals (Charmaz, 2014; Guba & Lincoln, 1994). Each reality is constructed within a culture at a specific moment in time and within social and structural contexts (Charmaz, 2014). In other words, there are multiple individual realities that are influenced by context (Mills et al., 2006a). A subjectivist epistemology in constructivist grounded theory emphasizes the inseparability of subjectivity and social existence (Charmaz, 2014). The researcher is therefore an integral part of the construction and interpretation of data with participants; in this way, the researcher becomes part of the findings (Charmaz, 2014). My own experiences as an UNS were a strong motivator for pursuing research on this phenomenon. This subjective bias is accepted, even embraced, because of the contribution, understanding, and enrichment it can bring to data collection and analysis (Streubert & Carpenter, 2011). As researchers, we create data with our participants, we decide what we see as significant in the data and describe what is happening (Charmaz, 2014). Therefore, data are constructed as a product of the research process rather than as an objective representation of reality (Charmaz, 2008a).

The aim of constructivist grounded theory is to construct an interpretive understanding of phenomena that accounts for context (Charmaz, 2008a, 2008b). The knowledge created from constructivist grounded theory has the potential to transform practice and social processes; these transformational processes should influence what researchers study and how they study it (Charmaz, 2014). By using constructivist grounded theory, the focus of this study is to construct an interpretive understanding of the moral experiences of UNSs (what is happening) and why they happen (why is it happening) by making patterns visible within their experiences. Further, this methodological approach contributes to and encourages the emergence of new thinking and knowledge about the moral experiences of UNSs during clinical placements.

3.3 Research Setting

The setting for this study is the Bachelor of Science in Nursing program at a public university located in Ottawa, Canada. The Bachelor of Science in Nursing has been accredited by the CNO. The post-secondary institution where data collection occurred is the largest bilingual (English-French) university in the world, with approximately 45,000 students enrolled, of which about 85% are undergraduate students. This university offers a four-year baccalaureate nursing program in both French and English where UNSs experience in-class, laboratory, simulation, and clinical education. Baccalaureate nursing programs are offered independently through the university where data collection occurred as well as in collaboration with a local college. A second-entry program is offered for students who complete all necessary prerequisites and are accepted into the Bachelor of Science in Nursing program. These students complete the required second-year nursing classes during the summer and join the four-year baccalaureate program cohort in the Fall of their third year of the program. The second-entry program is not currently accepting applications; however, it was available at the time of data collection. Students who

successfully complete the Bachelor of Science in Nursing are eligible to write a licensure exam to become registered nurses all provinces and territories with the exception of Quebec.

At the time of data collection, UNSs began their clinical placement in the second year of the program; this is when they are introduced to hands-on patient care. I have outlined each of the areas of practice and hours allocated for each clinical placement at the study institution in Table 1 below.

Table 1

Areas of practice and hours allocated for each clinical placement

Clinical placement areas of practice	Hours allocated for each clinical placement
Introduction to nursing practice	117
Adult medicine	
Mental health	
Maternity	
Children's medicine	
Community health	
Complex care	234
Consolidation (various locations)	336
Program total	1272

Except for consolidation, six to eight UNSs are paired with one clinical instructor for each clinical placement. The clinical instructor is someone who has knowledge of the specific practice area; therefore, it is typical that UNSs have different clinical instructors for each clinical placement area. For clinical placements in-hospital, the clinical instructor is present on the unit with the UNSs at all times and is actively involved in their learning. There is also a clinical coordinator who is assigned to multiple clinical placement groups. The clinical coordinator is not actively involved in the UNSs' day-to-day learning; however, they visit each of their assigned

clinical groups at least once during the clinical placement to speak with the UNSs and get feedback from them about their placement to date. During in-hospital clinical placements, UNSs are assigned to one or more patients for whom they are responsible. The number of patients assigned to an UNS can go as high as what would be considered a usual patient load for the unit on which they were practicing; this number can vary depending on the acuity of the unit. Staff nurses provide support for UNSs in collaboration with the clinical instructor.

Placements in the community are different in that clinical instructors are not always present with their group of UNSs. Although UNSs have more independence from their clinical instructor in the community, they typically work more closely with those who work, volunteer, or live where the community placement is located. Consolidation is the final clinical placement in the fourth year of the nursing program. For consolidation, unlike all other clinical placements, UNSs can request specific locations and areas of practice. Placements are subject to availability and some locations, such as pediatric units and critical care units, require a minimum grade point average and/or reference letters. For consolidation, UNSs are paired with a preceptor who is a nurse working in the clinical area. UNSs follow their preceptor's work schedule, meaning they might be in placement during days, evenings, nights, and weekends.

3.4 Participant Recruitment

The inclusion criteria for this study were: 1) current enrollment in the Bachelor of Science in Nursing program at the post-secondary institution where the Research Ethics Board approval was received, 2) 18 years of age or older, 3) ability to speak and read in English or French, 4) started or completed at least one clinical placement with direct patient care; and 5) willing to speak about their moral experiences within the context of their clinical placements.

Individuals who did not meet all the inclusion criteria and those who were unable or unwilling to provide informed consent were excluded.

I used a two-pronged approach to recruit participants. First, I put up recruitment posters (Appendix A) in both English and French around the campuses of the post-secondary institution where I received Research Ethics Board approval. Each recruitment poster had 12 detachable tabs that contained my name and email address so that UNSs could take my information and contact me at their convenience. Additionally, I reached out to two professors who were teaching an UNS course who both gave me permission to speak to their class (Appendix B). One class was the third year English Professionalism and Ethics class, while the other was the fourth-year French Complex Care class. I spent 5-10 minutes in each class and spoke about my research from the recruitment speech I prepared in both English and French.

I provided a monetary incentive (value of \$20) and parking reimbursement to participants who were interviewed due to its positive effect on recruitment (Edwards et al., 2009). The amount of \$20 was chosen to compensate UNSs for their time without causing undue coercion. Parking was reimbursed when applicable so that participants incurred no financial burden for their participation in the study.

3.5 Participant Sample

The question of sample size in constructivist grounded theory is not straightforward due to its dependency on multiple variables, that is, the research aim, homogeneity of participants, quality of the data obtained, nature of the topic, and resources available (Green & Thorogood, 2004; Morse, 2000). Theoretical sampling is used to seek and collect data to develop and delineate the theoretical properties of the categories of the emerging theory (Charmaz, 2014). Theoretical sampling continues until theoretical saturation is achieved, which is when no new

properties of the established categories are found and categories account for the patterns in the data (Glaser, 1978; Holton, 2007; Wiener, 2007). More plainly, the relationships between categories in the theory have been defined, checked, explained, and account for the range of variation within and between these categories (Charmaz, 2014). Theoretical saturation was pioneered within grounded theory and remains a cornerstone of this methodology (O'Reilly & Parker, 2013). A challenge of theoretical saturation, especially for a novice researcher, is that it requires the researcher to be self-critical about saturation throughout data analysis (Charmaz, 2014). This is because saturation is a judgement made by the researcher and not a predetermined point at which sampling can stop and saturation is certain (Wiener, 2007). It was, therefore, not possible to determine a specific number of participants *a priori* because theoretical saturation is based on judgement rather than a fixed number of participants to achieve sufficient power for statistical analyses (Charmaz, 2014). A range of participants was more appropriate in this case to allow greater flexibility during the research process while still adhering to a recognized standard. Determining a sample range based on a recognized standard both minimizes the risk that potentially important information is missed if the sample size is too small, and that data collected becomes redundant and participants are recruited unnecessarily, causing them undue burden, if the sample is too large. Charmaz (2014) does not offer direction or a specific range of participants during which theoretical saturation is frequently achieved. John Creswell (2007), a prolific author of quantitative, qualitative, and mixed methods approaches, recommends including between 20-30 participants in order to develop a well-saturated grounded theory. I used this 20-30 participant range to guide the number of participants recruited.

A total of 24 UNSs consented to participate in the study. All participants voluntarily completed a brief demographic survey at the end of the interview so that the sample could be

described (see Table 2). Of the 24 participants who were interviewed, 23 of the interviews were retained for data analysis. One interview was excluded from data analysis, including participant demographics, after it had been conducted because the moral experiences shared related to their experience of providing patient care in the context of their employment rather than during their clinical placement.

Table 2
Participant demographics

		Total (23)
Language of interview	English	15
	French	8
Age in years	18-24	20
	25-34	1
	35-44	1
	Over 44	1
Gender*	Woman	18
	Man	5
Race/Ethnicity	Aboriginal (Inuit, Métis, North American Indian)	-
	Arab/West Asian (e.g., Armenian, Egyptian, Iranian, Lebanese, Moroccan)	3
	Black (e.g., African, Haitian, Jamaican, Somali)	1
	Chinese	2
	Filipino	1
	Japanese	-
	Korean	-
	Latin American	1
	South Asian	-
	South East Asian	-
	White (Caucasian)	15
	Other _____	-
Year of study (in nursing)	2	-
	3	10
	4	13
Previously completed any post-secondary certificates, diplomas, or degrees	No	20
	Yes	3
Previously worked in the healthcare sector**	No	9
	Yes	14

* Gender was asked as an open-ended question. If a participant wrote male or female, it was converted to man or woman in the findings. This decision was made align with the language of gender rather than sex, because the researcher did not check the participant's biological traits.

** Employment included: personal support worker, pharmacy assistant, medical receptionist, health care aide, physician, physiotherapy assistant, and camp nurse. Three participants had held more than one type of employment in the healthcare sector.

Theoretical saturation was achieved after approximately 14 interviews. After this time, the stories shared by UNSs varied but the patterns in the data could be accounted for in the established categories. Therefore, no new categories were developed after interview 14. Interviews 15-23 served to further enrich and delineate the properties of the established categories. In March 2020, the post-secondary institution where data collection occurred closed its doors to in-person activities following the onset of the COVID-19 pandemic. I was in the process of scheduling interviews for four potential participants but ultimately, in collaboration with my thesis co-supervisors, I decided to close recruitment after the 24th participant and not interview these four. We felt confident that we had achieved data saturation and were unsure of the impact of the pandemic on subsequent participants and their interviews.

As a novice researcher, determining whether I had achieved theoretical saturation was a challenging and circuitous process, necessitating several rounds of back and forth between the data and my categories as I constructed a theory that was grounded in the data. In constructivist grounded theory, the constructed theory reflects an interpretation of the data, and coming to terms with this in “reality” rather than just in “theory”, was difficult because it meant that I needed to be confident in my interpretation of the data. To mitigate this challenge, I received support from my thesis co-supervisors and thesis advisory committee members. They reviewed portions of transcripts and provided feedback on iterations of the constructed categories to help keep the theory grounded in the data.

3.6 Data Collection

Prior to the interviews, I developed a semi-structured interview guide (Appendix C) with open-ended questions; I also included probing questions in the interview guide to gather additional information. I developed the semi-structured interview guide by drawing from my

own experiences as an UNS, drawing from the relational ethics and power theories that inform this study, reading published theses that were focused on UNSs, and receiving feedback from my thesis co-supervisors. The interview guide consisted of eight primary questions; three of the primary questions had additional prompting questions if needed. I did not always ask all eight questions during each interview; however, I did conclude each interview by asking the participants if they had any information they wanted to add. I conducted individual semi-structured interviews that lasted from 44 to 147 minutes each, with the average being 75 minutes. I conducted all interviews in various private rooms on one of the three university campuses. In total, 15 of the retained interviews were conducted in English and 8 in French, based on the participant's preferences. Further, I audio recorded all interviews after receiving written consent to do so and transcribed them verbatim. Interview data consisted primarily of verbal data, that is, what could be heard. I wrote down descriptive data of non-verbal cues and my preliminary thoughts and impressions on paper either discreetly during or immediately following the interviews. This additional data supplemented and provided context to the verbal data.

Finally, since data is constructed by both the researcher and participant, the researcher needs to be aware of power differentials between them (Mills et al., 2006a). The participant should be in a more equal position of power, which requires that researchers be cognizant of adopting a non-judgmental position and reflexive of the position of power that they inherently have because of the nature of the relationship between researcher and participant (Mills et al., 2006a). In order to minimize power differentials between myself and the participants, I had the participants choose the location of the interview to demonstrate to them that I trusted them and were willing to meet them where they were most comfortable. Further, I made a conscious effort to establish a position of empathic neutrality and mindfulness to help develop a trusting

relationship between each participant and myself. Empathic neutrality and mindfulness are strategies used where the interviewer seeks to understand the participant without judgement and be fully present in mind and body during data collection (Patton, 2015). I practiced being fully present by turning my phone off and keeping my mind focused on the interview. Finally, the \$20 incentive was provided to participants at the beginning of the interview so that there was no expectation of participation. The quality of data is dependent on researcher competency (Patton, 2015; Polit & Beck, 2012) which is why, as a novice researcher, it was important for me to be thoughtful and thorough in preparation for the interviews.

3.7 Data Analysis

The ontology and epistemology that underpin constructivist grounded theory influence how grounded theory is done, or rather, how an understanding of the data is *constructed*. As Charmaz (2014) notes, constructivist grounded theory tries to maintain the core elements of grounded theory – the inductive, comparative, emergent, and open-ended approach to research – yet seeks to resist the procedural or mechanical application of its methods. Constructivist grounded theory offers methodological tools that can be used rather than prescriptive recipes to follow and there is no one size fits all at any point during the research process (Charmaz, 2014). This highlights the flexibility of grounded theory as a methodology and avoids what Glaser considers the “forcing” of data. However, Charmaz (2014) warns that with flexibility comes ambiguity, and thus the researcher who takes on a constructivist grounded theory study must be willing to tolerate uncertainty during the research process.

In the context of this study, data analysis began during the interviews themselves and concluded during the final edits of the results chapter. During the interviews, the semi-structured format allowed me to delve into ideas that emerged during the interviews. As the interviews and

data analysis progressed, I began to see patterns within participants' stories that influenced the probing questions I asked in subsequent interviews. To familiarize myself with the data throughout analysis, I conducted and transcribed all interviews and read the transcripts at least three times. I began transcribing the interview audio recording following my first interview and continued to transcribe throughout and following the conclusion of all interviews. Once an interview was transcribed, I used NVivo 12, a qualitative data analysis software to organize and categorize the data.

I used a three-phased approach to data analysis as proposed by Charmaz (2014). These phases are tools intended to be used flexibly rather than as a rigid set of rules. The first phase, initial coding, was used to create provisional and comparative codes to help me explore the theoretical possibilities that could be discerned in the data. During initial coding, I was critical of my data by looking for tacit meanings and identifying significant processes by following the questions Charmaz asks of the data such as: "What process(es) is at issue here?", "How does this process develop?", and "When, why, and how does the process change?" (Charmaz, 2014, p. 127). During the second phase, focused coding, I synthesized, analyzed, and conceptualized larger segments of data. Focused coding helped to advance the theoretical direction of my analysis and construct more conceptual codes than during initial coding (See also Glaser, 1978). The initial codes that made the most analytical sense to categorize my data were then compared against one another in a process where some of the initial codes were coded again. As Charmaz (2014) proposed, I asked questions of my data such as: "What do you find when you compare your initial codes with data?", "Which of these codes best account for the data?", and "What do your comparisons between codes indicate?" (pp. 140-141). I then developed categories from the focused codes. To move from codes to categories, I decided which focused codes best

represented what I saw happening in the data and raised them to a tentative conceptual category (Charmaz, 2014). As I progressed through this analytic process, these tentative conceptual categories became more solidified when I began to define the category, explore its boundaries, and understand how it related to other categories (Charmaz, 2014). Finally, sociodemographic data (Appendix D) was analyzed descriptively. For each sociodemographic data point, I calculated the sum of responses received for each question. The entire data analysis process was done with ongoing feedback from my thesis co-supervisors and input from my committee members. Data analysis was an evolving and iterative process and included several renditions of category construction. I coded and re-coded my data on three occasions. The first time, during initial coding, the codes were too literal and specific; the second time they were too broad and vague. The result of the third round of coding is presented here. When the codes were too specific, I developed hundreds of codes because I had not asked the question “What is the participant actually talking about here?” in order to group varying stories with the same underlying themes. When the codes were too broad, they lost their meaning by trying to capture too much of the participants’ experiences. Ultimately, the three renditions of analysis circled around similar ideas or processes but were expressed differently. Being immersed in the data and enduring the circuitous process of constantly coming back to the data gives me confidence that the results presented in this thesis are grounded in the participants’ moral experiences.

Charmaz (2014) asserts that researchers, often unwittingly, bring preconceptions into the research process, although being aware of these preconceptions can actually enrich data analysis. Preconceptions are shaped by class, race, gender, age, embodiment, culture, and historical era. Because the researcher often takes their preconceptions for granted, they may remain invisible and unproblematic to them who may even deny their existence. Charmaz asks that researchers

remain open-minded and follow up on taken-for-granted meanings, assumptions, and tacit rules in participants' lives when collecting data. This process differentiates the method from Glaser's and Strauss', as well as Strauss and Corbin's grounded theories because the researchers' preconceptions might remain invisible in the latter two. If the researcher's preconceptions remain invisible, there is a risk that the researcher assumes there is a singular version of reality that exists between both researcher and participant. By being aware of their preconceptions, the researcher instead constructs a shared meaning and remains open to other versions of reality. To become more aware of my preconceptions, I spent time reflecting during data analysis on my own experiences as an UNS and the privileges I am afforded as someone whose identity sits squarely within the majority of UNSs where I live – a young, healthy, Caucasian, cisgender woman.

3.8 Rigour

Different authors have proposed various standards of rigour for qualitative research (e.g., Beck, 1993; Guba & Lincoln, 1989; Lincoln, 1995; Sandelowski, 1993) and debates between their merits ensued with little consensus achieved (Whittenmore et al., 2001). I have chosen the four criteria for evaluating grounded theory proposed by Charmaz (2014). They are: credibility, originality, resonance, and usefulness. I chose these four criteria because they align with the theoretical assumptions of constructivist grounded theory and attend to the unique features of this methodology (Charmaz & Thornberg, 2021; Chiovitti & Piran, 2003). Further, these criteria have been used by a number of authors who conducted constructivist grounded theory studies (e.g., Lee et al., 2019; Lin et al., 2019; Reyes et al., 2015).

3.8.1 Credibility

Credibility is concerned with the researcher's views and actions in relation to the data to develop a credible study (Charmaz, 2014). Charmaz and Thornberg (2021) state that credibility "begins with having sufficient relevant data for asking incisive questions about the data, making systematic comparisons throughout the research process, and developing a thorough analysis" (p. 315). I sought to achieve credibility in multiple ways throughout the research process. I became intimately familiar with the moral experiences of UNSs by collecting sufficient data and immersing myself in this data during collection and analysis. Additionally, I collected rich data by asking the participants to share their perspectives and understanding of their experiences. Finally, I transcribed all interviews verbatim and presented participant quotes throughout the findings to illustrate the constructed categories in their own words.

3.8.2 Originality

Originality refers to the insights made of a new phenomenon, or the new understandings made of a known phenomenon (Charmaz & Thornberg, 2021). The present research study is original in the sense that it sought to bring a new way of understanding the experiences of UNSs during clinical placements. I have a good awareness of existing literature on the specific types of experiences, such as moral distress, of UNSs because of the reading I have done on this topic. My research findings both challenge and extend current conceptualizations of this phenomenon in the literature. I identified no other studies conducted on the moral experiences of UNSs during clinical placements.

3.8.3 Resonance

Resonance means that the constructed theoretical understanding represents the experiences of the participants and provides insight for others who share their circumstances

(Charmaz, 2014; Charmaz & Thornberg, 2021). I sought to achieve resonance by speaking with my thesis co-supervisors and committee members to obtain other perspectives on the data; they were all UNSs themselves and interact with UNSs regularly in their work. Further, I moved beyond the details of individual stories to understand what was happening and reveal taken-for-granted meanings. The developed categories have been raised to a higher level of abstraction that encompasses the moral experiences of UNSs in a way that transcends individual stories. All UNSs should be able to see themselves and their moral experiences reflected in the theoretical understanding constructed from the data.

3.8.4 Usefulness

Usefulness refers to the relevant contribution the research makes to the studied phenomenon within the targeted setting and sample (Charmaz & Thornberg, 2021). In order to give the reader information about the study participants, I provided detailed descriptive information gathered from the sociodemographic questionnaire. I also provided a description of the post-secondary institution where data collection occurred and the Bachelor of Science in Nursing program to help readers determine if the findings are relevant in their context. Further, from this study I clarified the moral experiences of UNSs, identified new lines of inquiry for future research, and suggested opportunities for improvement in baccalaureate nursing programs. These implications all have the potential to affect the everyday worlds of UNSs both at the post-secondary institution where data collection occurred and beyond.

3.9 Ethics

I received approval from the Research Ethics Board (Appendix E) at the post-secondary institution where data collection occurred before recruiting and interviewing participants. In my Research Ethics Board application, I outlined that interviews about moral experiences during

clinical placements may cause the participants emotional discomfort during and/or after the interview. During the interviews, I asked participants to share one or more moral experience that had occurred in the context of their clinical placements. This allowed them to share the story or stories that they were willing to talk about and that were meaningful to them. The resulting stories varied in terms of the emotions solicited and their intensity. The participants shared a range of emotions felt and experiences lived, including ones that were morally challenging. Sharing morally challenging experiences has the potential to trigger a negative emotional reaction. However, the emotional discomfort caused by the interview was unlikely to be greater than what the participants experience in their day-to-day life. Conversely, I identified a potential benefit to participating in an interview; participants may feel relieved and empowered to talk about experiences that they felt have burdened them.

I established support strategies to protect the emotional wellbeing of all participants. I offered optional debriefing after the interview with myself, skipping a question, as well as pausing or stopping the interview at any time. Additionally, I gave all participants information cards (Appendix F) about counselling services available at the Student Academic Success Service at the post-secondary institution where data collection occurred where they could book an appointment to meet with a counselor. This service is free for all current students. Further, because this service is restricted to daytime hours, I also provided the contact information for the Distress Center of Ottawa, which accepts calls 24 hours/day and 7 days/week.

As a researcher conducting this research study, I heard a range of stories, including experiences that were morally challenging. I maintained regular contact with my thesis co-supervisors to help mitigate isolation and allow me to express my emotions in confidentiality. Finally, I completed the Tri-Council Policy Statement: Ethical Conduct for Research Involving

Humans Course on Research Ethics (TCPS 2: CORE) prior to any participant involvement in this study.

3.10 Consent and Confidentiality

I obtained written and verbal consent from each participant at the beginning of each interview. I had the participants sign two written consent forms (Appendix G), one copy for myself and the other for the participant to keep. I emailed the participants the consent form in either English or French before the interview to give them the opportunity to read it without pressure. Before signing the form, I gave the participants time to ask any questions so that consent was free and informed. Further, prior to conducting the interview, I reviewed the consent form and went over the study purpose, potential risks to participating, the duration of the interview, strategies used to maintain confidentiality, and the participant's right to withdraw from the study at any time. Finally, in addition, I also emailed participants a letter of information (Appendix H) that included the purpose of the study, participation (inclusion/exclusion criteria and commitment), financial incentive, my email address, and the names of my co-supervisors, Dr. Amanda Vandyk and Dr. Jean Daniel Jacob. The letter of information gave the participants information about the study so they could decide whether they were eligible and willing to participate. Participation in the study did not and will not affect the academic standing of any participants either positively or negatively.

All contact with participants, with the exception of the in-class recruitment presentation and interview itself, was done over email with me only. My email account is password protected and no one else has access to this email account. During recruitment, interested UNSs were asked to contact me by email. My co-supervisors' names and email addresses were provided on the consent form, but no participants reached out to them prior to or following the interviews.

The privacy of individual participants remained confidential during all parts of the research process and will continue to remain confidential following the completion of the research study. I removed all identifiers from interview transcripts and assigned participants a code (participant number) to maintain confidentiality. I used these codes (participant numbers) when quoting participants in the presentation of the results of this research. Further, no identifying information, such as ethnic group, has been or will be disclosed when quoting participants. My thesis co-supervisors (Drs. Vandyk and Jacob) and committee members (Drs. Lalonde and Wright) had access to the transcripts, when needed, with all identifiers removed, during the data analysis stage. The documents with identifying information, specifically the signed consent forms, completed demographic questionnaires, and documents identifying each participant with their assigned code, are kept in a locked filing cabinet in my personal locked cabinet in a locked room in the Center for Research on Health and Nursing at the post-secondary institution where data collection occurred; I am the only person who has access to these documents. These documents will not be published. Electronic records, such as transcripts and audio recordings, have been stored on a password protected hard drive in the same locked cabinet at the post-secondary institution where data collection occurred. When I accessed interview transcripts on my personal computer, I removed all participant identifiers, password protected each interview, and created a password to login into the computer. As approved in the Research ethics board submission, all data will be conserved indefinitely to provide the opportunity for secondary analysis in the future. If in the future I no longer have sole access to the private locked cupboard, all confidential paper and electronic documents will be stored in a locked filing cabinet in a locked room in the Center for Research on Health and Nursing at the post-secondary institution where data collection occurred. If a decision is made that no further

analysis will be conducted with the data, paper documents will be shredded, and electronic files will be permanently deleted.

At the time of data collection, one of my co-supervisors, Dr. Jean Daniel Jacob, was the assistant director for undergraduate programs at the School of Nursing. My co-supervisors and I had initial concerns around the confidentiality of participant identities; because of his administrative role, he might have been able to identify participants. As part of this role, Dr. Jacob interacted directly with UNSs and had access to confidential information whereby he could potentially identify a participant based on the story shared. I spoke with a protocol officer at the post-secondary institution's Research Ethics Board about this concern. Ultimately, because I indicated Dr. Jacob's involvement and administrative role on both the letter of information and consent form that were emailed to UNSs who were interested in the study, the UNSs could decide not to participate or share a story that could identify them to Dr. Jacob. As such, Dr. Jacob's involvement in the research process was not considered to be problematic as it related to the confidentiality of participants.

As a registered nurse, I am a member of the College of Nurses of Ontario, the professional regulatory body in Ontario. In 2018, the College published a document entitled *Mandatory Reporting: A Process Guide for Employers, Facility Operators and Nurses*, which outlines what is mandatory to report based on the role of employer, facility operator, and/or registered nurse. In addition to my self-reporting obligations, as a registered nurse, I am required to file a report if I believe that another healthcare professional has sexually abused a client (CNO, 2018b). In this case, I could no longer guarantee to protect the identity of the participant. However, none of the interview data included any report of sexual abuse of a client.

In the consent form, I asked participants to indicate whether or not they agreed to be contacted via email by me for the opportunity to read their interview transcript and clarify any elements that might be unclear. The purpose of this was to ensure that the participants had continued ownership over their interview data. All participants agreed, and after transcribing the interviews, I emailed them individual password protected transcripts with an invitation to review. I received responses from six participants who made no changes and no clarifications to their transcript.

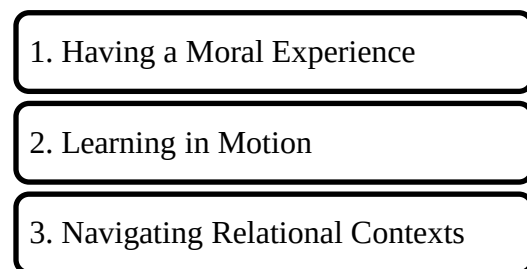
Finally, in the consent form I also asked participants whether or not they agreed to be contacted for a follow-up study should I conduct further research on this topic in the future; all participants agreed. At this time, I have not contacted any study participants for this purpose.

Chapter 4: Results

In this chapter I present the results developed from data analysis. This inductive analysis process led me to construct three categories: 1) having a moral experience; 2) learning in motion; and 3) navigating relational contexts (see Figure 1). All participant quotes have been kept in their original language, French and English, in the results chapter. The researcher's translation from French to English of all included French quotes can be found in Appendix I.

Figure 1

Categories



4.1 Having a Moral Experience

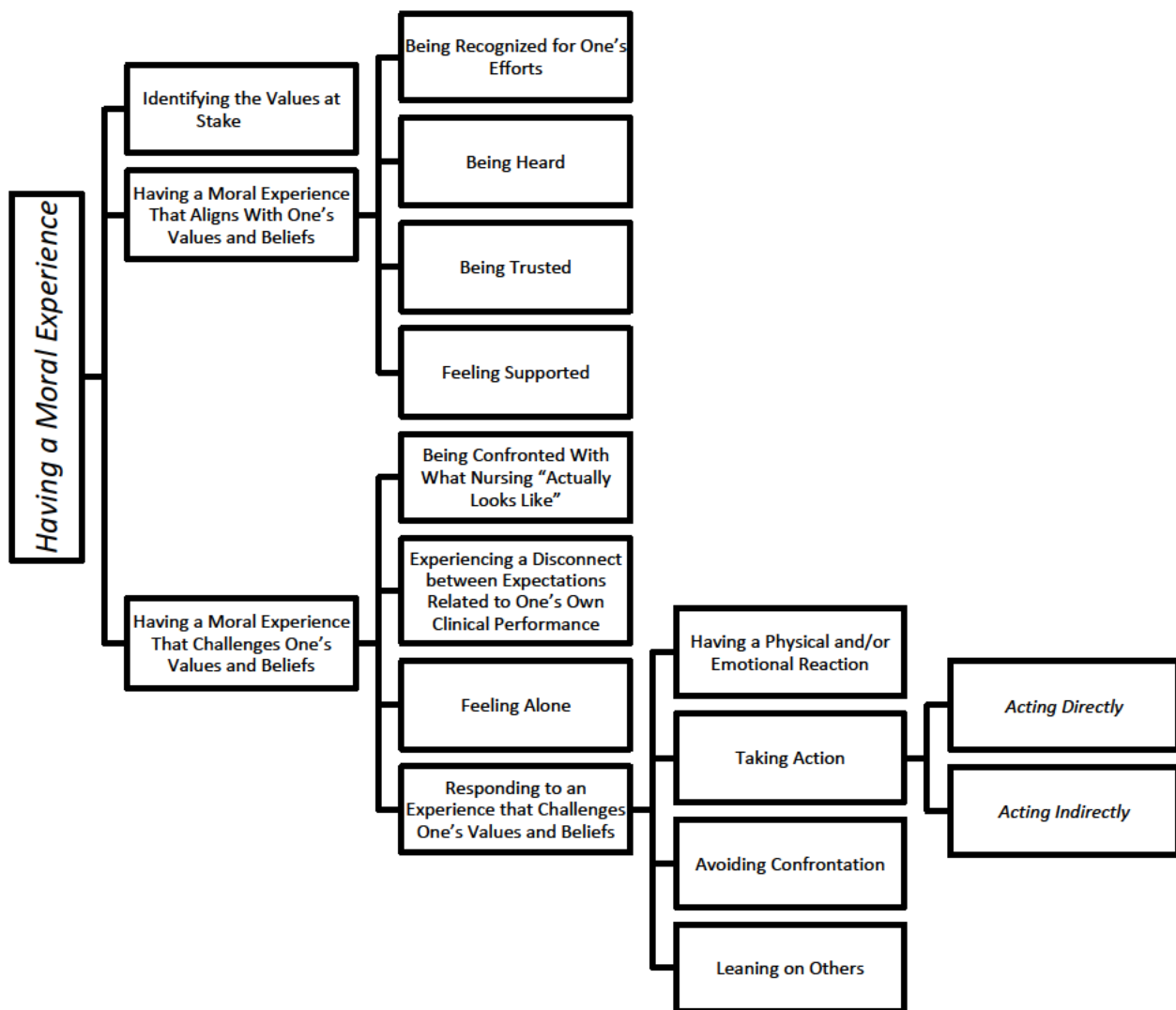
Having a moral experience represents the moral experiences during or in relation to clinical placements that the participants of this study described. Moral experiences are experiences where values are at stake. Within this category, I present having a moral experience that aligns with one's values and beliefs, as well as moral experiences that challenge one's values and beliefs. While these moral events are presented separately, they represent a spectrum rather than dichotomous or disconnected experiences. Further, some of the participants described moral experiences where some elements of the experience both aligned with and challenged their values and beliefs, or what they perceived to be right/wrong, just/unjust, or good/bad. It is important to note that I am not implying all participants shared the same values and beliefs; participants' descriptions of moral experiences are based on their interpretation of the experience

and not on a set of predetermined values against which I interpreted their moral experiences.

This category is made up of the following three sub-categories: 1) identifying the values at stake, 2) having a moral experience that aligns with one's values and beliefs, and 3) having a moral experience that challenges one's values and beliefs. See figure 2 for a visual representation of this category and sub-categories.

Figure 2

Category 1: Having a moral experience



4.1.1 Identifying the Values at Stake

The values that participants most frequently spoke about were: 1) providing safe, compassionate, competent, and ethical care, 2) promoting health and well-being, and 3) honouring dignity. First, the stories that resonated with providing safe, compassionate, competent, and ethical care centered on the participants' engagement in developing relationships with their patients. Many of the participants made conscious efforts to better understand each patient as an individual person so they could better address their needs and concerns. Second, promoting health and well-being was also present in many of the participants' stories. Many spoke about how they carefully attended to their patients' needs to improve not only health outcomes but their experience of receiving care. The participants also worked collaboratively with other healthcare professionals to maximize the health benefits for their patients. Finally, participants shared stories of honouring dignity and respect, which most often focused on treating all people with respect and working with all patients, regardless of social and economic circumstances, without judgement. In practice, this meant that they believed patients were people first with their diagnosis being secondary to who they were.

4.1.2 Having a Moral Experience That Aligns With One's Values and Beliefs

In the context of this study, having a moral experience that aligns with one's values and beliefs means that an experience that occurred during or in relation to a clinical placement aligned with what the participant perceived to be right, just, or good. In order to determine what was perceived to be right, just, or good in that context, participants used their existing knowledge to inform their interpretation of the experience and response to it. This category is made up of the following four sub-categories: 1) being recognized for one's efforts, 2) being heard, 3) being trusted, and 4) feeling supported.

4.1.2.1 Being Recognized for One's Efforts. Being recognized by others for the time, energy, and work that went into the participants' patient care during clinical placements was important and participants spoke about how they spent a lot of time preparing for their placements. For example, they were expected to go to their designated unit the day before in order to gather information about their assigned patient(s). The participants then took this patient information and conducted research to fill any gaps in their knowledge on various aspects of the patient's care, including their diagnosis, medications, and test results, among others. Participant 2 described the extensive preparation they did for their clinical placements "I studied for all of my placements like I was studying for the hardest exam" (P2).

When the participants in this study were recognized by others, especially by their clinical instructors, for their clinical preparation, they felt rewarded for their efforts; the time, energy and work that they had put in to prepare had paid off. The participants anticipated that if they did what was asked of them, then the outcome would align with what they perceived to be right, just, or good, and being rewarded for your clinical efforts typically encompassed positive feedback, increased responsibilities from their clinical instructor, and a passing grade for the placement. Take, for example, participant 14 who talked about a time they acted quickly when their patient started to deteriorate, and they received praise for their actions "Puis j'ai eu des félicitations de l'équipe de nursing puis de mon prof clinique. Mon prof a dit 'Tu as fait ce qu'il fallait faire'" (P14).

Another aspect of being recognized for one's efforts is in relationship to the emotional labour involved in patient care. When the participants described providing patient care, they frequently identified connection as important to their clinical practice. Participants spoke about how in order to connect with patients, they needed to "give of themselves" [in relationships there

is a mutual exchange (reciprocity) based on a give/take] and break down barriers so that their patients saw them as human beings and not just as healthcare professionals; this was a catalyst to connection. The participants “put themselves out there” to be judged as one human being relating to another. When the participants were vulnerable in this way to establish a relationship with their patient, they anticipated or at a minimum hoped that their efforts would be acknowledged by the patient. When their efforts were acknowledged, this positively reinforced that their efforts were worth the risk of rejection. As the following participant described, having a patient thank them for their efforts was a highly rewarding experience. This led to the development of a connection between the participant and the patient.

And we had this new patient, it was on my first rotation. She was new to the floor and I think she was about to pass away, she was “Do Not Resuscitate.” She was towards the end of her life and she was just really anxious that she was on the floor. ... Whenever someone would come near her and touch her or anything, I think her skin was really itching and burning, she would scream out. And because she's a bit bigger, you'd have to roll her to do something. And for her catheter and stuff, and she would just continuously cry out, and she'd always press her call button too. And so I was assigned to her with the other student, and whenever we would do something, the student would turn her over and I would hold her hand and look her in the eyes and be like, “Why don't you just focus on me and take some deep breathing and just like try to calm down.” I mean, I didn't say let's try to calm down because that's kind of rude. But I was like, Let's just try to make this kind of the best experience for her because she did need this care to be done, but it wasn't comfortable for her. And she would calm right down, she would take those deep,

deep breaths and at the end of my time with her, she was like, “Thank you so much, I will remember you forever.” And it was so cute, I’m gonna cry. (P4)

4.1.2.2 Being Heard. The participants interviewed believed that they should and would be heard by others in the context of their clinical placements. While they considered themselves learners, they believed that if they had something to say that others would *hear* them. That is to say, that others would actively listen to what the participant said and respond in a way that validated their knowledge and/or experience. When this happened, the experience aligned with their values and beliefs about what they perceived to be good, just, or right.

If the student nurses bring something up they [the clinical instructor] should believe them, they should take it seriously and then advocate for the patient. We’re not just making things up. It’s not like it’s not going to affect us in the long run, it is affecting us in the long run. (P17)

A specific situation in which several participants perceived they would or should be heard during their clinical placements was in relation to their theoretical knowledge. This was generally because the participants were taking concurrent classes that they felt equipped them with up-to-date information and best practices. Some of the participants shared, for example, that they saw practices during their clinical placements that did not meet current standards of practice. Because they had recently learned the theoretical knowledge that they were applying in practice, the participants believed that other healthcare practitioners would be receptive to information shared, even if it was different from what they knew or practiced. In one example, a participant made a recommendation about a medication that would be easier for the patient to swallow. The participant felt heard and the patient’s care improved as a result.

... one time I did a discharge on a patient. The doctor was writing the prescription because she [the patient] was leaving. And the patient had trouble swallowing big pills and it was I think Clarithromycin or something that was the big pills, the 500mg. And I'm like "You do know if you write her double the prescription in 250mg pills, it's smaller pills, right"? ... And he's like, "Oh, I didn't know that, cool. Ok, I'll do that." And I'm like "Ok, cool, nice." (P5)

When the participants felt heard, the experience remained unproblematic, and their values and beliefs went unchallenged because they felt heard in a way that they perceived to be appropriate for the circumstances.

4.1.2.3 Being Trusted. Being trusted refers to the idea that nurses or clinical instructors had confidence in the participants and gave them the autonomy to work within the scope of their knowledge and abilities. Several participants spoke about how they felt that being trusted in the clinical setting aligned with their values and beliefs about how they wanted to be treated.

Most of them [clinical instructors] were very nice. Geriatrics and med surg - they were astounding clinical instructors. They were very open to us doing things on our own. And if they felt confident in us, they gave us a lot more freedom and kind of, "Ok, you can go do the bed bath on your own because I've seen you do it before, you can go give this medication with your nurse." (P12)

However, wanting to be trusted is a little more nuanced. The participants noted that there was tension between being given enough autonomy to be able to practice their skills and critical thinking and balancing this autonomy with the constraints of having gaps in their skills and knowledge. In these instances, participants wanted to receive more support. Therefore, the

amount of trust given to a participant that they perceived to be right, just, or good depended on the participant's knowledge and skills at a specific moment in time.

Yeah, I mean I think she [clinical instructor] trusted me too much because she was just kind of like "Ok go" ... and I was standing over this patient with her son in the room.

And I was like "Oh my gosh, we've never done this before" and she's like "Oh really?" and I was like "Nope." (P3)

Some of the participants spoke to the origins of trust with others, which they believed would be built on mutual trust; the baseline of a relationship should be one of trust. Participant 21, for example, stated that "Bien j'aimerais penser que les profs de stage ont confiance en toutes leurs étudiants jusqu'à temps que quelque chose arrive pis qu'ils leur prouvent différemment" (P21). Only when the trust is broken is there a reason for the trust to no longer be there. In particular, being trusted was important because it fostered space for the participants to grow in confidence. In one example, participant 18 shared a positive reaction to being trusted by their clinical instructor. "It's wonderful, it's totally different, it's very rare. That's a good day. It brings up my confidence a little" (P18).

4.1.2.4 Feeling Supported. Often, participants perceived that what was right, good, or just was for them to be supported by individuals whom they looked up to or sought help from. In the clinical context, these individuals included clinical instructors and other healthcare providers, such as nurses and physicians.

I wouldn't say there was a specific moment, it was more like – number one was the general demeanor of the clinical instructors. They were both like very open people. And they didn't reprimand you if you had questions, they kind of used it as a teaching moment. (P12)

Conversely, participants did not seek support from patients because they perceived their own role as being a source of support for them. Clinical instructors were most often perceived as a source of support for the participants compared to other health professionals. When participants asked questions of their clinical instructor, they wanted to be encouraged in their pursuit of knowledge rather than reprimanded for the knowledge that they did not yet possess.

The participants believed that they should be supported during challenging moments in the clinical context when, for example, they had an unstable patient or had their first experience with death. The participants recognized that whatever was happening with the patient in these circumstances was beyond their level of comfort and/or knowledge. What they believed to be right in these instances was support that could be physical, emotional, or intellectual in nature. In one example, participant 19 talked about how it was important to them to seek support when an aspect of their patient's care exceeded their knowledge and/or comfort.

If something is over my head, I'm not going to try to figure it out by myself, I want to see what the right thing to do is because I don't want to... So when I need help I always go get help. I think that helps because they [the patients] know that if it's over your head, you're not just going to try to put a band aid on it or patch it up right?! (P19)

When the participants felt supported by their clinical instructor, they were more comfortable asking questions and making mistakes. In this context, making mistakes was less about making a medical error, for example, and more about being in a trusting relationship where it is safe to make mistakes while pushing their critical thinking skills and ability to make links between theory and practice. It was about taking risks and being willing to be vulnerable for others to judge their thinking processes. A relationship built on trust and respect for one another was instrumental for participants to feel safe asking questions.

Moi je trouve c'est tellement important. So là je n'ai pas peur de rentrer en stage puis avoir la mauvaise réponse. Comme je viens tout le temps préparé, je fais ma recherche de mes médicaments, les différentes conditions de mes patients et tout ça. Mais si jamais il y a quelque chose, comme on va dire je ne sais pas pourquoi que ce patient-là prends ce médicament-là Mes profs ils n'étaient jamais comme "Voyons donc, pourquoi que tu dis ça, c'est pas ça, c'est obviously ça." Mes profs ils ne faisaient jamais ça, ils étaient tout le temps comme "Ah c'est une bonne hypothèse mais ce n'est pas ça, c'est ça." Puis là tu vas le savoir pour la prochaine fois. So de cette façon-là, je n'avais pas peur d'essayer de faire des hypothèses par moi-même puis de leur dire. (P21)

4.1.3 Having a Moral Experience That Challenges One's Values and Beliefs

In the context of this study, having a moral experience that challenges one's values and beliefs means that an experience occurring during or in relation to a clinical placement was perceived by the participant to be bad, wrong, or unjust. The participants used their underlying values and beliefs that they developed over their lifetime, whether consciously or not, as the barometer upon which they gauged whether a moral experience challenged these beliefs. In the end, there was a disconnect between what the participants believed should happen and what occurred. In this category, I discuss the following four sub-categories: 1) being confronted with what nursing "actually looks like," 2) experiencing a disconnect between expectations related to one's own clinical performance, 3) feeling alone, and 4) responding to an experience that challenges one's values and beliefs.

4.1.3.1 Being Confronted With What Nursing "Actually Looks Like." Some of the participants spoke about how what they learned within the structured content of the nursing program and their preconceived perceptions about nursing practice did not necessarily translate

to the clinical setting. For them, theory and practice did not always align. As participant 2 stated: “She [clinical instructor] would say ‘Best practice says this but we’re going to do this because that’s the way we do it here on this unit – but if you go anywhere else, do it like this’” (P2).

Given that participants at this university typically take the theory class concurrently with the related clinical placement, their knowledge based on structured learning was both current and at the forefront of their minds. Some participants remarked that this made them acutely aware of when care practices did not align with what they learned in class or in laboratory sessions.

For one – during the long acting injection, one of the nurses – we’re not supposed to do dorsal gluteal injections anymore. But that nurse specifically taught me to do the dorsal gluteal injection on the patient and also to aspirate. And aspiration is also no longer best practice anymore. So sometimes you get conflicting information versus what you learned compared to what they actually do and you just kind of go with the flow and if something is really off, you recognize that and just think, “Ok, well, I did it like this, or they taught me to do it like this but I’m still going to stick to what I’ve learned because this seems to make more sense to me.” (P12)

The participants also spoke about the reality of working in an environment where resources, such as time as well as physical and structural resources, were limited. As a result of time constraints, the participants watched nurses make choices about what care they prioritized; some elements of patient care were either done only in part or abandoned altogether. Further, in an effort to try to get everything completed with these limited resources, some participants noticed that healthcare providers were cutting corners so that all the “taskable” items could be “checked off” their “to-do list.” Even if the task was completed, it did not mean that it was done in a way that the participants believed to be best practices or what they perceived to be good

patient care. Therefore, they witnessed care practices that did not align with their own vision of nursing practice or what they believed to be right, good, or just for a patient at a specific moment in time. The participants also noted that patients with high acuity concerns were prioritized by the nurses. As the participants witnessed the decisions that nurses made about how to allocate their finite time, the participants internalized the need to establish priorities and normalized the idea that certain elements of care might be lost at the expense of others.

Ouais, évidemment les infirmières n'ont pas autant de temps. Puis ce n'est pas leur faute, ils ont tellement de patients puis ils ont tellement de choses à faire. Puis si tu as quelqu'un qui est en crise d'asthme puis il a besoin d'un puffer, la priorité ça ne va pas être le monsieur qui est anxieux. (P15)

As alluded to in the quote above, the participants noted that getting to know a patient and supporting their emotional needs were lower priority items.

Puis je pense que les besoins émotionnels, they're not taskable things ... but to me it's the base of all nursing care. ... on travaille dans un système où le soutien émotionnel et le fait de connaître ton patient ... – it's not taskable, it's almost like it's not expected anymore. ... Yeah, ça me frustre vraiment. (P19)

Physical and structural resources included the material resources available as well as the structural spaces, such as the size of patient rooms. Even if the necessary physical or structural resources were available, the knowledge needed to use them by healthcare providers was not always guaranteed. For example, participant 2 perceived that the psychiatric unit and staff were ill equipped to deal with a medical emergency because of the lack of available medical resources. This lack of resources led the participant to perceive a delay in treatment for a patient who was actively bleeding. As the participant stated, this was not how they envisioned nursing practice.

It was definitely a very different side of nursing, I saw a more practical, what it actually looks like for nurses in that context, in the hospital, as opposed to the ideal world that we learn about in class where we have all these resources. I remember one patient who engaged in self-harm, it was someone in the EDP program, the eating disorder program, who was out on a pass and they had cut themselves on their abdomen and they came back to the unit because they didn't know what to do because they were bleeding a lot. And they got to the unit and their nurse was like "You need stitches but we don't have a suture kit on the unit, you have to go to emergency because I can't do this for you." And then that patient went to emergency and was sent back up because they were already admitted to the hospital so they couldn't go through emergency, they had to go back up to their unit and they had to run to a different floor, get the suture materials and try to do it there, but trying to do a proper sterile technique in a psychiatric unit can be very difficult having all that stuff around.

Finally, the clinical context and relationships that exist within it are complex, multidimensional, and full of nearly infinite possibilities. Participants learned theoretical principles in class or institutional policies during clinical placements, one of which was to create boundaries around their interactions and not share too much personal information with a patient. The participants recognized, however, that what they learned in theory or on paper may not necessarily be appropriate for all circumstances. At times, this created a disconnect between their theoretical education or knowledge and actual practice in the clinical environment. This might mean, for example, that they chose to share personal information about themselves in an effort to develop a therapeutic relationship with a patient.

There is no line, I don't think. And we're even taught all the time in school. Like, don't

share too much about yourself, you know, especially in mental health, the focus is on them [the patient] in your interviews. Don't share too much about yourself. But then you're in a situation where you do – they're sharing so much intimate details, to make them feel a bit more comfortable ... should you not say, at least a little bit of information about yourself? ... The line's different for everyone. It's true for every patient and for every nurse too. ... It's a big blurry thing. There's no line. It's a cloud. (P4)

4.1.3.2 Experiencing a Disconnect between Expectations Related to One's Own

Clinical Performance. Based on prior experiences, participants developed certain expectations around what was expected of them in the clinical context to be successful in the clinical placement. The participants described how they would act in ways they believed would help them pass the clinical placement. A disconnect occurred, however, when the participants' expectations did not align with what others, especially their clinical instructor, expected of them. This was often the result of unclear expectations as well as expectations that differed across clinical instructors.

And then my instructor let us do meds with our nurses. When I told my nurse I have to give Tylenol, she was like, "Yeah, I'll stand outside of the room to do charting, you're fine, the room is five feet away, you're fine." When my instructor saw that she got really mad because she's like, "You're giving meds without supervision." I was like, "Well, my nurse checked it with me at the door and then I just went in and gave it and did the correct identification and stuff." She was like, "No, that's not what we talked about, you're not allowed to give meds for the rest of the day." ... So, yeah, a few times that instructor was really tough to kind of know what I was allowed to do and what I was not allowed to do. (P22)

Other times, the expectations that had originally seemed clear to the participants then changed for any number of reasons, leaving the students unable to adapt to the new expectations. In this case, the participants believed they were meeting expectations, but were surprised when the expectation changed.

My instructor for mental health was kind of known to be very laid back, very easy, let us do our own thing. ... I just remember she put out the expectation, maybe she didn't mean it as strongly as she did, that we didn't need to know our medications by heart. ... She kind of said, "Medications, you don't need to know them by heart as long as you have your med cards, you're good to go." ... Then one day she came up and said [name of participant], "We're going to do your medications now, let's go and do them together." I had all my med cards and she was being very inquisitive, she was testing me a lot and I was looking at my cards and she got really mad, she said "You should know all this, I don't know why you're looking at your cards," and she said "How do you want to be a nurse if you don't know this already? This is our 4th week and you don't know what kind of medication this is, what's the side effect." ... I was caught off guard. ... I think just the type of person I am, I like the expectation, I work really hard to accomplish kind of thing. My med cards were beautifully done, if I had looked at them I would have known but the underlying expectation that was never said threw me off. (P18)

Additionally, participants noted that it was difficult for them to understand what was expected of them over the course of their clinical placement because these expectations could change depending on the context. For example, with supervision, a participant may be allowed to change a wound dressing from a knee replacement, but not a stage 4 sacral ulcer. Or they may not be allowed to change the dressing of a stage 4 ulcer the second week of clinical placement

but they are allowed during the fourth week of the same clinical placement. Additionally, they may be able to change the dressing on a medical unit but not on a psychiatric unit. Therefore, there were instances where participants made decisions about their practice that was appropriate for one context, and yet the expectation differed in another context. One participant shared how they were allowed to perform certain tasks in one context but not in another.

Et puis ouais, j'étais très optimiste, le jour du jumelage j'étais jumelé à une infirmière, elle m'a beaucoup expliquée. J'ai dit "Est-ce que je peux essayer ça, est-ce que je peux essayer l'autre" – "Oui, vas-y administrer les médicaments dilués en poudre par la sonde nasogastrique." J'ai dit "Est-ce que je peux pousser", elle dit "Tu fais." Et elle dit "Je dois prendre un prélèvement de sang." J'ai dit "Est-ce que je peux vous aider?" Elle a dit "oui, pourquoi pas." Et il paraît que la prof a tout vu, tout entendu, elle m'a appelé, elle a dit que tu n'as pas ton assignation demain. J'ai dit "Pourquoi?" "Tu as dépassé tes limites, tu es trop proactif." Mais j'ai dit "Qu'est-ce que j'ai fait?" Elle a commencé à crier sur moi ... "Pourquoi tu as fait ça, tu n'avais pas le droit?" Elle a dit que "Toi tu es dangereuse là." Elle m'a dit que je suis dangereuse, elle a dit que "Non, tu es une étudiante dangereuse, tu ne connais pas tes limites." Et depuis mon calvaire est commencé, donc elle m'a suivi, elle me pointait à chaque erreur etcetera. (P20)

4.1.3.3 Feeling Alone. Some of the participants felt alone during their clinical placements. At times, they felt unsupported or even abandoned by their clinical instructor or academic institution. When this happened, they believed they should have been better supported. Some of the participants spoke about being physically alone on the unit, primarily in reference to clinical instructors and school administrators. A high number of UNSs per single clinical instructor during clinical placements was one often cited reason.

And most of the time we couldn't find her [the clinical instructor]. There was once an incident when she left the floor, which technically means we can't be there. She has to be on the floor at all times, she has to be accessible. She got a phone call from her kid's school and she left for an hour. None of us could find her at all. ... And I get people mess up sometimes, but that was a big mess up – that was a big thing. And she was practicing irresponsibly, like she left us alone. (P2)

Conversely, there were times when participants were not supported in a way that they believed was right for the context. Most often, participants contended that the clinical instructor was not supportive. For example, one participant told the story of when they made an upsetting error during their clinical placement. Rather than having this mistake turn into a positive learning experience, the participant felt emotionally unsupported.

Donc, c'est ça, j'aurais mieux aimé que cette erreur là – puis t'sais moi j'étais dans tous mes états, je me sentais tellement mal, en plus un enfant on dirait ça l'empire. Puis t'sais une situation comme ça, j'avais besoin du support ou que quelqu'un me rassure ou quelqu'un qui me dise c'est pas grave, moi aussi j'en ai faite des erreurs. Puis finalement on avait juste réajusté les temps pour la prochaine dose puis toute était pour être correcte mais je n'ai pas eu ce support de ma professeure. Non. (P10)

Finally, several of the participants spoke about feeling alone within the School of Nursing. Within the School, there are specific employees who are tasked with supporting UNSs through challenging clinical placement situations. This support, however, did not necessarily play out in a way that aligned with what the participants believed to be right, good, or just.

Because at the beginning of the program, you're given these rose-coloured glasses, I think of them saying, "Come to us [school administrators], we're here for you guys, we

want to make sure that this experience is the most positive one you can have. Because it is a hard program, we're here for you." And then the more you realize you do need them or you do need the support, they're not as present as they say they are. (P22)

Some of the participants further elaborated on how some institutional supports were hidden or difficult to access, making it too burdensome to seek out support.

But yeah, if there was more visible support, if they could have somebody who handled these sorts of things. Because I feel like the reason why people don't really report is because it just seems so out of the way you know? You don't even know who to contact if something were to happen It just seems so out of the way. (P11)

At the School of Nursing at the post-secondary institution where data collection occurred there are clinical coordinators who, as part of their role, visit UNSs during their clinical placements to offer support to both UNSs and clinical instructors. Several of the participants spoke about their interactions with these coordinators, and it appeared that in some instances, the participants' expectations went unfulfilled. As participant 23 stated, having the clinical instructor present in the room while the clinical coordinator asked the participant about their clinical placement played an important role in their feeling of being unsupported. As a result of their clinical instructor's presence, the participant did not feel free to express their feelings freely with the clinical coordinator. This left the participant feeling unsupported by the clinical coordinator despite the clinical coordinator's visit.

Comme nous en santé mentale, on avait tous des problèmes avec notre prof, puis c'était super awkward à cause que la coordinatrice est venue puis notre prof elle n'est pas partie de la chambre. Puis on était comme "On va pas commencer à la 'trasher' quand que t'es drette là," c'est pas évident. Alors là on était juste comme "Oui ça va super bien." (P23)

Further, when some of the participants did reach out and sought support through formal administrative channels, the support received also did not necessarily align with what they perceived to be right, good, or just and they felt alone.

But they [the school administrators] had to wait for me to make three complaints, give them a doctor's note saying "I'm not going back." Because I can't. ... I just, the facilitator, she's not facilitating my learning. She's not helping me out. So for my own mental health and for my own sake, I can't go back. (P5)

4.1.3.4 Responding to an Experience that Challenges One's Values and Beliefs.

Following an experience that challenged participants' values and beliefs, the participants were confronted with a disconnect between what they believed to be right, good, or just, and what actually occurred. Participants responded to this disconnect by 1) having a physical and/or emotional reaction, 2) taking action, 3) avoiding confrontation, and/or 4) leaning on others.

4.1.3.4.1 Having a Physical and/or Emotional Reaction. The disconnect between what the participants' believed to be right, good, or just and what actually occurred was at times unsettling for them and solicited an emotional and/or physical response, such as the negative emotions of sadness, anger, and fear. Those who responded to moral experiences that challenged their values and beliefs with anger described how the anger could be either directed at oneself, usually as a result of an action not taken, or outwards, to the person the participant perceived to have acted in a way that was bad, wrong, or unjust. Participant 18 even spoke specifically about how the anger and frustration they felt manifested itself physically "You're just on your tippy toes all the time. Like my jaw's always clenched, I'm always ready for whatever they're [clinical instructors] going to throw at us" (P18).

Several participants also shared feeling so sad or upset by an experience that they cried during or shortly after the event occurred. This outpouring of emotion was often accompanied by feelings of helplessness. Participant 17 spoke about an incident involving the actions of a physician and the clinical team, where a patient had a fever and polyuria [high urine output]. The attending doctor wrote in their notes that the patient had no fever and did not address the overproduction of urine. When participant 17 brought this up to the clinical team, their response was to simply continue monitoring and not to address what the participant believed was a lie and the omission of important information in the chart by the attending physician. This experience did not align with what participant 17 believed to be good, right, or just resulting in feelings of helplessness.

The same patient. He [the physician] also lied in his note the same way. ... It had a huge impact on me. I went home and I started crying because the medical team wasn't doing anything to help the patient and on top of that, they gave them [the family] hope and then they're being pessimistic. And now they're lying in their notes and not – everything seemed wrong. I was crying for a good two hours and then my brother's like, "It's ok, you're human, I would question you if you wouldn't be crying right now." ... Everything in that situation added on and I couldn't take any more. (P17)

Some participants also expressed feeling fear as a result of events that challenged their values and beliefs, most often in reference to their clinical instructor. As participant 19 stated, "Dans notre groupe de stage on était toute terrified. Oui, terrified de lui [clinical instructor]. C'était vraiment de l'enseignement par intimidation" (P19). This fear also manifested itself physically among some of the participants. In one example, one participant talked about having nightmares about their clinical placements.

Finally, some participants also felt regret, often in relation to an action that they did not take when their values and beliefs had been challenged. While they believed that an experience was bad, wrong, or unjust, their actions (or inactions) suggested otherwise.

... mais en tant qu'étudiante infirmière c'était dur pour moi. Ça c'est un moment que je me sentais comme "I should have spoken up." J'aurais dû dire comme "On pourrais-tu utiliser un calibre un peu plus petit? Il [patient] est super irrité à cause de bla-bla-bla, il a spina bifida." Puis je n'ai pas speak-er up. Ça c'est quelque chose que moi personnellement je regrette de pas avoir fait. (P15)

At times, emotions of sadness, anger, fear, and guilt became overwhelming for participants and affected their lives outside of their clinical placements as well. As participant 5 said, "It spilled over into my life" (P5). At its most extreme, a small number of participants felt so overwhelmed as a result of these experiences that they no longer wanted to or could attend their clinical placement. In one example, participant 22 shared that "When we [participant and student colleague] had the bad placement, we would message each other before placement and be like, 'If I get hit by a bus could I just not go? Can I still pass the course but not go to clinical?'" (P22).

4.1.3.4.2 Taking Action. When participants described moral experiences that challenged their values and beliefs, several of them took action to try to better align the outcome of the experience with what they believe should have happened. The participants who took action did so directly or indirectly by attempting to alter the trajectory of events that had unfolded. This category is made up of the following two sub-categories: 1) acting directly, and 2) acting indirectly.

4.1.3.4.2.1 Acting Directly. Acting directly means that participants directly addressed the individual, event, or situation related to the experience that challenged their values and beliefs. There was a direct confrontation between the participant and another individual or individuals and was a way for the participants to assert what they believed to be the right, good, or just thing to do. In almost all circumstances where participants resisted action, it was done by speaking up for themselves, their patients, or for others like friends or colleagues.

Several participants spoke up for themselves to share their own perspective of the experience. They either directly addressed the person involved or spoke with someone whom they knew could influence them. In the following quote, the participant shared an experience where they arrived late to clinical; the participant believed the resulting actions of the clinical instructor were disproportionate to the mistake that was made.

J'avais un professeur de stage qui a été assez rough avec nous au début et c'était à cause qu'une des journées on était en retard pour l'orientation. ... Elle nous faisait des petits commentaires comme "Essayez de pas être en retard cette fois-ci." Juste pour nous rappeler qu'on était en retard la journée de l'orientation même si ce n'était pas notre faute. On a expliqué le e-mail, on lui a lu cette phrase puis on a interprété ça comme si vous n'avez pas la formation de 8 à 12h, vous pouvez venir à midi. ... So à un moment donnée elle a dit comme – c'était je pense deux semaines après que le stage a commencé et elle avait dit "Don't be late this time" encore. Et puis là j'étais comme "Are you still on that?" (P16)

Some participants also spoke up on behalf of their patients, to whom they felt accountable as their assigned student nurse. Importantly, the participants seemed to feel a greater sense of responsibility to advocate for their patients because of their proximity to them. Given

that UNSs are often assigned fewer patients than a practicing nurse on the unit, they have more time to spend with their patients, thus creating a stronger connection and emotional nearness to them. The actions of one participant who spoke up for their patient potentially prevented a tragedy.

Mais j'avais une patiente qui avait sickle cell disease Puis pour elle, à cause qu'elle en avait eu tellement [pain crisis], ça a causé un manque d'oxygène à son bébé puis là son bébé avait des gros problèmes. ... Ils ont dû faire un avortement ... puis là ça ne s'est pas bien passé. Je l'avais [patient] une couple de jours aussi, je l'ai eu comme quatre jours de suite. Elle saignait beaucoup beaucoup, plus que la normale. Moi je n'avais jamais vu un post-avortement. Mais de ce que j'ai vu dans les normes, elle saignait beaucoup plus que la norme. Puis beaucoup des infirmières disaient comme "Ah, elle vient d'avoir un avortement, c'est normal qu'elle saigne" mais j'étais comme "Oui, mais elle saigne beaucoup. Puis elle ne se sent vraiment pas bien." Puis sure enough on a fait des prises de sang puis son hémoglobine était comme 60 qui est super bas. Puis elle était super pâle et sweaty, alors j'étais comme "Elle va pas bien la madame." Finalement elle a été transférée à ICU mais ça ... c'était une situation que moi j'ai vraiment speak-er up. Ça c'était le soir, il était comme huit heure le soir, elle n'était pas dû pour des prises de sang avant le lendemain matin puis c'est moi qui a poussé d'en prendre. (P15)

Less common were participants who spoke up for people other than themselves or their patients. When it did happen, they used their voice to give added weight to the voices of others. In one instance, for example, all six participants from one clinical placement expressed their collective dissatisfaction with how four of them had been treated by their clinical instructor.

And then, eventually, all six of us [participants] ended up making complaints and we

submitted them to the nursing office just because the four had good reason to make complaints but then the other one and myself made one as like a point of saying, listen, we didn't fail, we weren't put on learning contracts but this is what we saw, this is what we were uncomfortable with. And then it doesn't just throw the other ones out for saying, they just are angry that they weren't doing well. (P2)

4.1.3.4.2 Acting Indirectly. Acting indirectly implies that there was still an action taken by the participant but there was no direct confrontation with any other individual(s) to address the perceived wrongdoing. It is important to note that participants who acted indirectly were not passive participants or observers of an event; they still acted. They acted in ways that they perceived to be right, but this action was often done discreetly so that others might or might not have known that it even occurred. Other participants used humour to indirectly voice their concern in an attempt to see what type of reaction they would receive; it was a way to test the waters without direct confrontation. Acting indirectly helped the participants to try to approximate what happened and what they believed should have happened while lessening their level of risk, such as the risk of being perceived as a difficult UNS. In one example, a participant approached a patient themselves to ask what they needed rather than confronting the nurse directly who was not giving the patient the attention the participant perceived to be important.

And a lot of times, if someone [patient] was talking at the window at the nursing station asking something, sometimes the nurses would go up and be like, "Sorry, we're busy right now" and close the window, which I really didn't like. And sometimes I would go outside and if it was one of my patients or someone I've talked to then I would go and be like "Is there something I can get for you? Are you ok?" (P3)

The participant did what they believed was right for the patients while avoiding direct

confrontation with the nurses on the unit, who likely were not aware of the action taken by the participant.

Although acting indirectly reduced the risk of confrontation while protecting the values at stake, there was often an element of secrecy to it because many of the participants hid their actions from others. One participant understood what their clinical instructor wanted them to do but followed a process that made more sense to them. In this instance, the instructor wanted the participant to chart on a portable computer in the room with the patient, whereas the participant wanted to chart on a stationary computer found at the nursing station after the patient assessment was done. While the result might have been the same – the charting was completed – the participant felt that they could better focus on their patient's assessment without having to simultaneously chart their findings in the room with the patient. Further, they believed that their documentation would be better if done after the assessment because they could focus on the documentation. The participant acted indirectly in defiance of their clinical instructor because while they knew what was expected of them, they acted otherwise without the knowledge of their clinical instructor.

Moi, je faisais toujours ce charting à l'ordi parce que ça se fait vraiment rapidement.

Mais ma prof était comme "Why do you do it on the computer, do it on the machine," and I'm like "Well I like doing it on the computer" so elle m'a dit de penser à le faire sur la machine [portable charting machine] but in my head I'm like "It doesn't make a difference as long as I do it." So I smile and nod and then I'm not going to do it that way [on the portable charting machine] parce que c'est pas ça que je veux faire. J'ai le même result, I'm charting it, it's getting done, ça ce fait plus rapidement – when I do it later, I sit down and I focus on it and I do my head to toe assessment and I make sure

everything's right, but right now I'm rushing and I don't want to do it now and in the end it's the same result. (P19)

Notably, two participants brought up an episode of indirect action that combined speaking up for oneself, for patients, and for others. A few participants stated that they wanted better mental health support than what they could receive through the university. They noted that some UNSs had started a club called "Beating Burnout" to promote mental wellness for UNSs at the university. It was run by volunteer UNSs who tried to fill a gap in support services by creating a space for UNSs to talk about how they were *actually* feeling with their peers and to provide information about available mental wellness resources. The creation of the "Beating Burnout" group was an indirect action to remedy what the participants believed was inadequate support, not by confronting the university or the school of nursing directly, but by creating their own support group. As the participant below mentions, it is unfortunate that there was a need for UNSs to shoulder this burden and volunteer their time to provide this service in the first place.

C'est tellement un programme [School of Nursing] petit aussi, que comme y a des avantages et y a des désavantages. Mais au moins on peut s'entraider un petit peu en connaissant les ins and outs. Puis maintenant il y a un groupe qui ont commencé un club qui est "Beating Burnout" puis eux autres ils font toute la santé mentale avec nursing puis toute. Alors il y a quand même des étudiants vraiment motivés qui veulent changer certains aspects, qui est bon. Mais le fait que sa prends ça, c'est aussi pas une bonne chose. (P23)

4.1.3.4.3 Avoiding Confrontation. In the context of this research, avoiding confrontation refers to the times when a participant made a conscious decision to comply in a specific situation or event despite not agreeing with what occurred. The participant may not have accepted the

event or situation on moral grounds but resigned themselves to accepting that the best action was no action at all. In the excerpt below, the participant is referring to a joke made by a nurse that the participants deemed to be inappropriate. Despite this, they chose not to act. Their clinical instructor was also employed on the unit which further complicated the situation.

I don't know, ... after clinical they [clinical instructor] could have been like, "So I know that this happened today and..." - but then no one, none of us [UNSs] went to her because we all felt that she was too close to the situation so that none of us could talk about that specific thing. So then no one told her that we were uncomfortable about it so who's to say that she didn't actually realize that it made us uncomfortable, and she just thought that we take it as she did, as a joke. (P3)

The participants who chose to avoid confrontation did so because it felt like the safest option available to them. In the story below, the participant identified that the risk of acting was perceived as being incompetent while in conflict with their clinical instructor.

That's one of the reasons and she [clinical instructor] didn't seem that approachable ... the moment you asked a question, she kind of flipped sides and turns on you. And given that, we [UNSs] didn't want to ask any questions that would essentially make her think that we're incompetent or stupid. So we just kept our mouths shut in that situation and followed her whims. (P12)

A common thread among many of the moral experiences shared by participants was that they would not just avoid a verbal confrontation as exemplified in the two passages above, but they would also physically avoid the person(s) with whom they disagreed.

Je ne me rappelle pas des commentaires, je me rappelle juste de m'être senti si petite dans ce stage-là. Je voulais éviter cette enseignante-là dans les couloirs et je voulais qu'elle me

laisse essayer faire mon travail toute seule. Parce que je savais que dès qu'elle allait regarder quelque chose, elle allait critiquer quelque chose et que j'allais me sentir plus pire. C'était pas comme parfois elle me donne des compliments, parfois elle me donne des critiques. C'est plus si elle me dit quelque chose, c'est pour me critiquer, c'est pour me dire que j'aurais dû mieux faire ou j'aurais dû faire quelque chose d'autre. Ça c'était la seule communication que j'avais avec cette personne-là donc je l'évitais physiquement, j'allais dans l'autre couloir à cause que je voulais pas qu'elle me voit parce que je savais que si elle me voyait, ça allait être quelque chose de négatif. (P16)

4.1.3.4.4 *Leaning on Others.* Many participants leaned on others, meaning that they sought support as a way to share some of the emotional labour of clinical practice and/or seek reinforcement for their values and beliefs. To get support, the participants needed to be vulnerable and express their feelings and experiences with others. As a result, the participants often felt connected to those they leaned on, creating a sense of community.

When I do feel conflicted or down, usually talking to other nursing peers is really helpful because they share in my feelings of wanting to do as well as possible, but obviously, not having that experience to know exactly what to do. ... And talking about it with my clinical instructor is also really helpful because they understand what we go through as well.... So having that support system is really good. (P12)

The participants spoke about the people whom they leaned on for support, specifically, other participants, nurses on the unit, professors, clinical instructors, and friends and family outside of school. Several participants spoke about seeking support specifically from their peers, friends or those they considered themselves close to in the nursing program. It was not necessarily enough to have someone simply be in the program to feel comfortable enough to lean

on them for support.

... moi personnellement je préfère parler à mes propres amis. Comme disons [...] que j'ai vraiment besoin de parler de quelque chose, ça aide pour moi que j'ai beaucoup d'amis en nursing, surtout mes meilleures amies parce que eux autres me connaissent puis je peux vraiment les réconforter puis vice versa. Whereas t'as un groupe de gens que je connais juste parce qu'ils sont dans le même programme, je ne le connais pas davantage, c'est dure de réconforter quelqu'un, pas dure mais c'est juste c'est plus facile quand c'est tes meilleurs amis puis tu les connais super bien. (P15)

This participant valued having their best friends in the program to provide support, people they felt comfortable being vulnerable with. Conversely, another participant shared an experience they had during their clinical placement with a group of peers and DGD [discussion group] professor but presented it as a hypothetical case. In this case, the participant did not have that same level of trust and comfort to share openly with the group and therefore did not disclose that the experience had actually happened to them. Proximity between the participant and the source(s) of support are factors that the participants considered when deciding their willingness to be vulnerable and lean on another for support. It also provides insight into the participant's decision to mitigate the level of risk associated with sharing their experience. There was a perceived lower level of risk when their story was shared anonymously with a group of people who had no influence on their clinical placement evaluation, whereas the risk would have been perceived as higher had the participant shared the experience with their clinical instructor.

[P1] It was other students, I actually presented it as hypothetical, and I wanted to see what they would say. Most of them caught on that it was really what was going on. But I wanted to get a feel for what they would do in that situation. ...

[EM] And so what was part of your thought process for not telling your clinical instructor?

[P1] ... I wasn't willing to take that risk. And I don't think it would have brought any more benefits. I was able to do a lot of critical reflection within myself and think about it. And talking about this with the other students in my group helped a little bit. But I still don't think that it would have made a positive difference. (P1)

Some of the participants leaned on clinical instructors and professors for support, although notably fewer did so. Those who did share their experiences with instructors or professors did so when they wanted advice on potential courses of action. One participant had a difficult experience with a physician and the DGD professor offered a perspective on what they believed the participant could have done.

And during one of the ethics DGDs, they [DGD professor] told us to share one of the stories. So I did share that and the nurse [DGD professor] told me that they [clinical nurses] should have reported the doctor to the manager or something. (P17)

Some of the participants spoke about leaning on nurses employed in the clinical setting. There appear to be two reasons that participants chose to do this. The first was that they did not feel as though they could lean on their clinical instructor. The clinical nurse then became the person they turned to instead, a potentially safer yet knowledgeable person. The second was that the nurses on the unit potentially had access to "insider" knowledge that could help the participant. Insider knowledge meaning knowledge gained through experience with people in a specific environment that someone without that experience might not be privy to.

I had no idea what I was going to do. And so I thought, "Ok, I have to go and talk to one of the nurses so that I can have a little bit of an insight of how to go about this."

Because, yes, there's evidence based practice that I can read, but I want to know in practice what has worked. (P7)

Although the least frequently mentioned by the participants, the final group of people they turned to was family and friends outside of the nursing program. One participant shared that the relational aspects of nursing school may make it difficult for others who are not in the program to relate to or understand their experiences.

I mean, everyone has that stress of school, right? And that emotional component comes in with every single program I'm sure whether or not you're in arts or sciences or math or whatever, of just having to sit down and study for hours upon hours. And I mean, that is a really stressful part of it, but we have more relational experiences. (P4)

Nearly all of the participants who spoke about seeking support referred to three contexts in which they leaned on others: post-clinical meetings, lunch/dinner hour during clinicals, and DGD sessions. The school of nursing has created post-clinical meetings, a structured time and space for UNSs in a clinical group to debrief about events that occurred during the shift with the clinical instructor and the other UNSs. The participants used this time to share their clinical experiences and to lean on others for support. The clinical instructor facilitates the discussion and debriefing during the post-clinical meetings, and in this context was a source of support for some participants. Conversely, the clinical instructor's involvement also deterred some participants from sharing their experiences when the experience involved the clinical instructor or because of their fear of a poor evaluation. Participants also used their time outside of this formal structure, frequently during their meal breaks, to talk together alone as a group of students. Finally, at the post-secondary institution where data collection occurred, DGD sessions are a component of the third year Nursing Professionalism and Ethics course. Each DGD is made

up of approximately 12 UNSs and one professor who facilitates group discussions about assignments and readings specific to the course. These professors are part- or full-time nursing professors who have a nursing license but are not involved in the clinical component of the program; thus the DGD professor has no influence on clinical placement evaluations. Although the DGD session is not intended to be used to speak about events that occurred during clinical placements, several participants still found them useful opportunities to seek support.

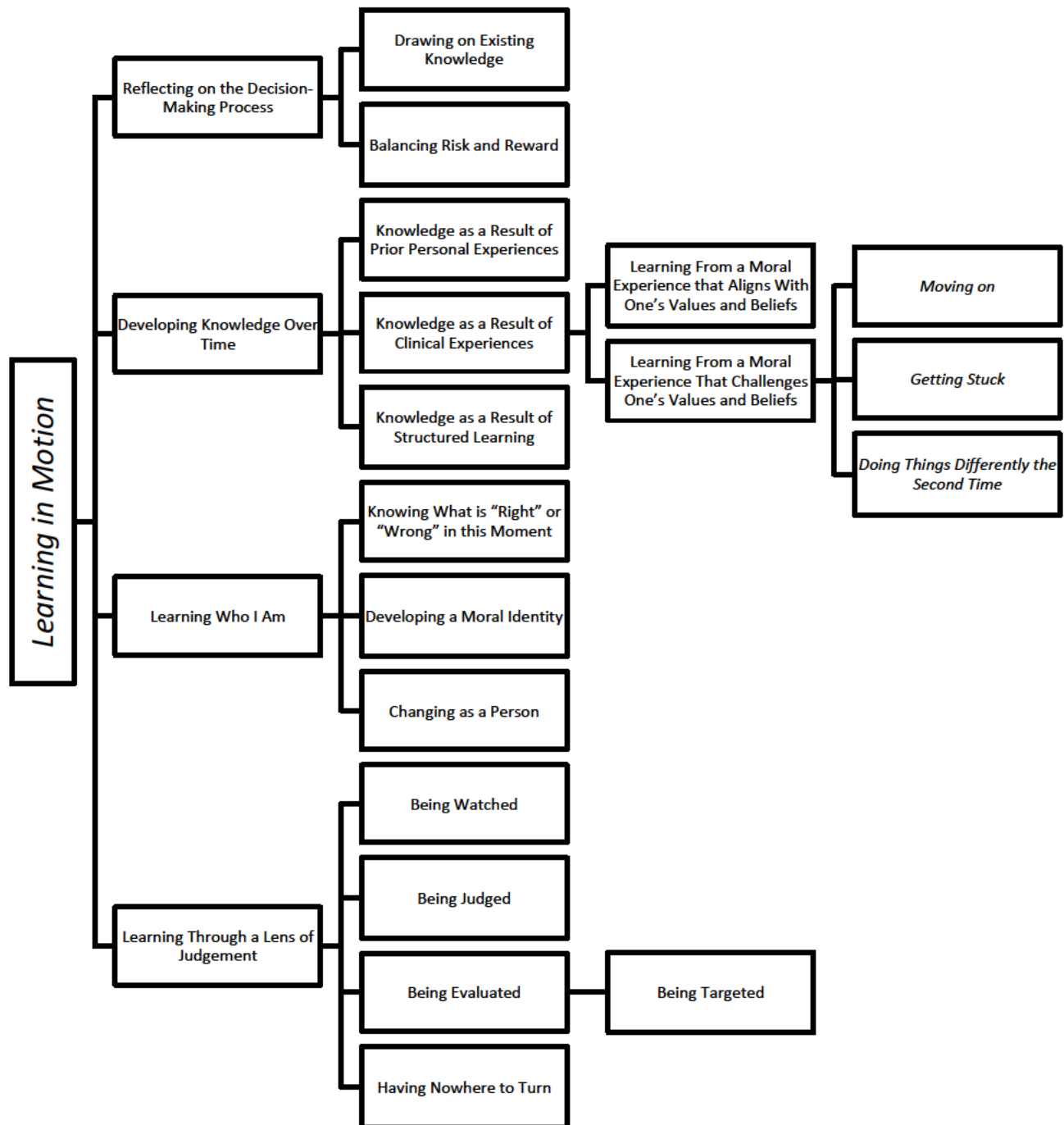
DGDs were really helpful, surprisingly. The DGD I had for ethics class, we were supposed to talk about articles and readings but our professor was really good in the sense that she'd go off on tangents. And we'd spend maybe an hour or two, just talking about our experiences in clinicals and going over what happened, what was wrong, what was good, how did that make you feel. It really allowed us to kind of relate to other people like, "Oh, I'm not the only one who's experiencing something like this." That was really nice. I'm not sure if it was structured because it wasn't really the intention of the DGD. But it helped. (P12)

4.2 Learning in Motion

The category learning in motion comprises four sub-categories: 1) reflecting on the decision-making process, 2) developing knowledge over time, 3) learning who I am, and 4) learning through a lens of judgement. During the interviews, participants spoke frequently about how they were learners within the clinical environment. Learning in motion is intended to illustrate learning as a process that the participants experienced as they navigated clinical placements as learners. In this category I will describe this learning process as well as present the ways in which participants brought knowledge to their clinical practice. See figure 3 for a visual representation of this category and sub-categories.

Figure 3

Category 2: Learning in motion



4.2.1 Reflecting on the Decision-Making Process

During clinical placements, every experience was made up of a series of actions, and each action represented a potential point where it could alter the event. Therefore, each action offered an opportunity for the participants to affect change. The participants made decisions about which actions they did or did not take based on 1) their existing knowledge, and 2) balancing risk and reward. The participants went through a decision-making process even if no action was taken and regardless of whether the experience aligned with or challenged their values and beliefs.

4.2.1.1 Drawing on Existing Knowledge. Participants were not blank slates and instead drew upon relevant knowledge and prior experiences when making decisions during or following a moral experience. During their decision-making process, the participants drew upon knowledge of self, knowledge of others, theoretical knowledge, and the experiences of others, which will be discussed below.

Knowledge of self was a factor in the participants' decision-making processes during clinical placements. For example, when I asked one participant why they had chosen not to confront their clinical instructor when they felt they were treated unfairly, they said they also did not like confrontation in their life outside of clinical settings. The participant recognized this and who they were as a person affected how they acted and reacted within the clinical setting.

Moi en tant que personne je ne suis pas vraiment quelqu'un qui est capable de confronter. Je n'ai jamais été capable d'aller voir le problème face à face puis de le dire, comme c'est pas correct ce que tu me dis, c'est pas correct les commentaires que tu me dis. Je me suis jamais senti que j'aurais pu et en même temps je savais que ça serait juste plus facile de rien faire et c'est toujours plus facile de rien faire. (P16)

The example above speaks to how past behaviour influences actions during clinical placements. Another aspect of knowing oneself that participants spoke about is the influence that personal values and beliefs had on their clinical practice. Again, the participants used knowledge of themselves to make decisions based on their own values and beliefs, such as knowing how they wanted to treat others. As participant 15 noted, “Moi je suis une personne que j’ai beaucoup de valeurs personnelles qui orientent vraiment la façon que je donne mes soins ou que j’agis avec une personne surtout en soins infirmiers” (P15).

Knowledge of others is the knowledge that participants had of other people in the clinical environment. Most frequently participants spoke about knowledge of their patients. The participants used their knowledge of other people to make decisions about what they perceived to be good, right, or just for that person. Therefore, decisions were not necessarily based on what the participants perceived to be good, right, or just for themselves, but rather what they perceived to be right for another person based on their knowledge of that other person. One participant explained why they kept their patient’s unauthorized cigarette stash a secret from the clinical instructor and staff. This student’s knowledge led them to believe that keeping trust with the patient was more vital than transparency with the instructor and staff.

[EM] How did you come to the decision that that was the right thing to do – to let him [patient] conceal it [cigarettes] to keep that trust with him? What was your decision making process that you said, this is what he showed me and this is what I’m going to do about it?

[P1] Well, the first was the trust, right? The fact that he [patient] came to me and showed me this when he said, “No one else knows about this, none of the nurses know.” That in and of itself, I didn’t want to breach the trust, right? Because in a situation where you’re

very, very much alone, right in the hospital, he didn't have any family really. ... So in terms of social relationships, he was very isolated, so the fact that he was able to come to me and tell me that was, I guess, a good step in terms of helping form healthy social relationships. And I think it would completely destroy any hope he had in forming successful social relationships if I took the only one he had and destroyed it. So I didn't think it was the right thing to do for that reason. (P1)

Concealing this information could have led to a reprimand for this participant, but maintaining trust and what they believed was right, good, or just for their patient was worth the risk to them.

The participants also made decisions during clinical placements based on theoretical knowledge learned during classes and laboratory simulations. Participants applied this knowledge during their clinical placements but it did not prepare them for all possible moral experiences. Rather it provided a platform from which participants felt they could justify their actions and subsequently tailor them to specific situations. In one example, a participant demonstrated that they relied upon their knowledge of best practices to ask their patients about suicide, a generally uncomfortable topic.

This is something that, that for me, was very new too because when, when [name of professor], our professor said, "Ok, so when you're doing your MSE [mental status exam] you have to ask your patients 'Do you have any feelings of killing yourself or harming others?'" ... The evidence-based practice for me is that, the asking. Because a lot of people don't want to ask because they think it's going to exacerbate their thoughts of killing themselves, whereas when you ask, the patients will have to open up a little bit and that little bit of opening that, you can start digging into what they're feeling about why they want to kill themselves or why they want to harm others. That evidence base

again, it's very comforting because you're like, "Oh, yes, I know what to do in this case."

Also, the critical thinking part comes into that, "How am I going to tailor this evidence based practice to my patient's needs," because not every suicidal ideation or homicidal ideation are the same. (P7)

Another source of knowledge upon which participants relied to make decisions during clinical placements was the experiences of others. Participants did not exist in a vacuum independent of others around them. In general, when participants spoke about learning from the experiences of others, it was in relation to watching or speaking with other UNSs to learn which actions caused which reactions. Therefore, participants might not have directly experienced something but learned from the experiences of other UNSs and integrated this knowledge into decisions about their own actions. Although one participant did not themselves experience being made to feel incompetent by an instructor, in order to avoid potential discomfort, the participant chose to stop asking this instructor questions because they did not want to get the same reaction as a colleague.

For example, on a patient's chart, my colleague had the patient as NPO [nothing by mouth], but also as a regular diet. She was confused as to why that was the case. And when she asked the clinical instructor, our instructor was like, "Oh, well, did you check that she had an ECT [electroconvulsive therapy]?" And the student said "No, I didn't check." She's like, "Oh, well, you should check first before you ask." And it made her feel really incompetent for asking, but it was a normal question to ask. Especially when we first started, we didn't know that you had to be NPO for ECT. ... So we stopped asking her questions after the second week, basically. (P12)

Finally, participants spoke about drawing knowledge from their personal experiences

outside of clinical placements. Participants' lived experiences influenced who they were and how they interacted with others, and they brought their individuality to their clinical practice. In one example, a participant had been hospitalized during their nursing education; this made them more understanding of patient experiences and influenced their practice during clinical placements.

... j'ai eu plusieurs commotions cérébrales durant mon bac [baccalaureate]. J'ai aussi été très malade, j'ai eu plusieurs chirurgies. ... Mais tout ça pour dire que moi j'ai passé beaucoup de temps, surtout les derniers quatre ans là dans les hôpitaux aussi. ... Alors ça m'a permis de vraiment voir beaucoup de choses des deux côtés. (P15)

Experiences outside of clinical placements also created a point of reference that the participants used when developing expectations about the clinical placements. This expectation was at times in relation to people, for example, expectations around the perceived roles of nurses. In other cases, the point of reference was developed in relation to the clinical environment itself.

The new building, A4, I don't want to say that it almost looked like a hotel, but I would say it's a modern take of what hospitals should look like. Because in the Philippines, I've been to hospitals there, they look like – they're literally what you imagine – what I imagined hospitals are, white walls, some not well-lit hallways and having stretchers outside in the hallway with some patients in them. (P7)

4.2.1.2 Balancing Risk and Reward. Participants usually knew what they believed to be right, good, or just, but there were risks and rewards for each action taken based upon these beliefs. The participants weighed these risks and rewards in relation to themselves and others, such as the patient or another UNS, following a moral experience.

When weighing the risks and rewards in relation to themselves, when, for example, they felt personally wronged in some capacity, the participant often perceived that the benefits of action outweighed the risks. One participant referred to a clinical placement where they did not like the way they were being treated by their clinical instructor. As a result of ongoing negative experiences, the participant developed intense anxiety before each day of the clinical placement. After making three complaints to the school of nursing, the student's clinical group was changed, which they said saved their life. When considering the risks and rewards around speaking up for oneself, the participant recounted how in the end there was no risk because things could not have become any worse than they already were.

To me it was like, "Well, it can't really get any worse than this." You know what I mean? It can't. ... I never regretted complaining because ... I don't like injustice. And I don't like not being advocated for because we're taught to advocate for other people who are really not always being advocated for. I'm so sorry, I just ... [voice trails as participant sounds upset] ... But I was like what's the alternative? I don't do well, and I fail. You know what I mean? Either way I'm screwed, that was my mindset at the time. And I was like, "You know what, the risk is already there. I'm already undergoing the risk, I'm already in the process of being on a learning contract." (P5)

Here the participant had decided that the rewards of speaking up outweighed the risks when considering the potential consequences for themselves. At other times, the potential risks outweighed the rewards. In these instances, the participants chose not to speak up because the risk was too great. One participant, a self-identified male, spoke about how he already stood out from the largely female cohort of UNSs and he did not want to attract further attention to himself

by speaking up. He knew he and his instructor did not always agree and he did not want to be labeled a difficult UNS. For him, the perceived risks were too great.

I feel like whenever you find an issue with your clinical instructor, if you have different point of views, it's very hard as nursing students to bring it up because it may be unintentional, but you're going to be labeled regardless of being a difficult nursing student. Or there's always that feeling in your head that he or she, as in a nursing instructor sees you as being lesser of the other students. So, I know for me, that's just my story but I know so many other students who have so many different stories about their clinical instructor and wanting to say something but if they do, they're going to be labeled. And that's our own judgment too, because of course, the clinical instructors aren't there to label us, they're there to help, provide support, but it's our fear. It's that fear in us that if we do say something that we feel that we will be labeled, but that may not be necessarily true however, but it's how we feel. (P8)

Participants also considered the risks and rewards when making decisions about moral events in relation to others, for example, other UNSs or their patients. Again, at times, in weighing their decisions on how to act for or speak up for other people, they perceived the rewards to be greater than the risks. One participant believed that they had the strongest relationship with their clinical instructor out of all the UNSs in their clinical group, which provided the confidence to speak up on behalf of the entire group in the face of what they perceived to be inappropriate comments from the instructor. Because of the quality of the relationship, the participant perceived that the risk of harm was minimized.

Je sais pas, ça a juste sorti, j'étais pu capable on dirait. C'était juste comme tout le monde [UNS clinical group], on s'était parlé puis on était comme, "je comprends pas pourquoi

elle [clinical instructor] est encore fâchée.” Puis ça faisait comme une couple de shifts donc quand elle a dit ça, j’ai juste – pis moi pis cette enseignante là on avait eu des jokes parfois, alors je me suis senti comme si j’étais correct de dire un petit commentaire comme ça avec la relation que j’avais construit avec elle pendant les derniers shifts. Mais je ne sais pas si ça aurait été la même chose pour mes autres collègues, c’est juste que je me suis senti comme si ce n’est pas moi qui le disait, il y avait personne d’autre qui l’aurait dit. (P16)

However, sometimes participants perceived that the risks outweighed the rewards, meaning that they chose not to speak up when they perceived that someone, usually a patient or another UNS, acted or was treated in a way that challenged their values and beliefs. A participant felt that the clinical instructor was raising their voice inappropriately towards a patient with dementia. Although not explicitly stated, there seemed to be little reward for speaking up on behalf of the patient. The patient had advanced dementia and therefore would not remember the interaction with the clinical instructor.

And the same instructor with a different patient that I had, that did have dementia, she would shout at him “Where are you? Where are you?” and he would say “Get out of my living room.” And I’m like, “He has dementia, he’s not going to be able to respond, it’s very progressed.” And then she’s like, “Sir, what’s your name? What’s your name?” And I’m like, “He’s not going to be able to respond, he doesn’t know his name.” But she just kept yelling at him and I found that it was upsetting him and I didn’t want to tell her to stop. Well, I kind of told her like, “I don’t think you’ll get any more out of him.” But then she kept pushing and I felt that was also morally tough to deal with because I don’t want

anyone to shout at my patient, but at the same time, to talk back at her was – definitely get slapped on the wrist kind of thing. So that was really tough to deal with. (P22)

4.2.2. Developing Knowledge Over Time

Developing knowledge over time is tied to, yet distinct from, reflecting on the decision-making process described above. Reflecting on the decision-making process describes the knowledge that the participants drew upon to make decisions during a moral experience; the knowledge that they drew upon was developed over time as they accumulated experiences. Developing knowledge over time represents the learning that occurred following a moral event. This new knowledge was then used by the participants to inform future decisions. If we consider the moral experience as the peak of an arc, the decision-making process that draws on existing knowledge represents the ascending part and developing new knowledge following a moral experience represents the descending part, which then loops back around to the ascending arc in a forward motion as knowledge is developed.

If this circuitous arc is considered to illustrate the learning process, it must also account for the progression of and cumulative effect of participants' learning. This is the forward motion of the arc. As the participants gained clinical experiences, their knowledge developed and had a cumulative effect over time. Many of the participants spoke about how they did not feel equipped for clinical practice in the beginning. Participant 12 stated that "... for the first week or two, you're kind of running around like a chicken with your head cut off. ... You do feel kind of incompetent in the beginning" (P12). "In the beginning" signified different moments in time depending on the participant's story. Usually, it was meant to reference the beginning of a new clinical placement or the beginning of the program compared to the end of the program. It also meant the start of third year compared to the start of fourth year, for example.

Il y a toujours cette idée que – puis c’est vrai que maintenant je connais beaucoup plus que je connaissais en deuxième année. C’est vrai qu’en deuxième année je connaissais beaucoup moins puis probablement je vais regarder dans quatre ans, puis je vais dire “Wow, en quatrième année de l’université je connaissais beaucoup moins que maintenant.” (P15)

Across the interviews, there were four overarching elements that emerged as being affected by the development of knowledge over time. They were confidence, comfort, critical thinking, and stress. The first, confidence, appears to have a direct relationship to knowledge. This means that as the participants’ knowledge increased over time, so too did their confidence in the clinical setting.

And as nursing students, I feel like we’re not really 100% sure of a lot of things at least in the beginning. Whereas I feel a bit more confident in my abilities and assessment and everything now. It wasn’t the case back in second year in our first placement. (P13)

Specifically as it relates to the development of confidence over time, some of the participants spoke about how they felt empowered to act in ways that better aligned with their values and beliefs following an experience where they felt they had compromised on what they perceived to be right. In these instances, it was about developing confidence to act differently in the future.

Puis si ça arriverait encore je pense que je mentionnerai mon opinion, “Regarde ça a de l’aire comme un vraiment gros calibre [cathéter urinaire], veux-tu que j’aille voir s’il y en a des petits?” Parce qu’essentiellement, le problème, j’avais entendu la résidente dire au téléphone qu’elle aussi pensait qu’elle devrait en avoir un plus petit mais sur notre unité on en avait pas. Puis c’est plus pour ça que ça m’a fait penser que c’était plus la paresse de pas vouloir aller sur une autre unité, ou ne pas vouloir aller en chercher un autre plus

petit. C'était juste comme "Oh, j'en ai un gros, je vais juste prendre ça même si ce n'était pas nécessairement la bonne pratique." C'est ça qui m'avait vraiment frustré surtout à ce moment-là, que c'est ça que moi j'avais en tête, je l'ai entendu vraiment valider ce que je pensais. J'aurais dû dire quelque chose. Je n'ai pas aimé me sentir comment je me suis senti après, et je n'ai pas aimé voir comment le patient se sentait après non plus. Donc je pense que si une situation comme ça arriverait encore, je prendrai la chance puis je dirais ce que je pensais. (P15)

The same direct relationship was also expressed by participants about their perceived comfort within the clinical setting.

I've really grown even as a person, period. Yeah, for sure. When I first started in this program I know, I was much more timid and prone to take orders rather than use my head and make my own orders. Not literally but just yeah. Yeah, I feel like I'm more comfortable as well in the environment, even though it's still not super fun for me, but I'm more comfortable in it for sure. (P11)

The same sentiment was also shared about the relationship with critical thinking and the development of knowledge. Over time, as the participants developed knowledge, they felt their critical thinking improved during clinical placements.

I had trouble critically reflecting or critically thinking in my first placement. And then come to my third year, I was able to think more critically, not just about putting together my patients' care holistically, but also critically thinking about "What does this patient really need right now?" (P8)

Finally, a few participants spoke about being unsure about what to do in a given situation where they were experiencing something that was unfamiliar to them. They felt unprepared to

manage the situation and in these instances, reached out for support to develop the knowledge that would subsequently help inform their decisions. These events then allowed participants to develop a point of reference or learn specific clinical skills to feel better prepared (more confident, calm, and less stressed) should they encounter another similar experience. When participants felt unsure about what to do, it was most often related to specific practical clinical skills.

There was one time where I was able to pack a stage four pressure ulcer, that was pretty cool. I was terrified at the time because we hadn't learned anything about it and our clinical instructor, she had me get all this stuff and I was standing there with my sterile gloves on and she was like "all right go" and I was like "I don't know how to do this, you've got to tell me step for step" because we had learned nothing about it. (P3)

The three types of knowledge that UNSs developed will be described below in the following three sub-categories: 1) knowledge as a result of prior personal experiences, 2) knowledge as a result of clinical experiences, and 3) knowledge as a result of structured learning.

4.2.2.1 Knowledge as a Result of Prior Personal Experiences. Knowledge as a result of prior personal experiences is transferable knowledge that participants developed outside of clinical placements in their personal life and that was then applied to inform decisions within the clinical environment. As 14 of 23 of the participants interviewed had prior work experience in healthcare, most of the stories they shared about transferable knowledge gained in their personal life was developed as a result of experiences during their employment in healthcare. For example, one participant learned about confidentiality in their workplace and then applied this knowledge during clinical placements.

C'est beaucoup de confort puis de support à la famille mais aussi la confidentialité. Dans

le centre de naissance, ... moi je ne peux rien dire [à la famille], je ne peux pas dire ce qui se passe, je ne peux pas dire que j'ai entendu un bébé, je ne peux pas dire qu'ils ont crié "It's a girl", je ne peux pas dire ça. ... Donc ça m'a aussi aidé à l'hôpital pendant mes stages parce que tu ne peux pas dire les résultats ou quelque chose à un patient. Il faut vraiment que tu dises rien mais en même temps les rassurer donc dire "on fait ce qu'on peut, tu vas le savoir aussitôt que possible." (P16)

Prior personal experiences provided valuable transferable knowledge that the participants could apply in the clinical environment. Therefore, not having developed knowledge as a result of personal experiences left some participants feeling less confident when providing patient care. One participant specifically referenced their lack of personal experience with people who have a mental illness as having an effect on their clinical experiences during their mental health placement. Because of this lack of previous experience, they felt unsure about how to interact with patients on the unit.

Je n'ai pas beaucoup de problème de santé mentale dans ma famille. Alors c'est quelque chose que je ne savais pas trop quoi faire. Surtout en arrivant en santé mentale, ça c'était mon pire stage. Je ne savais pas quoi faire, ... je ne savais pas comment agir, réagir face à ça. Puis ça c'est quelque chose qui a vraiment été difficile pour moi. (P15)

4.2.2.2 Knowledge as a Result of Clinical Experiences. Of all the ways in which participants developed knowledge, they most frequently spoke about the knowledge they developed during their clinical placements. I will first describe knowledge as a result of clinical experiences as a whole. I will then discuss their learning in relation to their specific moral experiences in the following two sub-categories: 1) learning from a moral experience that aligns with ones' values and beliefs, and 2) learning from a moral experience that challenges one's

values and beliefs.

Learning during clinical placements, with hands-on experiences with patients, was described as being a very valuable source of knowledge. Notice that the participant below explained how their clinical experiences allowed them to consolidate their knowledge learned during class. Without the practical application of what is learned during class time, the information is susceptible to being forgotten.

Puis aussi on va dire que si tu as des expériences en stage, ça me reste plus. Comme une lecture en classe, je vais apprendre quelque chose, je vais l'apprendre pour le test mais si jamais je ne la vois pas en stage, on dirait que ça ne reste pas. (P21)

Further, during each clinical placement, the participants experienced a learning curve where they adapted to new people and the new clinical environment. As each placement progressed, the participants developed a sense of familiarity with the clinical environment and felt more comfortable within it. Following the completion of one clinical placement and the start of another, the process of learning to navigate and adapt to the clinical environment and people started over again.

I think it's more this year that it's set in that I need to adapt more. Third year was really when we had four placements and they changed so quickly so I didn't really adapt ... but now I think if I had another year I would do a lot better knowing all of what could be expected and the questions to ask. (P18)

Finally, a few of the participants shared experiences where they made a mistake during their clinical placement and these experiences had a profound effect on them and their learning. These experiences could be difficult for the participant, yet they proved to be valuable sources of knowledge. Following a mistake, some participants spoke about how that experience followed

them and how they were very unlikely to make the same mistake again because of the repercussions they experienced afterwards. Therefore, the experience of making a mistake might have been very difficult for the participant, but the resulting knowledge developed was retained and applied to other clinical experiences. Another participant spoke about how, through a process of trial and error, they learned to navigate relationships with their patients. This example may be less striking than some of the other mistakes shared by other participants, but they clearly described how they learned from interactions with their patients and how their practice changed over time as a result of this trial and error.

Au début du stage, mes relations avec les patients n'étaient pas aussi bonnes qu'à la fin du stage. J'ai dû apprendre par dire quelque chose puis voire comment la personne réagit puis espérer que j'ai dit la bonne chose. Puis certaines fois ça n'a pas nécessairement fonctionné puis j'ai appris de mes erreurs puis j'ai changé un peu. Puis chaque personne est différente aussi donc certaines personnes vont réagir mieux à quelque chose que tu vas dire puis d'autres ne vont pas aimer ça. Donc je ne sais pas comment j'ai appris ça, je n'ai pas regardé des vidéos ou lu des livres, j'ai juste essayé de voir comme si moi je serais dans cette situation-là, comment est-ce que je me sentirais puis comment est-ce que je voudrais que quelqu'un m'approche. Puis des fois ça fonctionne, des fois ça ne fonctionne pas. Mais [...] à force d'avoir plusieurs interactions avec des patients ça te permet de mieux te développer puis mieux les aider aussi. (P15)

4.2.2.2.1 Learning From a Moral Experience that Aligns With One's Values and Beliefs. The participants who had a moral experience that aligned with their values and beliefs learned and grew as a result of these experiences. The learning was subtle but important nonetheless. When participants told stories that aligned with what they believed was right, just,

or good, the experience remained unproblematic to the participant because there was no jarring disconnect between what they perceived to be right and what occurred. The action (or inaction) aligned with their values and beliefs about what they perceived to be right in that specific circumstance, at that moment in time, within the larger sociopolitical context. Because the experience remained unproblematic, there was no trigger for the participant to necessarily reflect further about it. There was therefore no need to challenge any underlying values and/or beliefs that underpinned their interpretation of the event(s). In caring for a patient with a cognitive deficit, one participant stated that:

There was one time that I was feeding him [the patient] and I was just trying to keep talking about whatever, and so I was talking about the carrots on his plate and the mashed potatoes or whatever and I was like ... “Oh the chicken smells good, oh, this looks like carrots you know. I don’t actually like carrots that much, do you like carrots?” Because he could nod at something. He was nodding and eating and for the first time, he didn’t look distressed or anything like that. And from what I perceived from that situation, he appreciated just talking about normal things, like talking about how I don’t like carrots or how the sun was out for the first time in a week or something like that. I think just the normalcy of that, like as normal as that situation could be ... so I think he appreciated that. (P3)

Here the participant did not speak of any specific underlying values or beliefs that led them to try to connect with this patient despite the cognitive deficits. What they were aware of, however, was that establishing a sense of normalcy for the patient was important to them as were their beliefs about what kind of care they wanted to provide. The participant knew that it was the right thing to do but did not specifically identify why this was important for them. Despite this, it is

clear from the participant's perspective that the patient appreciated the normalcy of the interaction. Because of this positive feedback, the experience remained unproblematic to the participant and no further thought or action was needed at the time.

The participants' stories supported the idea that patient care is not based on general truths, that the relational space between individuals is situated in a specific time and place. This statement is echoed by several participants and is eloquently put into words by participant 3.

Obviously, there's the personal connection, but you need to have the knowledge to back up all these decisions that you make in critical situations and non-critical situations. ...

How to react in this situation, or what do you say in this situation, we do learn a lot of it.

But really, in that moment, it comes down to the knowledge that you have to make a decision by yourself, what you think is good in that moment and what is beneficial for the patient or best for the patient. (P3)

In other words, what the participants learned was based less on specific algorithms of circumstances ($x + y = z$) and more on a myriad of information that is specific to a time, place, and relational space. In this sense, participants developed a repertoire of experiences that they used to develop knowledge informing future decisions.

4.2.2.2 Learning From a Moral Experience That Challenges One's Values and Beliefs. A moral experience that challenges one's values and beliefs does not have the same result as one that aligns with them. Instead, it is problematic and messy. A moral experience that challenged the values and beliefs of a participant usually triggered that participant to reflect on the experience that took place. Specifically, participants often reflected on how things could have been done differently so that they better aligned with what they perceived to be right, good, or just in a specific circumstance at a specific moment in time. For example, could they have done

anything differently to affect the events that occurred, or should they adjust their underlying assumptions and beliefs about what is feasible in the clinical environment? Learning occurred from this type of reflection because it allowed participants to process what happened and learn how they might or might not adjust their actions in the future to avoid, respond to, or process events that challenged their values and beliefs. Following such an experience, participants' responses fell into three categories: 1) moving on, 2) getting stuck, and 3) doing things differently the second time.

4.2.2.2.1 Moving on. Moving on refers to participants' ability to live through an experience that challenged their values and beliefs and to put the experience behind them. This is not to say that they were not changed in some way or had not learned, instead, it meant that they created an emotional distance between the experience and their present lives. Sometimes this occurred because of the fast pace of the nursing program; they became so occupied with a new task that they no longer had time to dwell on a moral experience that challenged their values and beliefs. Participant 14, for example, shared how they tried to focus on the clinical instructors whom they felt supported them well in their learning and put the difficult experiences with others behind them.

OK, par rapport aux professeurs cliniques, la plupart d'entre eux sont d'excellentes personnes du côté professionnel. Mais aussi, comme partout dans la vie, il y en a quelques un qui honnêtement, moi je dirais qu'ils ne devraient pas être des enseignants, ils devraient faire autre chose. ... Mais il ne faut pas s'attarder à ces personnes, il faut s'attarder aux profs qui sont vraiment très compétent, qui m'ont marqué pendant mon séjour puis que je les trouve vraiment très compétent et qui sont des personnes sévères dans le sens qu'ils sont exigeants, des personnes exigeantes dans leur domaine, mais

juste. Je n'ai pas de problème avec les exigences ainsi que le travail fort, mais j'ai un peu de problème avec l'injustice par rapport aux étudiants. (P14)

4.2.2.2.2 *Getting Stuck*. Some participants dwelled on an experience for a long period of time. Those who were stuck on a particular experience seemed to carry a heavier emotional burden than those who were able to move on. There also seemed to be this sense that if the participant held on to the memory of an experience they would be able to prevent the same outcome from reoccurring. For example, one participant considered becoming a clinical instructor themselves to prevent future UNSs from feeling the way they felt following challenging events with their clinical instructor, speaking to the impact that getting stuck on a challenging experience could have on participants' lives and the lives of those around them. As another participant noted, they were unable to regain their confidence during their clinical placements following challenging interactions with a mental health placement clinical instructor.

Geriatrics, that was definitely the highest point of my confidence. My instructor was very encouraging, it was less penalization and more "here's what you're doing right." My confidence was soaring, I wish I had continued with that. But no, I think mental health [clinical placement] definitely decreased my confidence a lot more than it did any good. (P18)

4.2.2.2.3 *Doing Things Differently the Second Time*. Following a moral experience that challenged their values and beliefs, several of the participants described how they would do something differently if they were able to relive the experience. One of the emotional reactions to events that challenged their values and beliefs was the feeling of regret, which triggered some of the participants to consider alternative potential responses to the experience that occurred. They considered the ways they could have acted differently to better align the experience with

their values and beliefs. In almost every instance, the stories participants shared about doing things differently the second time were related to an action that the participant did not take.

To be honest, I was like, “What if I go back to the unit?” ... Definitely, if I had a second chance I would try to say something. I didn’t say anything and I regret that. But like I said, you learn from your mistakes not to do them again, but you don’t know what to do instead of what you did. (P17)

4.2.2.3 Knowledge as a Result of Structured Learning. Structured learning refers to the learning that took place in the theoretical courses of the nursing program. Best practice guidelines, for example, are taught in class and then applied during clinical placements, which allows for the practical application and integration of the theoretical knowledge participants gained during classes. Participant 4 talked about how they learned in class several ways to calm a patient down, which they later applied during an interaction with a patient who was distraught.

And then another experience would be, especially in class, you’re always taught, like, listen to the patient, and you’re taught all these different ways to help a patient calm down. If they’re a little upset like making eye contact, you can hold their hand a little bit, speak quietly and just like breathing exercises, if they’re anxious. (P4)

In addition to the theoretical course content delivered, some of the participants valued the knowledge gained by their course professors sharing their own clinical experiences. Learning about clinical practice “in real life” provided participants with insights and tools that they applied to their own clinical practice, information not necessarily found in textbooks. Instead, the course professors illustrated theoretical knowledge by providing a concrete example from their own practice. It was important to some participants that their course professors were nurses because of the knowledge that they brought to their class, with the knowledge gained becoming

transferable to participants' clinical experiences and decision-making processes.

And yeah it just helps to have one, professors who are nurses. And nurses who are open to educating because they really give you like a mini toolbox that you can work with, and then you can expand your toolbox the more that you interact with this, with the patient because you're going to start seeing what you can do and how you can tweak your care for them. Because you can't just be like, "Ok, I'm going to copy the way this nurse did it." But it's not the same patient. I, you know, that mini toolbox that they give you with their input of their past experiences, you can use bits and pieces of it, and then make your own toolbox. (P7)

One of the challenges some of the participants shared was that the timing of the delivery of the course content affected their ability to provide what they perceived to be competent patient care. They noted that clinical placements without the relevant accompanying theory made them feel ill equipped to practice within those settings. One participant had entered their first clinical placement with knowledge only about the functioning of a healthy body. Since patients were not necessarily healthy, this participant felt they had not yet developed the knowledge to practice confidently in that environment.

Even going into my first placement, when I didn't know really anything, we'd only learned about healthy adults. And then you're going into long term care where nobody's healthy and you're learning about all that stuff through the semester but how does that help me during my placement if I don't know it? (P2)

4.2.3 Learning Who I Am

As participants progressed through the undergraduate nursing program, they had moral experiences that affected them as people and professionals. They almost always spoke about

these experiences as to whether or not they aligned with or challenged their values and beliefs. But their interpretation of their moral experiences was subject to change over time; what the participants deemed good/bad, right/wrong, or just/unjust was inseparable from the person they were at the moment in which the moral experience occurred, shaping the way that they perceived their moral experiences. This category is made up of the following three sub-categories: 1) knowing what is “right” or “wrong” in this moment, 2) developing a moral identity, and 3) changing as a person.

4.2.3.1 Knowing What is “Right” or “Wrong” in this Moment. The participants made judgements about whether their moral experiences aligned with or challenged their values and beliefs. In almost all instances, the participants could articulate what they believed to be right, good, or just about their experiences. For example, the participant below witnessed floor nurses being more abrasive with the patient than what they considered to be appropriate; they knew that for them, this was wrong.

To distress the patient seemed wrong and rather than seeing that “oh, this patient is now agitated” or “what can I do to clarify this” in saying “I’m here to do this this and this” or “I’m just here to have a chat about this.” I think that would have gone miles in comforting the patient and putting them at ease in saying “we’re here to work together” type thing than being so quick, abrupt, a little bit abrasive, and then calling the patient delirious right in from of them is a little bit ridiculous in my eyes. That doesn’t really seem right to me to agitate the patient when you’re there to provide care for the patient.

(P13)

During the interviews, participants had time to reflect on their interpretation of a moral experience. At the time the moral experience occurred, however, their interpretation of whether

the experience aligned with or challenged their values and beliefs often happened rapidly, with many not even conscious of their decision-making process. Their interpretation of their moral experiences was temporally, contextually, and relationally bound. What they perceived to be “right” was not fixed because their interpretation was based on influencing factors that could change.

[EM] How did you decide that that was the right thing to do for that person in that moment?

[P4] I mean, it was the right thing for me to do for the patient at the moment. I don't know what someone else would have done. But I feel like I literally had 10 seconds to kind of just think, and I decided that at that moment. ... I just felt like it was the right thing to do because throughout the day, you could tell she was so low, that she did need someone to say, you're doing amazing. (P4)

4.2.3.2 Developing a Moral Identity. Developing a moral identity refers to participants coming into their own as people who provide patient care by making decisions about what kind of nurse they want to be and how they want to provide that care. The participants made choices throughout their clinical placements and these choices were reflected in stories about the ways in which the participants interacted with their patients. During clinical placements, participants were exposed to different nurses and healthcare providers whose approach to patient care sometimes differed from their own. They recognized that there was no universally prescribed approach to patient care and that not everyone would provide it in the same way. As a result, some of the participants experienced tension between their perception of “good” patient care based on their moral identity and the care that other healthcare professionals provided. As the participants developed their own moral identity, they became aware of this tension. For example,

one participant illustrated how their care differed from a clinical nurse's approach and that from their perspective, the patient's comfort was negatively affected.

Il y avait une fois, c'était le semestre passé, j'avais un patient palliatif. ... Mon patient il était in and out - je lui changeais la couche, puis je lui disais "on va tourner". Oui, ça lui prenait 20 secondes de plus de se tourner qu'un patient régulier, mais je trouve que c'était plus sensible de le laisser se tourner lui-même au lieu de lui garocher. ... Alors là on [patient and participant] travaillait bien ensemble toute la journée. Après ça, ... moi puis l'infirmière [qui est venu aider] on est en train de changer le patient puis elle [l'infirmière] lui tourne très rapidement, elle faisait sa tâche le plus vite possible. Puis là il [patient] commence à frapper [l'infirmière], mais obviously il va te frapper, moi aussi si tu commences à me manipuler toutes sortes de façons je te frapperais aussi. (P23)

A few participants spoke about how they perceived that their ability to provide good patient care was better as an UNS than they anticipated it would be once they became registered nurses. In almost every instance that a participant spoke about this, it was in relation to the time available to spend with patients and how they saw nurses become hardened as they tried to keep up with the pace of patient care with limited resources. Many of the participants linked their moral identity to their ability to provide "good" patient care.

And it's been pushed on me that that's a skill that you'll learn, you'll learn to leave it, but I don't know if I am the type of person to leave it. I don't know if I can. It's hard when you care so much and I talked about it with [name of a professor] actually, and I was like, "This is what I love about nursing, I love the narrative, I love hearing it, but when I'm a registered nurse, I won't have the time for that." And [name of same professor] like, "Well, you know, if you learn to manage your skills, you can make the time for that." But

I don't know. It's what worries me, ... that I won't have the time to engage with my patients, like I do now. What if I like being a nursing student more than I do a nurse? ... And then there's the nurses on the medicine unit who are run off their feet. I felt guilty for asking them for help because they're literally sprinting down the hall or something. (P6)

Further, not only did some participants speak about how they worried that the quality of their connections with patients would be inferior as a registered nurse, but there was also an element of powerlessness associated with it. They feared that there was no solution and ultimately, as time goes on, your moral identity as a nurse who provides "good" patient care erodes, potentially leading to burnout. In a sense, the way some participants spoke about this was that they were "whole," as in their moral identity was realized when they began their journey into patient care, and they were afraid that that "wholeness" might ultimately erode over time.

It also sucks because you get a taste of what it's like to do those things. Like you know what it's like to have that deep connection with a patient and then I'm going into my first year of practice and I'm going to very quickly realize that that's not possible. And that can be very – when I went home from my placement I was like "I did a good job today, I did the right things, I said the right things, I made them feel a little bit better because I spent time with them." The moment my staffing ratios are off, I'm worried I won't be able to do that right off the bat, which sucks, that that's the way that's going to be. ... And then people burnout because it's not what they're doing, they're not happy anymore. They don't feel like they've done a good job at the end of the day. They leave thinking they could have done more and then that sticks with you. (P2)

Finally, participants shared that part of developing their moral identity was understanding

how that identity fit within an organizational structure such as a hospital. The participants realized that they were not free to act however they wished; there were structural constraints that governed their scope and standards of practice.

It's tough. ... Because even for myself, I don't think I would work in mental health or in a situation where there were rules that I didn't align with personally, because I think I would do the right thing regardless and I don't want that to interfere with my job security or safety. ... I don't think I can work in mental health for similar reasons. Because I don't think that I would be – it would be too risky to act in the way that you think is most morally right I think in mental health situations where the rules kind of prevent you doing from what you think is right. ... But I think it's unfortunate because very smart and encouraged and motivated people who want to go into mental health may be limited by these factors, right? They could see that as a potential threat to their job, or it could change their practice, you know, they could go in wanting to enact change and do all this good. But then they can be very limited and very, you know, held back by the structural constraints, and that could change their moral identity, right? It could even you know, destroy it in some situations. (P1)

4.2.3.3 Changing as a Person. Participants also spoke about how experiences lived during clinical placements changed them as people outside of clinical placements. Their experiences in the clinical environment could affect the way that they understood and interacted with the world outside of clinical placements – “being a nursing student, you see those changes in yourself, because you're not just being trained academically, you're also being trained to be the type of person that a person would need” (P7). Some participants even felt their overall confidence and compassion develop as a result of their clinical placements.

I feel like I've been through a lot. And that has shaped me as a person and as a professional. ... As a person I feel like I am more compassionate ... but it has also made me more calm in the sense that I don't get like scared easily and I don't get freaked out easily. ... And I feel like I've been able to use my clinical judgment in my personal life a lot and in my own personal health. Whereas if I get bloodwork results that aren't exactly right, I don't freak out. Which is good I find. (P5)

Finally, another participant made a clear identifiable link between clinical practice and its effect on their personhood. The participant became more aware of the fact that every person has a story that has led them to be the way they are at a specific moment in time, and that they may be going through something that outsiders to that person's social circle are not privy to. This has made the participant more considerate of others in their daily life.

He [patient] affected me. He didn't just affect my care or my nursing trajectory – he did, but he affected me. I think that's why he really stuck, he changed me. ... I feel like I am more aware of people's histories. You know, I come from pharmacy assisting, I started when I was 15. I did it right up until entering university and I would see a lot of upset people. People are upset and they're angry, and that happens a lot. But now, looking back, maybe they're not just crabby Karen "Can I speak to the manager?" She's probably upset because she's a personal caregiver to her husband and he has kidney failure and we don't have the medications. You know me, a goofy 15-year-old was like "I'm sorry, mam, I don't have your medications" but really, I'm causing this poor woman distress who's probably burnt out caring for her husband with kidney failure, you know, in retrospect. So just knowing people and considering where they're coming from is so important. And that's how I go into every situation. (P6)

4.2.4 Learning Through a Lens of Judgement

The learning process that the participants described was not a neutral process; instead, their experiences of learning occurred through a lens of judgement. Learning through a lens of judgement refers to participants' experiences of being subjected to disciplinary techniques that were normalized in the clinical setting due to their status as learners. This category is made up of the following four sub-categories: 1) being watched, 2) being judged, 3) being evaluated, and 4) having nowhere to turn. While being watched, being judged, and being evaluated are presented as independent sub-categories, they interacted with and influenced one another. Broadly for example, when being watched, some participants felt they were being judged for the purpose of evaluating their clinical knowledge in order to determine whether they passed or failed a clinical placement. A poor evaluation further reinforced the watchful eye of the evaluating authority, typically the clinical instructor. Conversely, a positive evaluation placed the participant outside of the evaluating authority's gaze while they looked at other students more closely. The fourth sub-category, having nowhere to turn, is included in this section because it speaks to the experiences that participants shared about having no escape or recourse from being watched, being judged, and being evaluated.

4.2.4.1 Being Watched. Some of the participants spoke explicitly about how they sometimes felt that their every action in the clinical setting was being watched. This was usually in reference to the clinical instructor but also applied to anyone in the clinical setting, such as the patient's family or other UNSs. Being watched was typically spoken about negatively by the participants; being watched added pressure and stress to perform clinical excellence. In this sense, observing was not a neutral action but rather an exertion of power to see and know the observed, in this case, the participant. One participant spoke about the stress and how they felt

the watchful presence of their clinical instructor impeded their ability to perform a skill they had previously done successfully.

It got really bad to the point where I did a glucose scan in 4th year, and I was shaking. And she [clinical instructor] saw me shake, and she's like, "You're not comfortable, you're not ready." And I'm like, "But I've done this before countless times in med/surg." She's like "I need to do this with you again." And I'm like, "But the more you do it with me, the more stressed out I'm going to be." (P5)

The relationship between the observer and the participant being observed was more complex than it may appear at the outset. It was not as simple as the clinical instructor unilaterally observing the participant with the clinical instructor exercising power through observation and the participant being the powerless target of this observation. Based on the experiences of participants, it appeared that the relationship between the observer and the observed participant varied depending on the context and individual relationship between them. As one participant noted, the gaze of the clinical instructor was felt with certain instructors but not others.

[EM] Puis comme tu dis, elle [clinical instructor] a beaucoup de pouvoir.

[P10] Ah oui, non c'est certain. Puis on ressent ça comme étudiant. Pas avec tous les profs mais avec certains on sait qu'on se fait regarder. On est tout le temps de se faire évaluer en stage. C'est certain qu'on a du stress, on le ressent. (P10)

Mutual trust between the clinical instructor and the participant was a mediating factor in the participant's perception of being watched. In this sense, there was an inverse relationship between trust and being watched; the more trust between the participant and clinical instructor, the less the participants felt watched and the less trust, the more they felt watched. Further,

because every placement had a different patient population and each clinical instructor was a person with their own values, beliefs, and experiences, the trust between the participant and clinical instructor fluctuated, not only depending on the relationship between the individual participant and clinical instructor but also the setting in which the relationship existed. This meant that the trust between participants and clinical instructors was not necessarily stable across the entirety of the nursing program for the participants.

So my clinical instructor that I had, she mostly let us do everything with our nurses and if it was a new experience or something she would absolutely help us, if we needed any help she was there. And she was open to any questions, super supportive, she let us be more independent. So when I had my first comfort measures patient and I went straight to her and said, “I’ve never done this before, what do I do, what is care like, how do I talk to the family?” I was a little bit nervous because I’d never done it. She was very supportive and I just let her know since I had such a great nurse, I didn’t feel I had to go to my instructor and ask questions or say “What do I do now, the patient passed away, this, that.” ... She was a really good instructor and she let us learn with different nurses but was also very much there to support us. ... And when I was talking about my previous experience in mental health where my instructor was kind of the opposite and very much on top of us and like “Have we done this, this, and this? Make sure you’re doing this, blah blah blah” and to an extent, those things are helpful and it’s like “thank you for the reminder” or “yes I’ve done this, thanks for checking,” but they were stark opposites in the sense – she almost viewed us as like we couldn’t do anything. (P13)

As previously mentioned, participants not only felt watched by their clinical instructor but also by other individuals in the clinical setting. The clinical setting as a learning environment

was felt to be a very public learning space; in this sense, their learning during clinical placements felt like a public event where they were on display. In one instance for example, the participant was being watched by their pediatric patient's parent in addition to their clinical instructor, which placed the participant under additional scrutiny and ultimately shook their confidence.

There would be a child in there [patient's room] and the mother, which already is a lot to deal with and then my instructor would come and be another observer watching as I, for example, hung a [IV] line. She [clinical instructor] would ask me questions about it in front of the parent who's also obviously on edge, her child is in the hospital and then I'd already be kind of shaking because my instructor was pretty intimidating. And then the parent's kind of looking at me and then if I hung it wrong, she [clinical instructor] would let it happen and it was more of a public event rather than a take me aside, explain to me how to do it. And even her feedback would be in front of the family too, stuff like that, which was difficult because I was already less confident and then I just don't do well with that – my confidence was shaky. (P18)

In general, the participants considered other UNSs as their peers, many of whom even became friends. Despite other UNSs being peers or friends, to have them watch the participant perform a clinical task during placements added additional pressure.

[P18] And then all the other girls [students in clinical group] – I was first to go – so the other girls prepared really quickly and came off as knowing them [medications] a lot better than I did so that was kind of a big one. It doesn't seem like it was, but I was really shook by it.

[EM] And so, were there other students present who saw what was going on?

[P18] Yes, yes, there was one girl who saw. She prepared pretty quickly after that. (P18)

Finally, similarly to the relationship between the clinical instructor and participant, generalizations cannot be made about how participants perceived being observed by other UNSs – context mattered. In the story above, the participant spoke about being asked probing questions about medications. Because they were the first to be asked, the other UNSs watched and took note of the mistakes the participant made so as to not repeat them. The participant did not yet feel comfortable or competent in their knowledge of the medications that they were asked about. Conversely, another participant illustrates how being observed by other UNSs gave them a confidence boost. In this participant's experience however, this was a clinical task that they were successful at and felt knowledgeable about. The clinical instructor wanted to highlight to the other UNSs how well the participant was at giving baths to newborn babies. Therefore, the context in which the observation occurred affected the participant's experience of being observed, which seems to hold true regardless of the role of the observer – clinical instructor or UNS.

Alors, elle [clinical instructor] m'a beaucoup appris et elle a booster mon ego avec les bains du bébé parce qu'elle n'arrêtait pas de rentrer à chaque fois puis elle amenait mes collègues dans la chambre juste pour qu'ils voient comment donner des bains. C'était vraiment le fun puis les bébés étaient vraiment cute. Je pensais que j'étais un bébé whisperer! (P16)

4.2.4.2 Being Judged. Several of the participants also spoke about the pressure they felt to be perfect, or nearly perfect, when providing patient care. They spoke about different kinds of pressures, which I have divided into internal and external pressures. Internal pressures refer to those that participants put on themselves, whereas external pressures refer to those put upon the participants by others. Participants spoke predominantly about the clinical instructor as a source

of external pressure but this external pressure could come from anyone in the clinical environment. The pressure to be perfect, or nearly perfect, conflicts with participants' perception of themselves as learners who were allowed to make mistakes and grow. The participants felt pressure to be perfect, or nearly perfect, because if they made a mistake, they expected that there would be a resulting negative consequence.

I think going into clinicals, nursing students put an unrealistic expectation on themselves that we can't make mistakes because the view of us already is kind of like, we're new, we're newbies, we're not really competent in much, and we might feel this urge to prove them wrong. And so we set these really high expectations, like I have to know everything if they question me or ask me about a procedure, I have to know what exactly is what. ... I had a nurse ask me about the function of a drug, and I gave the completely wrong answer. And they're like, "Nope, it's something else." And it didn't matter for them because it was just like, "This is what it's actually for." I don't think they thought of us as less, but for me, I felt super incompetent at that moment, "Why didn't I know what this medication was? They're my patient, I should have known what medication it's for. They're going to think of me as stupid or something like that." We internalize it a lot and it bothers us for longer than it should just because again, everybody makes mistakes, but because we set such high expectations, when we do fail it, it matters a lot more to us than other people. (P12)

Note that when the participant did make a mistake, the unit nurse did not express dissatisfaction with the participant's knowledge, and yet the participant still perceived themselves to be incompetent in that moment. In other words, while the participant felt incompetent, there was no externally imposed consequence or penalty for failing to provide the

correct answer to the question. Some of the other participants, however, did experience penalties or negative consequences, typically from the clinical instructor, for making a mistake during their clinical placement. As one participant described it, the UNSs in their placement had to do a presentation about an area of knowledge where they had fallen short of meeting expectations. Giving a presentation to the other UNSs in the clinical placement group was described by the participant as being an insidious form of punishment, because it was disguised as a learning opportunity where the other participants in the placement would not know that the participant had made a mistake. In reality, the other UNSs knew exactly what it meant when another UNS presented on a specific topic.

But if you got something wrong, you had to do a presentation on it which meant everyone knew that you got it wrong. And she had it under the guise of “well nobody knows unless you tell them,” but we all knew the moment you do a presentation exactly what that means. (P2)

Not all instances where participants faced negative consequences for their mistakes were so insidious. Some consequences experienced were more overt, for example, not being allowed to administer medication.

In contrast, other participants spoke about even when they had what they perceived to be a good relationship with their clinical instructor, they still felt judged, but through a positive lens, reinforcing that the participant was meeting or exceeding expectations. This is similar to trust being a mediating factor from being watched by others. Based on the stories shared by participants, their experience of being watched and judged by others appeared to be influenced by the relationship between the participant and the other individual. One participant spoke about

the good relationships they had with their clinical instructors and how their clinical instructors judged them kindly and affirmed that they were succeeding during their clinical placements.

I've been really lucky that I've had amazing clinical instructors. They've all been really nice. And my first one made me feel so happy because she was like, "I think you're in the program you should be in." And that was a really nice thing to hear. And like you said, these are the stories that make you want to stay in the program. The clinical instructors who are there seeing your actual skills, and when they say that you're doing really well, I think that's something really positive about where you're at. And I think that's really nice to hear as well. (P4)

4.2.4.3 Being Evaluated. Several of the participants referenced the Clinical Evaluation Online (CEO) or Évaluation Clinique en Ligne (ECL), the French equivalent, during the interviews. The CEO/ECL is an online tool used by the school of nursing at the post-secondary institution where data collection occurred to document and track the progress of an UNS in attaining learning outcomes. The CEO/ECL is made up of five program and clinical outcomes through which UNSs are evaluated: self-directed learner, effective communicator, critical thinker, evolving professional, and knowledge worker. Under each of these five outcomes are subsections to which the UNS and clinical instructor provide clinical examples to justify the UNS's level of performance. Clinical instructors and coordinators can access the CEO/ECL evaluations from current and previous clinical placements to better assess an UNS's strengths and areas of potential growth. On the CEO/ECL website, the term used to describe the online evaluation tool is a "pedagogical tool." This term is in contrast to the ways in which some of the participants spoke about the CEO/ECL, many of whom viewed it as a channel for clinical instructors to exercise power. They perceived that the CEO/ECL was used as a way to highlight

the participant's shortcomings so that punitive action, such as being put on a learning contract or failing a clinical placement, was more easily justified, rather than using it as a way to tailor learning in specific areas for those who did not meet certain outcomes. At the post-secondary institution where data collection occurred, a learning contract is a document used to track the learning of an UNS who has been identified as not meeting the learning outcomes during a clinical placement. One participant contended that the CEO/ECL was a punishment tool and that UNSs should do everything possible to avoid being put on a learning contract.

Donc il faut changer ça aussi, il faut changer les trucs de pouvoir absolu, le fameux contrat d'apprentissage. ... Peut-être il y a une logique derrière ça, peut-être la logique elle est bien fondée, mais la façon que certains profs utilisent le contrat d'apprentissage, je ne pense pas que ça va en lien avec ce qu'ils [the university] veulent faire avec un contrat d'apprentissage. ... Fait tout dans ton pouvoir pour ne pas avoir un contrat d'apprentissage parce que si tu as un contrat d'apprentissage, tu es à moitié mort. Ton stage c'est presque fini pour toi. C'est ça l'idée. Tout le monde a peur du contrat, le fameux contrat d'apprentissage. C'est un outil de châtiment. ... C'est un outil de coercition là. C'est un outil de punishment. (P14)

Several other participants talked about the negative aspects of the COE/ECL and the use of learning contracts. For example, one told a story about the time their clinical instructor seemingly joked about how she gives out learning contracts "like candy" to fourth-year UNSs. The message was that the clinical instructor held a lot of power and could hand out learning contracts whenever they wanted. Another contended that rather than providing an objective and unbiased evaluation of their clinical abilities, the clinical evaluation was based on likability as judged by the instructor, leaving a lasting impression that the CEO/ECL was used to evaluate the

participant as a person rather than their knowledge/clinical abilities. “Ce n’est pas par rapport à tes connaissances que tu vas être évalué, c’est par rapport à si ton prof de stage, il t’aime ou il ne t’aime pas” (P14). Finally, other participants spoke about how the objectives of the CEO/ECL acted like moving targets, reinforcing the idea that they perceived the evaluation tool as a subjective measure of their clinical abilities.

A small number of the participants described their experiences of not meeting the prescribed outcomes in the CEO/ECL. Some of those who failed to do so found the resulting actions of their clinical instructor to be equally or even more upsetting than the failure or near failure of the clinical placement itself. One felt berated by the instructor during a meeting with the clinical coordinator where the instructor criticized the participant’s clinical shortcomings for two hours. The participant ultimately failed the clinical placement but felt that the meeting with the instructor and coordinator was itself more upsetting than actually failing the placement.

Et puis elle [clinical instructor] a tellement crié dans le bureau de la coordinatrice. ... En tout cas, j’ai eu le contrat d’apprentissage et puis ils ont dit “tu dois écrire des stratégies pour améliorer.” ... La coordinatrice dit que “Voilà, si tu tiens les trois derniers shifts tu passeras.” Et puis la prof a tout fait bien sûr pour que j’échoue, elle a dit “à quoi sert le calcium pour ce patient?” J’ai dit “Pour maintenir le niveau de calcium parce que c’était bas pour prévenir la perte.” Elle a dit “Non, c’est pas pour ça, tu as tes cartes?” Et puis moi je n’avais pas les cartes de médicaments écrit à la main. Elle a dit “Ton stage est fini, quitte.” Voilà, c’est comme ça j’ai échoué. Et puis ce n’est pas le fait que j’ai échoué, parce que la vie, en tout cas ma vie m’a donné beaucoup de surprises, beaucoup de changements, beaucoup de défis. ... Au dernier jour d’évaluation, on vient toujours pour 15 minutes relire la dernière fois pour envoyer l’évaluation [CEO/ECL]. Et c’était ce

jour, c'est toujours dans le bureau de [name of the clinical coordinator] coordinatrice et puis cette prof [clinical instructor], elle a commencé encore pourquoi elle m'a fait échouer. Chaque horreur elle a passé trois fois, cinq fois, chaque horreur – deux heures sont déjà écoulés, j'étais en retard pour mon cours d'éthique. ... C'est comme si elle voulait se justifier pendant deux heures. (P20)

One final story shared by a participant speaks to the weight of the clinical instructor's evaluation. Unlike the previous participant, this participant did pass their clinical placement, but the judgement of their clinical abilities and capacity to practice nursing left the participant upset.

So by the time the final evaluation came along, I remember being the last to go and everyone came out from our CEO final evaluation. ... And the girls [other students] were like, "ya, she thinks I'd be great in peds [pediatrics]" or "ah, she really likes me, she thinks I should do mental health." And then I remember going in and she kind of said "Are you sure nursing's for you? Maybe you should do something research related or think about switching programs." And I just remember being very upset by that obviously. That was upsetting. (P18)

Notably, not a single participant who discussed the CEO/ECL as an evaluation tool had anything positive to say about it, although it does not necessarily mean no one did. Those who found the CEO/ECL unproblematic had no trigger for them to reflect on it further and bring it up during the interview. Being targeted is the singular sub-category within being evaluated and will be discussed below.

4.2.4.3.1 Being Targeted. While many of the participants shared experiences about themselves being watched, judged, and evaluated, with a few who spoke about how they had seen others targeted by their clinical instructor. They frequently used the term "targeted" to

describe this singling out of themselves or others. In all of these stories, the clinical instructor was the individual doing the targeting.

And I just felt like I was being totally singled out. And it wasn't just a "me thought", everybody's like, "I don't know why she's [clinical instructor's] treating you like this?" ... So I was like "Yeah, this isn't fair, she shouldn't be treating me like this, nobody should ever be treated like this. Nobody should be put into a small room being literally drilled down. Being totally just degraded and yelled at." And it was very personal, it wasn't professional the way that she was mad at me, she was angry. And I'm like "Why are you so angry? What did I do to you?" (P5)

Some participants also put a lot of time and thought into avoiding becoming the clinical instructor's target. Some participants had made a mistake or fell short of an expectation, which triggered the clinical instructor to focus more closely on them. More common, however, were participants who did not understand why they or others were or were not targeted by the clinical instructor.

I don't know why I was lucky, I was one of the few who wasn't targeted by her [clinical instructor] in any way. ... I would try to think of all the questions I heard everyone else get asked and already have that lined up in case she asked me or anything. And that's not a bad thing, it is a good thing to know. I think it was just I asked the nurses more questions than I asked her. If I didn't know something I asked a nurse first and then I would talk to my instructor about it but other than that, I don't really know why she didn't target me. I initially thought she wasn't going to like me very much. ... I don't think I'm any smarter or better in practice than my colleagues were. I think it was just strictly, I wasn't on her radar as someone who was an issue. (P2)

Participant 2 pointed out the subjective nature of being targeted. Just because they were not targeted did not mean they did not make mistakes. In this case the participant's progressive hearing loss had the potential to make them miss important breath sounds, but these mistakes went undetected, unlike those of another participant in the same clinical placement who failed in part for wrongly identifying a patient's breath sounds.

And there are some things, if she [clinical instructor] had paid better attention, she probably would have caught that I was doing this thing wrong or doing this thing wrong. I lost my hearing last year and I didn't know I was losing it and I was using a stethoscope that wasn't loud enough for me. ... And so I was probably missing a lot of stuff because I just couldn't hear it. But she never came with me to do my head to toe [evaluation] so she never listened, so she never knew if I missed anything. It was crazy the kind of experience I had compared to my other classmates, specifically even in our group. (P2)

4.2.4.4 Having Nowhere to Turn. Having nowhere to turn speaks to participants' perception of having no one or no resources within the educational institution where they could safely share their unfiltered experiences of being watched, judged, and evaluated during clinical placements. Some of the more informal channels of support, such as speaking with a professor or a clinical instructor, were not always felt to be safe options for the participants because of the interconnectedness of those who work within the university. Some participants felt that there was a risk their story would be shared with other employees, which they believed could potentially cause problems of being singled out in subsequent clinical placements. This fear persisted even when participants believed that a course professor or clinical instructor was open and willing to talk with them.

[EM] Avez-vous un exemple d'injustice ?

[P14] Il y en a plusieurs, il y en a plusieurs. C'est juste que les étudiants, ils ne vont pas te parler parce qu'ils ont peur de pas passer à travers. Parce qu'ils sont encore des étudiants puis ils ont peur de ne pas pour voir finir leurs études. Mais oui, c'est une réalité qui existe ici dans la faculté. Mais en tant qu'étudiante on a peur, honte de parler de ces genres de choses ici. On sait tous qu'il existe, ... on a passé tous par des situations comme ça. Pas tous, plusieurs personnes. Mais on essaye de ne pas parler trop, de continuer pour finir puis sortir avec le petit papier [diploma] puis se trouver un travail.

[EM] Pourquoi pensez-vous qu'il y a cette peur en tant qu'étudiant? D'en parler?

[P14] Parce que ici à l'université on se connaît tous, tout le monde connaît tout le monde.

[EM] Comme entre étudiants ou...

[P14] Entre les profs, donc si tu as un problème avec un instructeur clinique, tous les autres ils vont être au courant. Puis donc dès que tu vas faire ton prochain stage ça pourrait te nuire. Donc on ne parle pas. On se dit entre nous "Ok, fait attention à ça" puis tu continues. (P14)

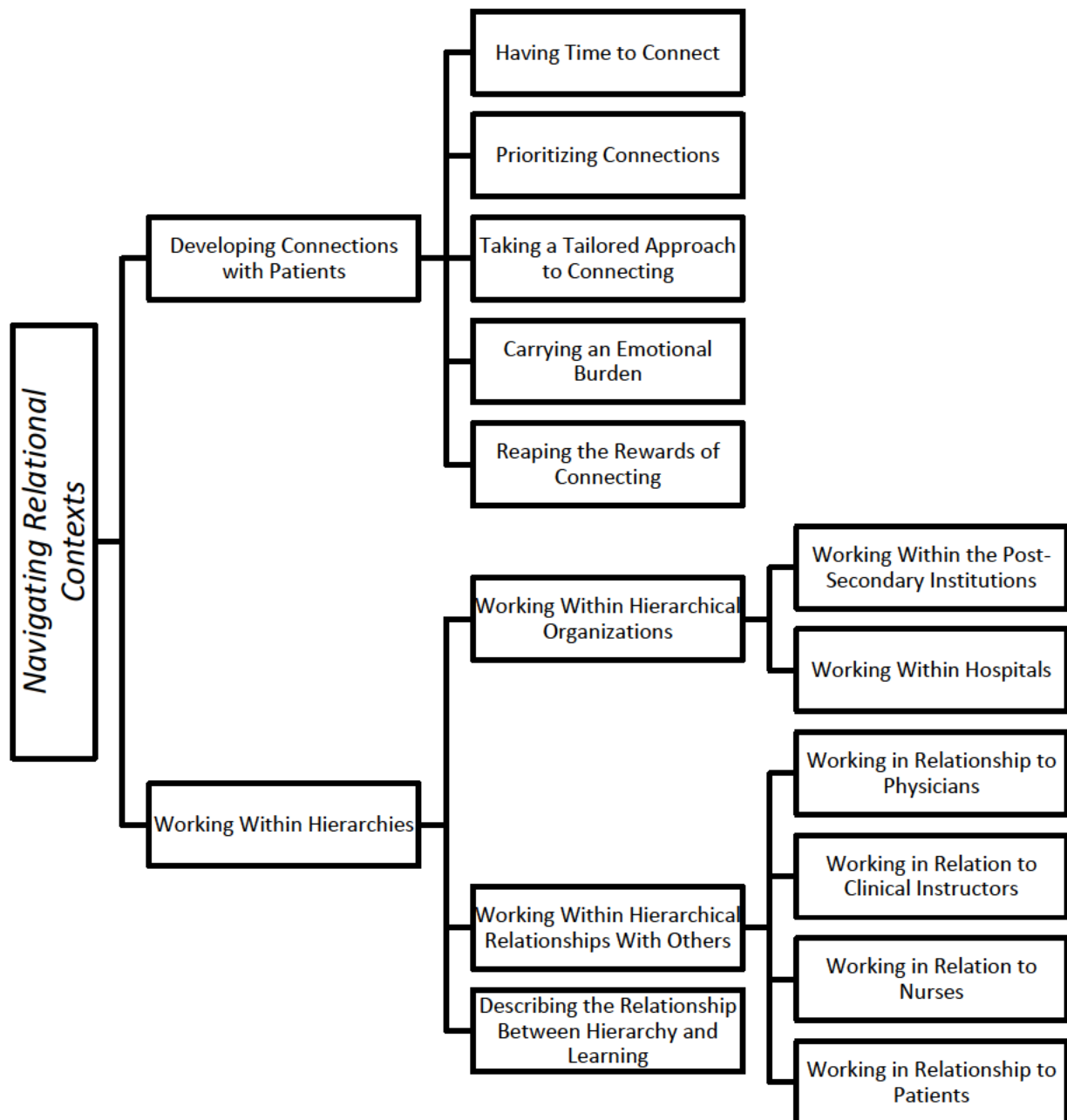
As a result of feeling that they had nowhere to turn, participants most frequently unburdened their experiences of being watched, judged, and evaluated in the clinical setting on other UNSs. This represented the safest option to them given the potential risks of becoming visible or getting labeled as a difficult student if they shared their story with employees within the university.

On ne parle pas de ça avec les autres profs. Même juste en parlant maintenant durant l'entrevue, je sais c'est une entrevue anonyme mais ça génère aussi une certaine réticence. ... La plupart des gens se disent "écoute, j'ai beaucoup de choses à passer à

travers, j'ai ma famille, j'ai mes choses, j'ai mis beaucoup d'argent, d'effort, des pleurs, du stress à passer à travers l'université, ... je ne peux pas perdre tout ça." Donc ... on essaye de finir puis on essaye d'oublier. ... Le support c'est entre les étudiants, on n'est pas si brave to go to talk to someone else because we are afraid. Parce que c'est beaucoup d'effort, beaucoup d'argent, puis le risque c'est très important. (P14)

4.3 Navigating Relational Contexts

The participants spoke about navigating clinical and organizational environments as well as relationships with others within these environments. The concept of navigating is intended to illustrate that the participants were learning about the clinical environment while simultaneously maneuvering through an interconnected web of relationships within this environment to determine where they fit. Under this category I will discuss the following two sub-categories: 1) developing connections with patients, and 2) working within hierarchies. See figure 4 for a visual representation of this category and sub-categories.

Figure 4**Category 3: Navigating relational contexts**

4.3.1 Developing Connections with Patients

Most of the participants shared experiences of connecting with their patients. For some participants, connecting was the reason they decided that they wanted to become nurses or what they liked most about nursing.

I don't think people get in [to nursing] to give medications or dress a cool wound, I feel like a lot of, at least of the friends I have in nursing, definitely got in for people – connecting with people, talking to people, providing care for people. (P13)

The participants frequently used the verb “know” as in “knowing” your patient. Participants spoke about getting to know their patients, beyond what was written in their chart or reflected in a shift handover. They did this by communicating with them in order to relate to them as another human being, and not just a body with a diagnosis. Several participants felt that the relationship between patient and nurse needed to be reciprocal. It was not enough to ask questions and receive information from patients, there needed to be a give and take during the exchange. Some participants, for example, shared stories of their own lives with their patients to facilitate the connection between them.

In the moment, I don't think it is conscious, but I'll do it all the time. Because I think it's important, you know, yeah, we're nurses, but I'm also a human being and it's nice for your patient to remember that being a nurse is a job. ... Giving them a tiny little bit of me just lets them know, “Oh, yeah, this is another person, they're actually here for me.” And it gives them something to relate to. ... It's being able to affiliate with one another as human beings. Because that's what it really is. You know, being a nurse is a social concept, being a human being, it's reality. (P6)

Developing connections with patients is made up the five sub-categories below: 1) having time

to connect, 2) prioritizing connections, 3) taking a tailored approach to connecting, 4) carrying an emotional burden, and 5) reaping the rewards of connecting.

4.3.1.1 Having Time to Connect. Many of the participants spoke about the importance of having the time in order to connect with patients and realized that since they had smaller patient loads than practicing nurses, they had more time to spend with their assigned patients.

C'est certain qu'au début, les premières semaines – si je donne l'exemple des soins complexes ... on n'avait pas beaucoup de patients, on en avait un ou deux. Puis t'as vraiment le temps de connecter avec ton patient puis comprendre ton patient au complet... (P10)

Participants spoke about connecting as a fundamental part of their clinical practice; the mere idea of being unable to have enough time to make these connections was a source of distress. When the participants perceived that they could not or would not be able to practice in the ways that mattered to them, they described it as a loss, a loss of being able to make a difference in patients' lives.

Oui, parce qu'eux [nurses] ils n'ont pas le temps. Puis j'ai peur, ça c'est quelque chose que j'ai peur, si je me trouve dans une job où que j'ai quatre, cinq, six patients, je ne vais plus avoir le temps de faire ça [connect with patients]. Puis c'est tellement important pour moi – I would be in moral distress to be in this job and to not be doing the parts I like about it everyday. ... C'est comme ça que je me sens pis je ne sais pas comment que tu peux avoir une charge de quatre, cinq, six patients – comme comment est-ce que t'apprends à connaître les gens quand t'as six patients? I don't know, c'est beaucoup. I think it's asking too much. (P19)

As participants progressed through the program, their patient load increased to come closer to or match that of a nurse practicing on the unit. This was difficult for some participants to come to terms with because it meant having less time available for each patient. The following fourth-year participant spoke about how their perception of the amount of time they thought they would have with patients changed as a result of their increased patient load.

When I started I thought I'd have a lot more time with patients and a lot more time to speak with them and connect with them and all those things that people get into nursing for. ... And then you have a million things to do and you haven't eaten yet or you haven't gone to the bathroom. It's definitely different than I thought it would be. I don't know where I thought I'd find this time. (P13)

Finally, some participants spoke about how different clinical units had differing amounts of physical care required for their specific patient populations. For example, more was required on a medical/surgical unit than on a mental health unit. They noted that the more physical care required, the less time they had to get to know their patients. Participant 12 felt that they had more time on the mental health unit to connect with their patients.

For the mental health placement, there wasn't really much for us to do, so I got to spend a lot of time with the two patients that I had. And I did get to know them a lot better than if I was in the medical surgical ward, where everything was kind of based off of tasks. I would rarely have that free time to just chat with the patient, to sit with them, listen to them play the guitar. It would be more like, I would try and squeeze in as much conversation when I'm doing tasks like dressing changes or like bed bath. So yeah, it definitely facilitated a lot more therapeutic relationship development just because I had that free time. (P12)

4.3.1.2 Prioritizing Connections. Participants also spoke about how they prioritized developing a connection with their patients. As participant 6 explained, connections did not just happen, they required a conscious effort in addition to having the time available to do so.

Absolutely, I mean, I've been exposed to the day in a life of a registered nurse on a medicine unit and on a psychiatric unit where you know, quote unquote, that nurses on the psychiatric unit, they have time – they don't use it. And they would tell me "I picked this job because I didn't want to break my back. I wanted an easy nursing job." (P6)

Later in the interview, this same participant observed that time needed to be actively used towards the development of a connection with the patient.

I think it's that extra time and space. I have it. Not everybody will use it, but we should, I have that. I think that's what that is. Because everything else fits in there, that time and that space. (P6)

Although many participants spoke about how they had made the effort to connect with patients, some of them also noted that they did not necessarily need long periods of time to develop these connections. They spoke about how connecting could happen during most interactions with their patients. One participant, for example, used the time during a patient's routine position changes to develop a connection with them. In essence, the participants found it important to actively utilize both the smaller and larger moments of time during care to develop connections with their patients.

It definitely has to be, not worked in, you don't consciously think "I'm going to connect with a patient today" but just being open and any task you're doing – connecting with the patient, speaking with the patient when you're doing this, this and this. You kind of have to do both at the same time. (P13)

4.3.1.3 Taking a Tailored Approach to Connecting. When speaking about relationships with their patients, the participants considered that each patient was different, that they were their own unique person. Therefore, what worked in relation to connecting with one patient did not necessarily work for another. The participants spoke about adapting their behaviour and utilizing various strategies for different patients and circumstances. For example, learning what did and did not work in trying to connect with patients who had physical or cognitive limitations was at times challenging for participants.

And I think the reason why I liked that [mental health] placement so much was because I was able to build, again, I'm going to link this back to being a compassionate caregiver, I think I was able to build on my skills and build on what exactly it is to provide individualized care and build a therapeutic report and how difficult it can be – specifically in mental health. And learning different strategies for different patients, because they're all different. Some patients may like to talk, some may not, they don't want to talk at all. And so I had to learn all those struggles, and those difficulties and I think that really helped me build my therapeutic report abilities. (P8)

The participants spoke about connection as an important source of knowledge. When they got to know their patients, they could tailor the patient's care to better align with their specific care decisions and goals. In practice, this meant that the participants could better support their patients in their decisions and develop a better understanding of the factors that influenced those decisions. Participant 1 for example shared how they connected with their patient by showing them respect. This helped the participant better support their patient's decision-making processes.

I did spend a lot of time with him [patient] and I really respected him. ... He brought it up

often that, you really show me respect and that's not that common these days, you show me a lot of respect. ... I very much gave him that respect, you know, when he spoke I let him speak. When he didn't want to do something, we didn't do it. And I gave him that freedom, all the while maintaining boundaries, right? ... And I respected his decisions and things like that. (P1)

4.3.1.4 Carrying an Emotional Burden. Some of the participants stated that they felt an emotional burden in the process of connecting with their patients that took a toll on their wellbeing. Some cried while others became jaded as a result of the emotional burden they felt when, for example, a patient passed away and the connection was severed. Participant 6 illustrates how they felt as a result of repeatedly giving of themselves and developing connections with their patients, to the point that they questioned their ability to maintain the emotional distance that they believed was necessary to sustain nursing practice.

I get super drained, I get attached [to my patients]. I know that and it's hard for me. Everybody tells me you've got to learn to separate yourself, but if I separate myself I don't think I can be a nurse. I became a nurse because I saw myself in the profession, I don't think I can do it. I'm just going to have to learn to only give a little bit I think. (P6)

4.3.1.5 Reaping the Rewards of Connecting. Many of the participants spoke about how personally rewarding it was to feel that they connected with their patients and made a difference in their lives. It helps to better understand why, despite the emotional burden, participants continued to value their connection with their patients.

There's definitely a bunch more times that I spoke with patients and connected with patients and people and things like that but ... that's what makes me feel good at the end of the day. ... I remember I had one patient, it was my very first day of this 4th year

placement. ... And starting with one [patient], there wasn't much to do, you finished everything by 7:30 in the morning and I had a fairly independent patient so I wasn't doing all these bed baths and transfers and boosts and all these things that tend to be time consuming. So I was able to talk with this patient quite a bit and she really opened up to me. ... I was very happy to have that experience and just connect with her [patient] because it wasn't one way, it wasn't me trying to connect, it was her very much wanting someone to talk to and listen to her. Ya, that felt good. (P13)

4.3.2 Working Within Hierarchies

A frequent topic of conversation during the interviews with participants was about hierarchies within the clinical environment and how they perceived themselves within these hierarchies. Participants described hierarchies in terms of power where they situated themselves as being both powerful and powerless depending on the context. The participants also spoke about a connection between their perceived power within hierarchies in relation to the knowledge they possessed at the time of the moral experience. This link will be further developed below and woven in throughout this section.

Participants described two distinct hierarchical relationships: organizational hierarchies and hierarchical relationships with other people. The organizational hierarchies they referred to were the post-secondary institution itself and the school of nursing, as well as hospitals, and hierarchical relationships with other people were with physicians, clinical instructors, patients, other UNSs, and nurses. Finally, several of the participants made links between these hierarchies and the effect it had on their learning, also described below. This category is therefore made up of the following three sub-categories: 1) working within hierarchical organizations, 2) working

within hierarchical relationships with others, and 3) describing the relationship between hierarchy and learning.

4.3.2.1 Working Within Hierarchical Organizations. Participants spoke about their relationship with the post-secondary institution, the school of nursing, and their clinical environments, usually hospital units, where they practiced during their clinical placements. They viewed these organizations as being powerful and perceived themselves as having little influence within them. In essence, they perceived that these organizations were too big for them to matter and too powerful for them to affect change. This category is made up of the following two sub-categories: 1) working within the post-secondary institution, and 2) working within hospitals.

4.3.2.1.1 Working Within the Post-Secondary Institution. Some of the participants were very explicit that the post-secondary institution where data collection occurred and the school of nursing (they made few distinctions between the two) were powerful organizations. They believed that these organizations were not neutral and the structures in place within them created relationships in which the participants felt powerless.

On a beaucoup de relations comme ça en sciences infirmières, les relations de pouvoir. [name of the university] c'est une business, c'est puissant. C'est comme ils ont vraiment ce pouvoir là sur nous des fois. (P10)

The school [of nursing], because you feel like the system is out to get you. The system, the way that this [nursing] program is designed is out to get you. (P5)

Interestingly, some participants seemed to distinguish between their relationship with the post-secondary institution where data collection occurred as an organization and their relationship with the people employed within the organization, such as clinical instructors and administrators.

Pour revenir à l'exemple tantôt de la professeure avec l'histoire qu'on est parti [du stage] plus tôt. On se disait "Oh on pourrait aller voir [name of administrator] puis parler de cette histoire-là." Parce qu'[il/elle] est vraiment rejoignable [name of administrator], je trouve qu'[il/elle] est terre à terre puis [il/elle] est jeune puis on dirait qu'on se sent plus confortable avec. Puis tu sais ça, les autres filles disaient "Oh on devrait aller voir [name of administrator]" mais en même temps on se dit "Peut être que ça ne va rien changer parce que c'est déjà terminé puis au moins on a déjà passé." Mais c'est certain qu'on dirait que [...] l'[name of the university] c'est un gros géant comparé à nous comme étudiants. (P10)

It is important to understand how participants perceived themselves in relation to the post-secondary institution where data collection occurred and the school of nursing because their experiences in relation to these organizations influenced their clinical experiences. One participant for example decided to keep feedback about a clinical placement to themselves because they believed it would not be used constructively to improve clinical experiences.

It's kind of known throughout our program that those feedback forms [about clinical placements and the clinical instructor] just go to the instructor and no one else reads them. So from early on I learned submitting, even constructive feedback or feedback of any kind is a dead end through that outlet. I think that more of a formal meeting with the head of the placement, or the coordinator would have been really nice. More of a sit down, how are you doing, rather than a "So you like the placement, that's great. I got to go." That would have been nice. Definitely something from the nursing faculty because just the university in general is great but they don't really understand as well, you know. So I think something from the coordinator would have been really nice. (P18)

4.3.2.1.2 Working Within Hospitals. Fewer participants spoke about their relationship with hospitals and clinical units but the consistent messaging from those who did was that working within a hospital could constrain their actions. Participants at the post-secondary institution where data collection occurred have clinical placements outside of the hospital settings but none of those interviewed spoke about their relationship with these other organizations.

There's definitely structural constraints, right? That's the nature of it. And I don't want to say that's the nature of nursing but there are very common ethical dilemmas that we will encounter. And part of it is being in a hospital where there are rules that you have to follow. And a lot of the time those rules don't coincide or align perfectly with what your moral identity is, right? They don't perfectly align with what you consider to be moral action or agency or moral decision making. And that could be very easily limited by the rules of the hospital. (P1)

4.3.2.2 Working Within Hierarchical Relationships With Others. Working within hierarchical relationships with others refers to how participants perceived themselves in relation to those they interacted with in the clinical setting. The participants spoke about their relationships with the following individuals that make up the four sub-categories below: 1) working in relation to physicians, 2) working in relation to clinical instructors, 3) working in relation to nurses, and 4) working in relation to patients. These sub-categories will follow an overview of working within hierarchical relationships with others more broadly.

In contrast to working in hierarchical organizations, where participants felt unilaterally powerless, the participants spoke about having the capacity to exercise power in some

relationships in the clinical setting. However, as participant 12 explained below, the hierarchy on the unit was more or less obvious depending on the specific context and relationship.

There's definitely a hierarchy in there. For the medical surgical placement, I didn't see it as much just because it was mainly RNs that were present, very few RPNs. And again, interactions between physicians and RNs were very limited, so I didn't get to witness much. But for mental health, a big thing was seniority. I would hear some of the nursing staff complain about other nursing staff because they might have worked more years in this hospital, for example, and because of that, they think that they deserve more privileges like "I deserve to get my break at this specific time and I take priority over the rest of you guys." (P12)

Only one participant diverged from this type of narrative and instead described their relationships with others in the clinical setting as being a circle, with the patient at the center and with no one holding or exercising more power than another.

Several of the participants spoke about their "place" in relationship to others in the clinical context. What is clear from the interviews was that their place, their fit, or the space that they occupied within the hierarchy, was not necessarily fixed in time or clear; at times feeling unsure of the space they were intended to occupy. When probed to describe where they thought their specific position was, several participants described themselves as being at or near the bottom. For example, participant 11 felt less important than those they claimed were higher up within the perceived hierarchy. Similarly, other participants who identified themselves as low within the hierarchy equated a lower position with less power.

When I first started, I felt like I wasn't even there. But with time I feel like I grew a bit. I still don't feel like I'm super important. Obviously, our skill set expanded in fourth and

third year, we get to do more things. But I still feel like a student, maybe a bit more than a student, because I know I've had experiences but overall, I feel like I'm still low on the pedestal. (P11)

As participants moved through the program and gained more experience and knowledge, they perceived themselves as somewhat higher, suggesting the fluid nature of their position, which meant they recognized that they held more responsibility to fulfill the nursing role. Participant 15 illustrates this upwards transition by speaking up for a patient, reflecting their increased sense of responsibility.

J'ai toujours un feeling – pas je me cache un peu, mais je reste – comme des fois je ne dis pas certaines choses ou je pense quelque chose mais je ne le dis pas à cause que je me dis “Eux autres savent ce qu'ils font, ce n'est pas ma place de leur dire ce que je pense.” Puis ça c'est quelque chose que ma professeure en soins complexe nous disait, “Regardes, vous êtes presque infirmière, c'est le temps que vous commencez à advocate pour vos patients parce qu'éventuellement ça va être vous.” C'est important de commencer en soins complexe tout de suite avant votre consolidation, de s'habituer à vraiment “speak up” puis surtout quand que c'est quelque chose important. (P15)

An important distinction must be made here about what movement within the hierarchy meant for the participants. As noted above, participants' positions within it could be fluid, changing over time. Nonetheless, their position as an UNS was still constrained. If the positioning of a participant represented one rung on a ladder, he or she moved slightly up or down without stepping off that rung. Participant 8 referred to a moral experience where they did not speak up when they knew something that challenged their values and beliefs, and believed that their positioning, specifically as an UNS, constrained their actions in that moment.

I would be more willing to say something but then again, I don't know if I would [speak up], to be honest. I want to say that the right answer is I would say something. But me, in my position as a nursing student, there's so much consequences that can occur from it. And we want to strive for "yeah, we'll advocate for what we want in terms of our own profession," but I'm hoping to do that as an RN, and as a fully-fledged professional. But as a student, we're seen as being there to just learn, and ... we don't want to step on any toes. And so that's definitely difficult and of course, I want to say that "yeah, I would say something" but I don't think I would. (P8)

4.3.2.2.1 Working in Relation to Physicians. The relationship between participants and physicians was one of the most frequently discussed relationships, even though a few stated they had few interactions with physicians themselves. The overwhelming impression was that participants viewed physicians as intimidating whether or not they had had what they perceived to be a good or bad experience with them.

Je me sens un peu mal à l'aise des fois. Surtout quand les médecins faisaient l'évaluation, j'étais juste là puis je n'étais pas sûre. Il me demandait des questions puis là, je n'étais pas sûre si j'avais fait la bonne chose. Puis c'était un peu intimidant des fois aussi, surtout dans les situations un peu plus urgentes. (P15)

When I asked the participants who felt intimidated about why they felt that way, their responses circled around the idea that physicians were more knowledgeable than them. This speaks to a link between knowledge and power within relationships in the clinical setting, specifically, the more/type knowledge, the greater the perception of power within the hierarchy.

Because they [physicians] look at us as nursing students, they can tell, you know what I mean? You can tell somebody's a nursing student. Because a) they're not as comfortable,

they're younger I feel like with nurses, they say less. With nursing students, I feel like I try to convey everything. And that can be to them kind of like, "Oh my God, she's a nursing student." You know what I mean? But yeah, intimidating as in they know more than me. And they show that they know more than me. There's always that fear that they're like, "Oh my God, you don't know anything" or "Oh my God, that blood pressure is fine on this floor, you'd know if you spent more time" or something like that. ... Not as forward but I find when I did rounds that one time, I was like "I don't want to talk to a doctor ever again!" I'm like "Man, you guys are not nice." (P5)

A very small number of participants did not share the belief that physicians exercised more power than the staff nurses on the unit. In all instances, they believed that these nurses, because they spent the most time with patients and knew them better than anyone else, therefore had the ability to influence the patient's plan of care. Again, the perception of knowledge and power were linked in these stories.

On the unit, from my experience, what I saw, they [clinical nurses] have a lot of ability to enact change, right? The rounds are mostly led by the nurses in terms of this is what's been going on with the patient in the past few days. And based on that information, that physician can make a decision on what to do, or if they want to change anything or keep it stagnant. Advocacy is a big thing in terms of nurses' power, to advocate for patients and to give them a voice. ... So that's powerful, right, that they really can shape how the physician or how others view the patient based on what they discuss at rounds or even at the charting stations. (P1)

It is important to note that the way a participant perceived a physician was based on individual behaviour – smiling and taking the time to listen to the participant were behaviours

and characteristics that made a physician seem less intimidating and therefore more approachable. Younger physicians and residents were also seen as more approachable than more senior physicians.

[P5] And I find that a lot of times it is a class system. But it's because the people, they think of themselves as higher than. I know it's very biased to say but it's just with the doctors I find. They're very, you know, "I'm a doctor." But a lot of them aren't, it really depends on the person. ... I find that it has more to do with, have they been here for years. That's a), b) their age. I find a lot of the older guys ... they're like they know everything.

[EM] And so the ones who are younger or have been there less...

[P5] Yeah, are less intimidating and are more approachable, and they can talk and have a conversation with you. (P5)

Finally, although some of the participants stated having few interactions with physicians, they had a strong perception that physicians were above them within the hierarchy. When I asked the participants at the beginning of the interviews about how they ended up in the nursing program, the conversation often led to discussions about the stigma that surrounded nurses and nursing practice. Several of the participants spoke about the perception (or misperception) of nurses' roles. They had preconceived ideas that physicians were more powerful than nurses, stemming from longstanding beliefs about the role of nurses as well as what they had seen more recently portrayed in the media.

Quand j'ai appliqué en 11^e année, je ne savais pas le montant de responsabilité que les infirmières avaient. Je pensais vraiment comme on les présentait dans les shows à la télévision ... ils n'ont pas vraiment de décisions à prendre, ils font juste suivre tous les

ordres. Mais avec mes stages et avec mes classes puis tout ça, j'ai vraiment réalisé que les infirmières on a un gros mot à dire, on est vraiment avocat pour les patients. Donc c'est vraiment nous qui faisons des grosses décisions quand même puis on supporte la famille. (P21)

4.3.2.2.2 Working in Relation to Clinical Instructors. Almost all of the participants who spoke about their relationship with their clinical instructor perceived themselves as being lower within the hierarchy than their clinical instructors. Participant 20 spoke directly to this hierarchy. "Moi je suis une personne influençable par les autres, surtout les profs [clinical instructors] qui sont au-dessus de toi par hiérarchie, par leur position. Je ne suis qu'une étudiante" (P20). Similar to physicians, the way that participants perceived clinical instructors within the unit hierarchy was also influenced by the clinical instructor's individual behaviours. When the instructor was patient and kind, for example, differences of power were reduced.

[EM] Qu'est ce qui est différent si ..., tu sais un professeur clinique qui est vraiment ... bon puis un avec qui on s'entends moins bien avec. C'est quoi la différence pour toi?

[P10] Les relations de pouvoir. Quand que les professeurs cliniques ont vraiment cette relation top down, c'est comme, ça ne fonctionne pas avec moi parce que quand il y a du stress, je ne vais pas bien réussir. Mais quand vraiment je peux comprendre – pas qu'on est des amis, mais plus comme collègue, pas vraiment collègue, je sais que t'es ma professeure, mais une approche douce puis une approche non-stressante. Puis ça c'était ma professeure de soins complexe, pas de stress. Puis elle nous posait des questions mais si on ne connaît pas la réponse ce n'est vraiment pas la fin du monde puis on va juste faire un peu de recherche après. Donc moi ce que j'ai de la misère c'est quand je ressens que mon professeur a un pouvoir sur moi, c'est stressant. (P10)

An important relational dynamic that was more specific to the participant-clinical instructor relationship was the element of dependency. Several participants spoke about how, as a function of their status as UNSs who do not have a license to practice nursing independently, they were often dependent on their clinical instructor. The participants understood that they worked under their clinical instructor's nursing license and needed to follow the instructor's direction in order to succeed during the clinical placement. One of the most frequent problems the participants noted was that they were sometimes required to wait for their instructor to give medications, resulting at times in patients having to wait extended periods to receive their medication.

I wanted to give them [the patient] the ondansetron to help with that [nausea] and my clinical instructor is like, "I'm too busy, I'll be with you in a minute." And I'm like, "Well can I give it with my nurse?" She's like, "No." Because we had the issue the previous shift. So I was like, "Ok, I'll wait, but I want to give it before they throw up because then it's not going to do anything." And I told her this and it was like an hour, hour and a half later, my patient had gotten sick. My nurse got mad because she's like, "Why didn't you give it? I could have given it." And I said, "I know, I told my instructor that either I can give it with you or you can just give it or I can wait." Those were the three options and my instructor wanted me to wait. So the patient threw up, was really annoyed, the nurse was annoyed, I was annoyed, but my instructor was like, "Well, you could have been more ready." And I was like "I had the medication in a cup with all the 'rights' beside it." How more ready could I be? I waited in the hallway, I went to get her a few times but she was busy. So it was really hard to be like, "I want to take initiative, but I can't, I'm showing you my critical thinking but it's not working." It was really

tough. (P22)

4.3.2.2.3 Working in Relation to Nurses. Some participants also spoke about their relationship to the nurses who were employed in the settings where clinical placements were held. Again, although participants have placements outside of hospitals, all conversations about the relationship with nurses were about those working in a hospital setting. Overall, the participants perceived nurses as being above them in the hierarchy or, as one participant contended, nurses were the sharks and they were a dolphin among the sharks.

[P7] All nurses have been through nursing school and just having that little empathy for nursing students will very much improve not only the education nursing students will get, but also the perspective that nursing students get about what good nursing really looks like. Because once you're that nurse who always goes back to the process that you've gone through, you will always remember that "I have to always be as humble as I was and readily available. Because these new nursing students, they need us to tell them our experiences to help them build their little toolboxes." And without that, it's like almost just throwing nursing students into a tank of sharks and learning how to be friends with those sharks.

[EM] Are you a shark in that situation?

[P7] No.

[EM] No?

[P7] No. ... I'm like a dolphin. (P7)

Although the overarching impression from participants was that they considered themselves below clinical nurses in the hierarchy, several participants also spoke about times when they felt more on a similar level. Participants could better relate to and were better received

by the nurses who remembered what it was like to be an UNS. Some of the participants also spoke about feeling almost like a colleague to the nurses because they were able to reduce the nurse's workload and bring up-to-date knowledge of patient care.

I think they [nurses] do, especially because of the whole staffing, even though we're not nurses, we do add an extra set of eyes. We are fresh out, we just learned about this last week so we know what we're looking for. So sometimes we do catch things that doctors or nurses who have been practicing for a while miss. And both of the units I've been on, all of the nurses were super thankful we were there ... they were like "Oh my goodness do I have a nursing student today?" And they were excited, like "Oh yes! So you're going to do everything right?!" So that was really cool. ... That probably added to the experience because we didn't feel like their friends, but we did feel like their colleagues. And a lot of them were like – I don't know if mentor is the right word – but they gave a lot of really good insight into like "When you become a nurse, look for these things in a job, I've switched four different departments in the last few years, it's fine, it's normal if you don't like the first job you get." Which is nice going in. (P2)

Alternatively, some participants felt that they were a burden to the nurses when, for example, they could not administer medications independently or had to ask where basic supplies were located. They believed that their knowledge gaps caused more work for the nurses, and in these instances, the participants felt a greater power gap. As a result of this power imbalance, they felt they had little ability to change the situation.

On the geriatric unit I was assigned with a really rude nurse. I always ended up getting her and it would overwhelm me a lot because her attitude was absolutely horrible. ... I remember the first time I saw her, my clinical instructor told me, so this is - she said her

name. And she's like, "This is going to be your student nurse, she's going to shadow you." I remember her first expression was rolling her eyes. And I was like, "Ok," and everyone else in my class also saw that and they're like "Good luck." ... She was also really rude to the patients. And one of the times I did tell the clinical instructor, she didn't do anything about it. ... And what upset me the most is that she is a recent graduate from [name of university] and I was like, seriously? I wasn't expecting that from her. (P17)

As already alluded to, participants felt more like colleagues to the nurses who remembered what it was like to be an UNS and demonstrated some empathy with them as learners. This explains participant 17's surprise because their paired nurse was a recent graduate, someone who was not far removed from being an UNS themselves, and was acting in a way that the participant perceived to be rude and condescending. Further, as participant 7 noted,

I touched on it a little bit, it would be nice if they [schools] are able to teach nursing students that when they get out there, to always remember that they've been nursing students before because that will also foster education – there's nursing students that will follow after us and it will also bring that humility as well that "Oh, I was a nursing student."

4.3.2.2.4 Working in Relation to Patients. The participants perceived that in their role as patient care providers, they were inherently higher in the hierarchy than patients. Participant 1, for example, stated that in "The power dynamic of the nurse-patient relationship, the nurse is always the most powerful person" (P1). Despite this belief, however, several of the participants described how important it was to them to minimize the patient's perception of any power differential between them. Interestingly, the techniques that the participants used were similar to

the behaviours they had pointed to as making people they considered above them in the hierarchy more approachable.

No, I definitely like to be on the same level [as my patient]. I would never want to view myself as higher than someone else just because they're under my care. And we're definitely taught that in nursing school, about the power imbalance and appreciating that it exists and decreasing the level. ... Being on the same level as the patient as best you can, even though you are providing their care, they depend on you for all these things. I appreciate a patient being with me and speaking with me and opening up and being vulnerable so I can help them in their care. Just connecting with people I enjoy, and I never want to seem like I'm above the patient or anything like that. And I try my best to be friendly as best I can and be someone they can ask questions to and not feel silly or not feel like they don't know what they're asking. (P13)

4.3.2.3 Describing the Relationship Between Hierarchy and Learning. Many of the participants spoke about the stress they experienced during clinical placements. Although there may have been multiple sources of stress, some of the participants attributed it specifically to relationships with people, particularly the clinical instructors, whom they believed were in a relatively higher position. Being stressed negatively impacted learning during clinical placements.

Si vous avez un étudiant qui est stressé, il a peur, il ne peut pas apprendre, c'est clair comme de l'eau. Il ne va pas apprendre, il va juste faire les choses pour que vous, en tant que professeur, que vous soyez ok avec lui. Mais il ne peut pas apprendre. Pour apprendre il faut être en esprit. C'est sûr que le travail comme nursing c'est stressant, oui, c'est sûr. Mais il ne faut pas donner trop de stress à l'étudiant, l'étudiant il ne va pas

performer. ... Parce que lui là, il va falloir qu'il applique toutes les connaissances qu'il n'a jamais eu parce qu'il était stressé à donner des pilules et pas stressé à réfléchir comme il faut, avoir la pensée critique. (P14)

Participant 19 used the word "intimidation" as an indicator of a type of top down approach that was a significant source of stress that inhibited learning. The alternative to a top down approach was one where the participants felt supported in their learning.

Pis il y a certains profs de stage où ce que leur environnement d'apprentissage est tellement plus convenable à l'apprentissage que d'autres profs. L'apprentissage par intimidation on dirait ce n'était vraiment pas mon affaire, je ne sais pas qui aimerait ça, mais c'était super difficile. J'avais de la difficulté à manger, ... je commençais à avoir des rêves, comme "Ah! J'ai donné de l'insuline à un patient sans prendre sa glycémie pis là je l'ai tué." Des affaires comme ça. Parce que j'avais tellement de stress relié à mon stage pis là ce n'était pas une bonne expérience d'apprentissage. (P19)

Conversely, some participants remarked that a more supportive approach to teaching reduced perceived imbalances of power and as a result, they experienced less stress and improved learning. This was similar to the ways in which participants spoke about physicians and clinical instructors reducing the power imbalance by being more approachable and therefore less intimidating. Thus, individual healthcare professionals and clinical instructors had the capacity to affect a participant's learning based on their relationship with the participant.

I would say 99% of the nurses were so great and so willing to teach and patient with questions and have really good answers, they were really knowledgeable. ... She [clinical nurse] answered any questions I had really well, I was shocked she even knew the answers. So, she stood out to me because she was my favourite ever and it was just such a

good experience being a nursing student with her because she was so patient with me and ya, it was a good for learning. ... With her it was easy, she was patient with questions, I never felt stupid for asking something. She just made me feel at ease and I think she did that for patients too. So it was a relaxing day but also filled with tons of education. (P13)

Identifying and minimizing power imbalances in relationships that increased stress for the participants was seen as important. This was not only because it affected their learning, but also because of the negative impact this stress had on the participant's patients. When the participants felt their stress increased as a result of power imbalances, they felt their ability to focus on patient care was disrupted. For example, participant 11 described how this stress could have caused a decrease in the quality of the patient care they provided.

I feel like if you have less stress, you can focus on your job – the focus of the clinical placement, it's the patient before us. And I feel when we are stressed, stress about what our teacher's thinking of us, or anything like that, it takes the focus off of the patient. And when it takes focus off the patient, the patient's going to hurt from it. And then also, your mind's not in the right place, and then it's a snowball effect. I feel like when stress is not in the equation, for one, the patient receives the best care that they could get from us, and then us too, we learn better, and we're more at ease and the placement can progress better because you have less stresses there. Like it's a disrupter, right?

Chapter 5: Discussion

In this chapter I start with a brief overview of the study. Following this, I discuss the theoretical relationships between the constructed categories. I then engage in a discussion about elements of the findings that I felt were important or meaningful to explore, and integrate them into the existing literature: 1. The invisibility of moral uncertainty and moral dilemmas, 2. Reframing our understanding of action in response to experiences that challenge one's values and beliefs, and 3. Recognizing the relational dimensions of clinical practicum learning in undergraduate nursing education. I also address the limitations of this study, and identify implications for education, practice, and research. Due to the context of this study, the implications for education are more fully developed than what is typical in a dissertation. These implications/recommendations are based on the findings and supported by existing literature. The chapter ends with a conclusion.

5.1 Summary of the Findings

The purpose of this study was to examine the clinical placement-related moral experiences of UNSs – in a way that accounts for the relational dimensions – and understand how these moral experiences shape them as learners. I used constructivist grounded theory, as described by Charmaz (2014), to construct a theoretical understanding of this phenomenon. Consistent with constructivist grounded theory, I used theoretical sampling until I achieved theoretical saturation and developed categories reflecting a preliminary theory. All participants were recruited from a bilingual post-secondary institution in Ontario, Canada. In total, 23 participant interviews were retained for analysis. The majority of participants were self-identified Caucasian women between the ages of 18-24. Of the 23 interviews, 15 were conducted in English and eight in French.

Following an iterative process between data collection and data analysis, I constructed three intersecting categories: 1. Having a moral experience, 2. Learning in motion, and 3. Navigating relational contexts. Given that this study focused on moral experiences broadly, the data were rich with experiences representing notions of good/bad, right/wrong, just/unjust, and everything in between.

The findings from this study speak to the range of moral experiences that the participants lived. Many had experiences that challenged their values and beliefs about what they perceived to be good, right, or just. They shared stories of perceived medical malpractice, of being berated by their clinical instructor, of patient needs going unmet, among many others. Conversely, several of the participants shared moral experiences that aligned with their values and beliefs of what they perceived to be good, right, or just. They shared stories of making a difference to someone, of being knowledgeable, of contributing to saving their patient's life, of being supported in their learning, and other moral experiences that reminded them why they wanted to become nurses. Many of the participants spoke about how their moral experiences, whether they aligned with or challenged their values and beliefs, changed them as people and as future nurses. These experiences did not remain compartmentalized and confined to the clinical hours that they worked – they infiltrated all aspects of their lives. They reported being changed because of their moral experiences lived during their clinical practicums.

The participants' learning developed over time. In this sense, the knowledge that they had at the beginning of their third year was different from the knowledge that they had in their fourth, for example. Moral experiences were an impetus for the development of knowledge. What constituted knowledge, however, was not limited to what the participants learned in textbooks. They brought knowledge to the clinical environment from their own personal experiences, from

past clinical practicums, and from structured learning such as classes and laboratory sessions. The participants used the knowledge they had to inform their decisions, which affected their responses to moral experiences. Further, during this learning process, the participants learned who they were and who they wanted to be, and in some cases, who they did not want to be as people and nurses. Both the personal and professional identities of the participants influenced one another; they were not mutually exclusive. The participants brought their whole personhood with them when they provided care during clinical placements. Similarly, they carried their clinical experiences with them in their lives outside of clinical placements, which affected their perceptions of the world and the ways in which they interacted within it. Further, while many participants expressed how valuable clinical placements were to their learning, there was an overarching perception that they were regularly under judgement and scrutiny. They felt their actions were carefully monitored to ensure they were meeting expectations, and they were either rewarded or reprimanded depending on how closely they approached these expectations.

Finally, the participants navigated relationships in the clinical environments where they were not only learning how to provide patient care but were also encountering new physical spaces and the relationships that existed within them. They spoke at length about the relationships they developed with their patients and the resulting sense of happiness. Power dynamics between the participants and clinical instructors, however, created particularly difficult relationships to navigate.

Ultimately, the results from this study help to better understand the moral experiences of UNSs during their clinical placements, the learning process that occurs because of these moral experiences, and the ways in which the participants related to organizations and others in their

clinical environments. The stories shared by the participants served to construct a theoretical understanding of the ways in which moral experiences shape UNSs as learners.

5.2 Constructing a Theoretical Understanding of the Moral Experiences of Undergraduate Nursing Students During Clinical Placements

According to Thornberg and Charmaz (2012), “A theory states relationships between abstract concepts and may aim for either explanation or understanding” (p. 41). The process of theorizing in grounded theory consists of constructing an account of these relationships (Charmaz, 2014). In other words, you engage in theorizing throughout the analytical phase as you build the categories and define the relationships between them. These relationships can be understood by answering questions about what happened, how it ensued, and, at times, why it happened (Charmaz, 2014). I engaged in this theoretical process during data analysis and constructed an account of the relationships between the three categories: 1. Having a moral experience, 2. Learning in motion, and 3. Navigating relational contexts. These relationships are described below in the following three sections: 1. Having a moral experience and learning in motion, 2. Having a moral experience and navigating relational contexts, and 3. Learning in motion and navigating relational contexts. At the end of this section, I provide an overview of the ways in which the above three categories fit together (please see: Putting the pieces together).

5.2.1 Relationship 1: Having a Moral Experience and Learning in Motion

Learning in motion is a circuitous process and the moral experiences of UNSs represent the catalyst for learning and the development of knowledge. Knowledge development in this context refers to the knowledge that UNSs create as they learn about who they are and where they fit in relation to the world around them. UNSs develop knowledge both when their moral experiences challenge and align with their values and beliefs about what they perceive to be

good, right, or just. When their moral experiences align with their values and beliefs, the experiences are unproblematic because their values and beliefs remain unchallenged. In these instances, their values and beliefs about what is right, good, or just are reinforced. Conversely, when their moral experiences challenge their values and beliefs, UNSs are aware of the disconnect between what occurred and that they think ought to have occurred. As a result, UNSs either learn to adapt their values and beliefs about what they perceive ought to be or remain resolute in these beliefs. During this learning process, UNSs' moral identity develops as they interpret the ways in which they see their values and beliefs are realized or thwarted during clinical placements.

Knowledge developed, both within and outside of an UNS's nursing education, provides the basis for their interpretation and action in response to moral experiences during clinical placements. In this way, learning is a circuitous process that moves in a non-linear direction through time. Learning is circuitous in that UNSs develop knowledge as a result of moral experiences and use that knowledge to inform future experiences. Learning is non-linear in that UNSs live a spectrum of experiences that both reinforce and challenge what they know and who they are. Further, knowledge development is not linear. UNSs do not accumulate knowledge that will lead them to become increasingly correct from a moral standpoint in their interpretation of experiences and actions in response to them. Knowing what is good, right, or just is not universally applicable because it is dependent on the people involved and the context in which it occurs. Knowledge of how to enact what is good, right, or just, is therefore not fixed, it is in motion; continually being realized and thwarted in everyday nursing practice. This is in contrast to the stepwise development of knowledge related to specific skills, like dressing changes, that are universally applicable. Therefore, when learning is considered from an ethical and relational

perspective, knowledge is not accrued in a stepwise manner, instead, it is a dynamic, multidirectional process.

5.2.2 Relationship 2: Having a Moral Experience and Navigating Relational Contexts

Moral experiences are experiences where there are values at stake. All moral experiences, therefore, involve relationships with individuals or groups that occur within particular contexts; what is perceived to be good, right, or just is in relation to oneself or others. There are no values at stake when there are no relationships involved. For example, there are no values at stake when changing a dressing on a mannequin in a simulation laboratory, however, there may be values at stake when that same dressing is changed on a patient. Moral experiences are therefore inseparable from the relationships that make up these experiences and the contexts in which they occur. When UNSs navigate relationships, they have moral experiences that align with or challenge their values and beliefs.

Power is exercised in all relationships and all moral experiences involve relationships. As such, the moral experiences of UNSs during clinical placements can be understood and interpreted in terms of relations of power and UNSs are objects of disciplinary power. When UNSs engage with others during their moral experiences, they are subjected to disciplinary technologies of hierarchical observation, normalizing judgement, and examination. Given the relational nature of moral experiences, relations of power and the ways in which UNSs perceive themselves in relation to others are inseparable from the moral experiences of UNSs.

5.2.3 Relationship 3: Learning in Motion and Navigating Relational Contexts

Learning during clinical placements is not limited to the development of knowledge of clinical tasks. Clinical tasks are specialized practical skills UNSs learn and perform during the provision of patient care. Some examples of clinical tasks include dressing changes, inserting

nasogastric tubes, documenting vital signs, and transferring patients safely from a bed to a chair. Instead, UNSs' learning also includes navigating relationships and becoming socialized to their role in relation to others in the clinical environment. The ways in which UNSs navigate relationships are shaped by the materialization of the knowledge-power dyad that governs and constrains their ways of knowing and being. In a world where infinite ways of being are possible, UNSs learn to govern their behaviour by weighing the risks and rewards of their actions.

Learning to navigate relationships is a non-linear process whereby UNSs interact with others, and continually adapt their actions based on feedback received. The learning process is continually in motion because all people are different and the relationships between people are dependent on the context in which they occur. What might be right for one patient might be wrong for another. What might be right for one patient in one context might be wrong for that same patient in another context. Therefore, UNSs are continuously learning to navigate relationships in the clinical environment.

5.2.4 Putting the Pieces Together

To understand the findings as a whole, it is important to consider how the categories relate to one another. The first category, having a moral experience, represents the experiences UNSs have where there are values at stake during clinical placements. Moral experiences are the catalysts for UNSs' learning. Their prior moral experiences inform their knowledge of what is good, right, or just. The second category, learning in motion, articulates UNSs' learning process. When UNSs learn, they develop knowledge, and this knowledge informs the ways in which they interpret and respond to moral experiences during clinical placements. Therefore, UNSs' interpretation and response to their moral experiences are dependent on where their knowledge is situated within this learning process at the time of the moral experience. The third category,

navigating relational contexts, is the context that frames all UNSs moral experiences. UNSs moral experiences occur in relationship to themselves, other people, and the environment. In other words, UNSs moral experiences and subsequent learning during clinical placements occur within a relational space and these moral experiences are dependent on the relationships within that space.

5.3 The Invisibility of Moral Uncertainty and Moral Dilemmas

As part of this study, I sought to answer the question “What are the moral experiences of UNSs in the context of clinical placement?” Existing research demonstrates that nurses and UNSs experience moral uncertainty and moral dilemmas when providing care (e.g., Greig et al., 2021; Kelley et al., 2022). It is therefore interesting that the moral experiences shared by the participants in this study rarely reflected uncertainty or dilemmas, raising questions as to why. It seems more probable that the participants experienced moral uncertainty and moral dilemmas during clinical practice; however, these experiences were not well captured in this study. It is possible that these experiences were not well captured because it was only in hindsight that participants could tell whether the experience aligned with or challenged their values and beliefs. Additionally, the way the researcher conceptualizes moral uncertainty and moral dilemmas affects the way in which the participants’ stories are understood and interpreted. These reflections are important because without them, based on the constructed findings, there is a risk of concluding that the participants did not experience moral uncertainty and moral dilemmas. In this section, I start by defining moral uncertainty and moral dilemmas. Following that, I explore possible reasons why the findings in this study rarely reflected them.

Clinical environments are complex and multifaceted; they are made up of a series of ongoing negotiations between the self, others, and the environment to navigate what is good,

right, or just. However, what is right, good, or just is not a set of universally applicable truths, meaning what is right for one person may not be for another (Gastmans et al., 1998). In practice, this means that there may be conflict among staff or family members, for example, about what is good, right, or just even under the same circumstances. It might also be that the risk/harm benefit is not clearly known upfront; knowing what is right relies on unknown factors that cannot be understood until after a decision is made. This reflects the grey zone of nursing practice wherein lie moral uncertainty and moral dilemmas (Jurchak et al., 2017). According to the Canadian Nurses Association (2017), a moral dilemma is defined as what “arise[s] when there are equally compelling reasons for and against two or more possible courses of action, and where choosing one course of action means that something else is relinquished or let go” (p. 6). In other words, there are equally competing values at stake and a course of action will prioritize one value over another. Moral uncertainty is less studied in the context of nursing practice than other moral concepts, such as moral distress, and disagreement persists regarding its precise definition (Dorman & Raffin Bouchal, 2020). Moral uncertainty can be understood as what arises when there is uncertainty around what the right, good, or just action is, because the consequences of the action are unknown or unwanted but unavoidable and, therefore, success is not guaranteed (Chiaranai, 2011; Dorman & Raffin Bouchal, 2020).

The first reflection, methodological in nature, is where hindsight revealed whether the moral experience aligned with or challenged the participant’s values and beliefs. Researchers have shown that people better remember experiences with high emotional involvement (Berntsen & Rubin, 2002; Talarico et al., 2004). Therefore, the experiences participants shared may have been very good or very bad, rather than those where the discomfort or uncertainty has since been resolved. Jameton (2013), who coined the term moral distress, asserted that “Once the choice is

made and action is undertaken, the psychological elements of distress tend to diminish” (p. 303). When a judgement is made as to whether the experience aligned with or challenged their values and beliefs the discomfort or uncertainty might fade. As a result, the moral uncertainty and moral dilemma that was felt at the time the experience occurred becomes more difficult to capture because the emotional intensity has diminished. In the event of a moral dilemma, where there are equally compelling reasons for and against two or more possible actions, regardless of the outcome, at least one value is compromised. The intent is thus to choose the action which is the most good, right, or just (Jameton, 1984). Again, while there will always be some level of compromise, the outcome of the event reveals whether the most good, right, or just course of action occurred based on the participants’ judgement of the experience. When I asked the participants about their moral experiences, they were more likely to remember and recount those that elicited a strong emotional response at the time of the experience.

The second reflection is interpretive in nature and relates to the ways in which my experiences and understanding of moral concepts, such as moral uncertainty and moral dilemma, influenced the ways in which I interpreted the participants’ moral experiences. As a qualitative researcher, I engaged in reflexivity as part of the research process. Reflexivity is the “process of a continual internal dialogue and critical self-evaluation of [a] researcher’s positionality as well as active acknowledgement and explicit recognition that this position may affect the research process and outcome” (Berger, 2015, p. 220). By engaging in reflexivity, I aimed to recognize, examine, and understand how the person that I am (praxis, role, and social position) influenced the research process (Flick, 2013; Palaganas et al., 2017; Peddle, 2020). My own biases and subjectivity were made explicit to provide a better understanding of the lens through which I constructed an interpretive understanding of the moral experiences of UNSs that is grounded in

the data. There is ongoing conceptual ambiguity about what defines specific experiences such as moral distress, moral uncertainty, and moral dilemmas (Morley et al., 2019). Recently, for example, Dorman & Raffin Bouchal (2020) outlined the antecedents, related concepts, attributes, and consequences of both moral distress and moral uncertainty in the context of medical assistance in dying. Despite the independent tables that outline these items, one for moral distress and one for moral uncertainty, there is clear overlap between some of the elements of each of these moral experiences, highlighting the challenge of differentiating between these specific moral experiences. In response to this ambiguity, I had to decide, as a researcher, how I understood these moral experiences. This understanding was influenced by my knowledge of the literature and prior moral experiences. Therefore, my interpretation of the data might differ from another researcher who has had different experiences and developed a different understanding of these moral concepts. As a result, another researcher might interpret the data where experiences of moral uncertainty and moral dilemmas are visible to them.

When using constructivist grounded theory, the researcher will inevitably influence all aspects of the research process from the questions asked to the presentation of the findings. Acknowledging reflexivity makes this process visible and leaves space for variation in the interpretation of data. In the context of this study, I found little evidence of moral uncertainty and moral dilemmas. Prior research demonstrates that UNSs do indeed experience moral uncertainty and moral dilemmas (e.g. Greig et al., 2021; Kelley et al., 2022); therefore, their relative absence in this study raises questions. Both hindsight and reflexivity may help explain how evidence of moral uncertainty and dilemmas were not well captured in the participants' stories. This process of reflection suggests that firm conclusions cannot be drawn as to whether or not the participants experienced moral uncertainty and moral dilemmas.

5.4 Reframing our Understanding of Action in Response to Experiences that Challenge One's Values and Beliefs

The actions of UNSs in response to experiences that challenge their values and beliefs is not well captured in the literature. This is mainly because they have typically been looked at in terms of the speaking up/silence dichotomy – where speaking up involves directly confronting the wrongdoer or using formal reporting channels and silence involves doing nothing. UNSs are typically categorized as staying silent rather than speaking up in the face of perceived wrongdoings (Bradbury-Jones et al., 2007; Levell-Jones & Lathlean, 2009). When actions are categorized in terms of this dichotomy, there is a range of options between them that is not captured. Often, in this study, the participants acted or used their voice in some capacity in reaction to experiences that challenged their values and beliefs, employing a range of actions between the speaking up/silence dichotomy. In this section, I challenge the dichotomy between speaking up/silence and reframe it as a spectrum. This is followed by looking at some of the ways in which UNSs' actions are constrained within this spectrum in the context of clinical placements.

5.4.1 Understanding Taking Action as Being on a Spectrum

In this section, I operationalize the idea of a spectrum by drawing on whistleblowing literature and describe how this concept better captures UNSs' responses to experiences that challenge their values and beliefs. Research done on whistleblowing in nursing has similarly challenged the dichotomy between speaking up and staying silent (Gagnon & Perron, 2020; Teo & Caspersz, 2011). At the heart of speaking up, which includes whistleblowing, is the desire to achieve change in some capacity (Jackson et al., 2011). Whistleblowing is considered to be at one end of the speaking up/silence dichotomy because it is used as a last resort when all other

methods to achieve change are unsuccessful (Gagnon & Perron, 2020). On the other end of the silence/speaking up dichotomy is turning inward, which involves no action at all; the experience is internalized and not spoken about or addressed.

This dichotomy offers a limited understanding of action because it does not account for behaviours used to mitigate the need for whistleblowing (Gagnon & Perron, 2020; Jones & Kelly, 2014). For this reason, considering a range of actions as being on a spectrum better captures the participants' responses when confronted with experiences that challenged their values and beliefs. Very few of the participants' actions fell at the extreme ends of the silence/speaking up dichotomy; none engaged in whistleblowing and only a small number were entirely silent. It is important to note, however, that the choice to not speak up or act did not mean that they condoned situations that they considered incompetent, non-compassionate, unsafe, or unethical.

Although none of the participants engaged in whistleblowing as it is currently defined, they were not all silent and inactive. Instead, most of the participants employed a range of actions in response to experiences that challenged their values and beliefs. Some voiced their concerns to others, such as another UNS, a nurse on the unit, or their clinical instructor. Several also tried to resolve or diffuse a perceived wrongdoing without confronting the person or persons directly, working quietly and strategically to minimize risk of harm to their reputation, wellbeing, or academic standing. It is important to note that while participants believed themselves to be at the bottom of a hierarchy of power relations, their actions nevertheless demonstrate that they did indeed exercise some power despite their perception of powerlessness. This perception of power(lessness) likely reflects their understanding of more common conceptualizations of power, where it is held by certain groups to the detriment of others (Perron

et al., 2005). Moving beyond such conceptualizations and engaging with power as a fluid entity between people helps to contextualize and better appreciate the ways in which UNSs can exercise power (and act) despite various challenges they face as learners.

The finding that UNSs use a range of actions was similarly identified by Bradbury-Jones et al. (2011b), who use the term “negotiated voice” to characterize the bridging actions situated between “exit” (silence) and “voice” (speaking up); in other words, UNSs used their voice but tempered it. They consider exit to be where UNSs withdrew from a situation, unable to voice their concerns despite wishing to express their opinion, need, or concern. Conversely, they consider voice to be where UNSs felt empowered to explicitly ask questions and have their opinion, need or concern addressed. Understanding that UNSs “speak up” through actions by using various modalities and channels is important. Just because an UNS did not pursue specific channels to address the wrongdoing does not mean that they did nothing. Similarly, Bickhoff et al. (2017) conducted a literature review of moral courage in UNSs and identified ‘indirect challenging’ as a theme. UNSs avoided directly confronting the person(s) involved in the perceived wrongdoing and instead acted in other ways that they believed conveyed their disapproval (Bickhoff et al, 2017). This included removing themselves from the situation or speaking with a manager (Gunther, 2011; Levett-Jones et al., 2007; Rees et al., 2014). Considering a range of actions rather than a dichotomy avoids the erroneous conclusion that UNSs do nothing if they do not directly confront the person who engaged in the perceived wrongdoing.

When the use of voice is considered to be on a spectrum, educators and researchers can explore the ways in which UNSs carry out their vision of nursing care; they can also highlight the challenges they face. Further, this way of thinking challenges the perception that UNSs are

powerless in the clinical environment. This understanding can act as a catalyst to develop ways to better support UNSs' use of voice while minimizing the risks of doing so. Integrating understanding of voice into nursing education may help UNSs negotiate its use in the clinical environment but it also makes evident some inherent challenges in healthcare education.

5.4.1 Negotiating the Choice of Action

The findings from this study challenge existing literature that reports UNSs as often failing to use their voice in clinical practice, even when speaking up is warranted (Bradbury-Jones et al., 2007; Levell-Jones & Lathlean, 2009). Instead, the findings demonstrate that the participants chose to act in some capacity when they had experiences that challenged their values and beliefs. The participants' choice of actions was interesting because they demonstrate the ways in which they negotiated the spectrum of available actions.

UNSs' capacity to act is constrained by professional norms and expectations. This is described as disciplinary power, and UNSs may be objects of disciplinary power within institutions (Hope, 2016). The meaning of the term discipline is twofold; it refers to practices used as a form of control of conduct and social possibility, as well as scholarly disciplines made up of a collection of knowledge (McHoul & Grace, 1993). Foucault makes the historical link between these two meanings of discipline – discipline as a body of knowledge and disciplinary practices as forms of control of conduct and social possibility (McHoul & Grace, 1993). Scholarly disciplines, like nursing, are bodies of knowledge that serve to define the norms and expectations of its constituents and the individuals who are subjected to them (Perron et al., 2005). The capacity for UNSs to act is constrained by disciplinary norms and expectations; actions are restricted or controlled by relations of power. Existing literature on this topic has identified why some UNSs choose to temper their actions or take no action at all, including a

lack of confidence and experience to raise the concern, a desire to please a superior, and a fear of failing the clinical placement (Bradbury-Jones et al., 2011a; Ion et al., 2016; Kent et al., 2015).

In this section, I highlight the ways in which the participants' actions, based on the stories they shared, were constrained in response to experiences that challenged their values and beliefs. As noted earlier, they were not free to act however they wished; their actions took place within relations of power that were affected by their status as learners. They also faced the norms and expectations of the nursing profession and broader clinical environment. First, the participants considered the risks and benefits of their actions and how the risks especially might constrain their actions. Second, they perceived that they lacked knowledge as learners, which affected their choice of action in response to experiences that challenged their values and beliefs.

When considering their choice of action, the participants weighed the risks and rewards of a particular action and this balance between risk and reward during decision making is supported by existing research with UNSs (Bickhoff et al., 2016; Ion et al., 2016). A significant risk expressed by the participants was being identified or seen within the school system as a problem student: "I don't want to be labeled as a troublemaking student or anything like that" (P22). UNSs' choice of actions often leans towards maintaining the status quo, so as to "not rock the boat" even when they do act (Levett-Jones & Lathlean, 2009). Further, the participants were aware that their clinical instructor had the capacity to pass or fail them and doing anything that could jeopardize the relationship with their clinical instructor represented a high level of risk. Similarly, a study by Reid-Searl et al. (2009) found that fear of a negative evaluation or of failing the clinical placement was a source of internal conflict for UNSs. The participants placed a great deal of value on passing a clinical placement because the consequences of failing could be significant, such as being held back a semester or even a year. Therefore, the participants felt a

tremendous amount of pressure to succeed during their clinical placements in order to progress in the program. UNSs adopt strategies to “get through” the clinical placement by tempering their actions so as to “play the game” and not “rock the boat” (Gunther, 2011; Reid-Searl et al., 2009). This may also explain the participants’ limited use of formal internal channels to report perceived wrongdoings because of the risk of being identified or seen within the system. The participants who did speak up at the administrative level did so only when they had little to lose, including, for example, when they were already at risk of failing a clinical placement. This means that the participants who reached out to the school of nursing administrators often did so when their situation was dire, rather than reaching out earlier when their concerns might have been more easily addressed. Eventually, however, the benefits outweighed the risks in these situations, and the participants chose to put themselves at risk of being singled out within the school system. It is also interesting to note that the participants who did go so far as to speak with a school administrator only did so when they or their peer experienced a perceived wrongdoing themselves, and none of the study participants did so when the perceived wrongdoing was aimed at a patient. While no participants engaged in the act of whistleblowing, research on nurses and UNSs who did engage in the practice found that they most often spoke up because of patient-related concerns (Jackson et al., 2014; Mannion et al., 2018).

Second, it has been shown that UNSs can lack confidence in their own judgement (Bellefontaine, 2009; Ion et al., 2015) and some of the participants’ experiences reflected this finding. Several spoke about their perceived lack of knowledge and their role as learners, implying that their judgement about what was “right” was somehow less important or informed than others in the same environment. As Bellefontaine (2009) described it, this perception often resulted in UNSs doubting their own clinical reasoning and judgement. From a discursive

standpoint, I see this understanding resulting from power-knowledge dynamics that govern the clinical environment and trickle down to UNS's experiences during clinical placements.

According to Foucault (1980), knowledge and power are intrinsically linked and mutually generative. From this perspective, power limits what knowledge is accepted or valued. With its emphasis on "science" and medical models of knowledge, (Hennerman, 1995), the nature of nursing knowledge is influenced by historical, social, and political factors has been devalued (Doering, 1992). Although not always explicit, such power relations come to affect the way nurses see themselves and "their" (devalued) knowledge (Davis & Fowler, 2018), leading to embodied passivity, submissiveness, and obedience (Peter et al., 2004). Much like the results of this study, the relations between power and knowledge affect the experiences of UNSs as they navigate their way through these power dynamics that permeate clinical environments and position them as less knowledgeable from both a disciplinary standpoint (being a nurse) as well as a professional standpoint (student learners) (Ferns & Meerabeau, 2009; Grealish & Trevitt, 2005).

Several participants believed that they were situated at the bottom of the metaphorical ladder in relation to others and thus felt they had to temper their actions or be silent. Their responses to experiences that challenged their values and beliefs were not isolated and have been previously documented in existing literature (e.g. Bickhoff et al., 2015; Levett-Jones & Lathlean, 2009; Reid-Searl et al., 2009). When UNSs feel their knowledge is devalued or they lack confidence in their knowledge, their decision to act in response to poor practice is affected (Baxter & Rideout, 2006; Gunther, 2011). Bickhoff et al. (2015), in their research on moral courage, similarly identified being "just a student" and lack of confidence/knowledge as themes that influenced UNSs' decisions to challenge poor practices. The findings suggest that current

structures in the clinical environment serve to perpetuate structures of docility where UNSs find their knowledge devalued. Those participants who navigated structures of docility by tempering their actions wanted to remain “unseen” and “unproblematic.”

Levett-Jones and Lathlean (2009) describe the tempering of actions when UNSs are faced with experiences that challenge their values and beliefs as conforming practices. In their study, they discovered that some UNSs conformed to experiences that caused disillusionment and distress in an effort to fit in on the clinical unit and increase their belongingness in relation to others. This aligns with the participants’ efforts in this study to mitigate their actions so as not to become too visible within organizational settings. Although most did act when they had experiences that challenged their values and beliefs, they acted in ways that were more covert. This allowed them to both demonstrate their disapproval of these experiences and maintain the status quo and not “rock the boat” in order to get through the clinical placement.

In summary, the participants in this study were aware of issues and care practices that they perceived to be incompetent, non-compassionate, unsafe, or unethical and that impeded their ability to provide what they believed was good care. They made decisions about how to act based on their interpretation of these experiences and the perceived risks and benefits of their actions as well as their knowledge at the time of the experience. Ultimately, most participants who experienced or witnessed a perceived wrongdoing did act in some capacity, but their actions were often undertaken covertly or cautiously in order to reduce their risk of harm while still demonstrating their disapproval. Understanding action as taking place along a spectrum of possible actions will help to better capture the experiences of UNSs and challenge the perception that they are silent when their values and beliefs are challenged. It also suggests that UNSs are

not as powerless as they may believe themselves to be. Instead, UNSs exercise power as they negotiate relationships with and within institutional structures.

5.5 Recognizing the Relational Dimensions of Clinical Practicum Learning in

Undergraduate Nursing Education

In an effort to understand UNSs' moral experiences, I inadvertently found that the relational dimensions of clinical placements were a fundamental aspect of the participants' learning. The relational aspects of nursing care have been described as the invisible work of nurses (DeFrino, 2009). Relational work involves navigating relationships and the environments in which these relationships exist. The findings from this study suggest that UNSs also engage in this invisible relational work. Despite challenges experienced during clinical placements, many participants expressed how valuable they were to their learning and preparation to become registered nurses. In this section, I will discuss how UNSs learn to navigate these kinds of relationships and describe some of the lessons learned from COVID-19 as it relates to clinical learning.

5.5.1 Learning to Navigate Relationships

Many of the participants spoke about learning during clinical placements in terms of navigating relationships and new clinical environments. The relational work of nurses is a fundamental aspect of nursing and represents a source of power and value in practice (DeFrino, 2009). From this perspective, relational work is work; it is a skill that is learned and should be valued, nurtured, and practiced, rather than perceived as an innate skill that nurses as human beings possess. The participants were challenged to adapt to individuals within networks of people during each clinical placement. Further, the participants, as well as UNSs more broadly, not only navigate relationships with other people but also with organizational structures and

cultures (Raso et al., 2019). These human and organizational relational dimensions of clinical practice were integral to the participants' learning. Learning to navigate these relationships is a socialization process into behaviours and practice that has been described as the "hidden curriculum" (Allan et al., 2011; Cribb & Bignold, 1999). The unintended learning outcomes related to the socialization process that makes up the hidden curriculum are often related to political socialization, professional values, and hierarchies (Akçakoca & Orgun, 2021). Additionally, what is taught in classroom settings may differ from the lessons and actions learned as part of the hidden curriculum in the clinical setting (Kelly, 2020). The hidden curriculum is implicit and therefore not readily accessible (Gaiser, 2009; Stern et al., 2006); making it difficult and arguably impossible to teach in classroom, simulation, or laboratory settings. Clinical placements represent an invaluable aspect of the learning that occurs in the process of becoming registered nurses.

5.5.2 Lessons Learned from COVID-19 as it Relates to Clinical Learning

The COVID-19 pandemic highlighted challenges faced by UNSs who did not have access to in-person clinical placements. Those who had no access were not afforded the same opportunities to develop the relational skills that are learned in those environments. These challenges, which will be described below, demonstrate the value of in-person relational learning that occurs during clinical placements.

The COVID-19 pandemic was a catalyst for many post-secondary institutions to transition from in-person to online learning (Bdair, 2021). As hospitals became overwhelmed with a large influx of patients with COVID-19, and with such uncertainty around it especially at the onset of the pandemic, UNSs were pushed out of many clinical environments. In an effort to ensure the continued education of UNSs, nursing programs not only transitioned to online

learning for their theory courses, but many also developed virtual clinical placements as a replacement for the in-person clinical placements and laboratory sessions (Jiménez-Rodríguez et al., 2020; Yale School of Nursing, 2020). Virtual simulations have existed in many nursing programs for several years and research has been conducted to determine the impact of this learning modality for UNSs (Foronda et al., 2020). Virtual simulation as well as in-person simulations have been touted by some as a substitute under certain conditions for up to 50% of clinical practicum hours (Fogg et al., 2020; Hayden et al., 2014; Rutherford-Hemming et al., 2016). When comparing learning outcomes, such as knowledge acquisition and retention over time, I found few studies that compared virtual simulation to in-person clinical learning outcomes (e.g. Fung et al., 2021). Most often, comparisons made in the literature were between virtual simulation and in-person simulations (laboratory sessions). In-person simulation learning does not necessarily equate to in-person practice, therefore, the findings are not necessarily transferable between these two learning modalities and settings.

The transition to mostly or entirely online learning for UNSs during the pandemic was abrupt and schools needed to act and adapt quickly to the changing landscape (Leaver et al., 2022). Research is now starting to emerge that points to challenges UNSs faced because of this transition to virtual learning modalities (Heilferty et al., 2021; Michel et al., 2021). Some felt that their academic performance suffered, they experienced significant stress and isolation, and they believed that the version of nursing they were learning in their online classes, laboratory sessions, and virtual simulations no longer reflected the current reality of nursing practice. The transition to online learning for UNSs was not entirely negative however, with some UNSs feeling an increased sense of camaraderie, a strengthened desire to be a nurse, and a greater flexibility in managing home responsibilities (Heilferty et al., 2021; Michel et al., 2021).

Evidence is also starting to emerge about the experiences of UNSs who graduated shortly before or after the onset of the COVID-19 pandemic (e.g., Casey et al., 2021; Crimson et al., 2021; García-Martín et al., 2021; Hodges et al., 2021; Kovancı, & Atlı Özbaş, 2022). There is reason to believe that UNSs who graduated during the COVID-19 pandemic without the opportunity to practice relational work during clinical placements struggled to transition into the workplace. This demonstrates that relational work is a skill that is developed and is an integral part of the learning that occurs during clinical practicums. When in-person clinical practicums are not offered or available, relational skills are more difficult to develop and may make transitioning into the clinical environment more challenging.

5.6 Limitations

This study has a number of limitations. It is important to acknowledge research limitations, not as a way to reduce the value of the research, but rather to address the specific ways in which the perspective and approach of a researcher affects the interpretation and potential application of the research (Wright, 2012). There are five limitations of this study: the first is related to data collection occurring at one university, the second is concerned with the limitations of interviews, the third is related to the implications the administrative roles of my co-supervisors had for participant confidentiality, the fourth is related to the changing global context in relation to the COVID-19 pandemic since data collection occurred, and the fifth is concerned with the absence of a model.

The first limitation is that because the research setting is limited to one university in Canada, the stories shared by the participants may reflect the specific culture and context of that university. The program design may also have influenced their clinical experiences, such as the timing between clinical placements and concurrent theory courses, the quantity and timing of the

clinical placements within the program, the evaluation methods used to assess the participant's clinical performance, and the ratio between clinical instructors and UNSs during clinical placements. Beyond the nursing program itself, the university has its own culture and the availability of student services, such as those pertaining to mental health, legal aid, and mentoring, may be specific to each educational institution. Conducting the study at one university may limit the transferability of the findings to other settings but I have offered extensive descriptions of the university setting and Bachelor of Science in Nursing program in order to give sufficient information to the reader to determine if the findings are relevant to their specific environment. However, one benefit of the university is that it is a bilingual institution and I was able to collect data in both English and French.

The second limitation is related to interviews as a source of data collection. Interviews in and of themselves are not a limitation but some aspects of the decision to conduct them have implications for the results of the study. The interviews were conducted by one researcher, which did ensure some degree of consistency across interviews, averting a potential problem that can arise with multiple interviewers (Matteson & Lincoln, 2009). It also meant that the quality of the data was dependent on the ability of this same researcher. The decisions about which questions to ask and the body language used during the interviews were personal decisions, made consciously and subconsciously, and reflect my own thinking and personhood. If the interviews had been conducted by another individual, the data obtained may have varied (Matteson & Lincoln, 2009), a reasonable and expected outcome given the subjective nature of reality and co-construction of data.

It was also important for me to be aware of and mitigate undue influences that could occur when interviewing students (Canadian Institutes of Health Research et al., 2018; Matteson

& Lincoln, 2009). At the time of data collection, I was not teaching and therefore a student's decision to participate would have no impact on their academic standing. Because I held no more power or authority over participants than is expected in a participant-interviewer relationship, I did not take any special precautions before, during, or after the interviews. At the beginning of the interviews, I reviewed the consent form, which outlined who my thesis co-supervisors were and their involvement in the research, as well as the steps taken to protect participants' personal information. I also asked low-pressure open-ended questions at the beginning of the interview to establish a sense of trust. This allowed me to connect with the participant and helped them feel more comfortable sharing their experiences during clinical placements that may have been sensitive or elicited a strong emotional response.

An additional challenge of conducting interviews was the large volume of data collected. Twenty-three retained interviews that lasted an average of 75 minutes generated hundreds of pages of transcripts to analyze. Although there is an inherent bias that is accepted in qualitative research, the large volume of data may have amplified the risk that others who read the transcripts may have had a different interpretation of the data. I worked with my thesis co-supervisors to get differing perspectives on pieces of data. I also returned to the data when constructing my findings in order to continually ground the findings.

The third limitation is related to the administrative roles of my thesis co-supervisors. My co-supervisors, Dr. Amanda Vandyk and Dr. Jean Daniel Jacob, and I had concerns about their ability to identify the participants from the interview data. They are both employed in the school of nursing at the university where data was collected, and at the time the interviews were conducted, Dr. Vandyk was an Assistant Professor who may have taught some of the participants, and Dr. Jacob was an Associate Professor who held an administrative role as the

Assistant Director, Undergraduate Studies. We identified their roles within the school of nursing in our Research Ethics Board application, but this was not identified as problematic. The names of Dr. Vandyk and Dr. Jacob, along with their contact information, were explicitly put on the consent form that was sent to all interested UNSs to help them decide whether or not they were willing to consent to the interview. Because of this, all participants knew that these two individuals were involved in the research process but that all data from the interviews would be anonymized before being viewed by anyone on the research team. Although the positions held by Dr. Vandyk and Dr. Jacob were not problematic from an ethical standpoint, some UNSs may not have felt comfortable participating in the interview, knowing that the data, though anonymized, would be viewed by my thesis co-supervisors. The interview data would in no way influence an UNSs' academic standing or course grades but the fear of retribution or being identified because of their information may have deterred some.

The fourth limitation is related to the changing global context due to the COVID-19 pandemic. Data collection for this study ended in February 2020. On March 11th 2020, the World Health Organization declared COVID-19 a pandemic (Cucinotta & Vanelli, 2020). Later that same month, the Ontario government announced a state of emergency (Government of Ontario, 2022). In an effort to reduce the transmission of COVID-19, many practices and policies in healthcare settings changed. While the World Health organization has not yet declared the COVID-19 pandemic over, the state of emergency in Ontario has ended. School has now resumed on campuses across Ontario and UNSs can again have clinical practicums in healthcare organizations. Despite this, there may be lingering effects of the COVID-19 pandemic that might mean that the moral experiences of UNSs pre- and post-pandemic are different. Therefore, because data collection for this study concluded before the onset of the COVID-19 pandemic, the

findings may not reflect current realities of UNSs. The findings from this study, however, present a theoretical understanding, rather than a description, of the stories shared by participants. A theoretical understanding transcends individual stories, therefore even if they do not capture specific elements of stories related to COVID-19, the findings should resonate with UNSs regardless of whether or not they were students prior to, during, or after the onset of the COVID-19 pandemic.

The fifth and final limitation is related to the absence of a model. A model is a visual depiction of the categories and relationships between them. Models are frequently included in grounded theory publications (e.g. Edwards et al., 2021; Jacob & Holmes, 2011; Nagel et al., 2017). I worked in collaboration with my thesis co-supervisors, Dr. Amanda Vandyk and Dr. Jean Daniel Jacob to come up with various visual representations of the categories and relationships between them. This was a worthwhile process because it challenged us to speak about how the categories relate to each other. Unfortunately, we were unable to come up with a model that meaningfully represented the constructed categories.

The categories in this study are described in terms of processes. Moral experiences are the catalyst for learning and these experiences occur within relational contexts. As a process, learning in motion is non-linear and could not be accurately represented in a model. UNSs are constantly learning, it is dynamic and moves in all directions. Future research could seek to better understand this learning process and articulate a visual representation of the process.

5.7 Implications for Education, Practice, and Research

The participants in this study shared their moral experiences that ranged from the good to the bad, the happy to the sad, the expected to the unexpected, and everything in between. A

broader understanding of their experiences during clinical placements is a springboard to the development of implications in three spheres: education, practice, and research.

5.7.1 Implications for Education

With the focus of this study on the experiences of UNSs, the implications for education are extensive, with multiple areas of interest, and are developed and supported with theory and/or existing literature more than is typically expected in a doctoral study. Each of the implications below has actionable insights that served as the rationale for including them here rather than in the body of the discussion. The implications for education represent an important contribution of this research study. The five implications discussed are: 1. Developing clear reporting processes, 2. Creating spaces outside the lens of judgment, 3. Investing in clinical learning, 4. Clinical instructor feedback, and 5. Interprofessional collaboration in nursing education.

5.7.1.1 Developing Clear Reporting Processes. Milligan et al. (2017) identified a gap in the literature on when, how, and to whom UNSs should report when raising a concern related to their clinical practice. This was similarly found in this study. Currently, the process of reporting a perceived wrongdoing in the school of nursing largely falls on UNSs to navigate; the process is more implicit than explicitly delineated. Further research could be conducted in this area and on the development of standardized reporting processes in nursing programs.

When developing reporting processes, the focus should be on creating transparency with clear steps and guidelines for both UNSs and administrators. One example of such a reporting process is a ladder approach described by Espin and Meikle (2014), in which reporting continues to increasingly higher levels of authority until a satisfactory response is obtained. Creating a clearly defined reporting ladder may help reduce perceived barriers to reporting (Milligan et al.,

2017), create trust in the system, and open communication between administrators and UNSs so that UNSs are raising their concerns before the situation becomes dire.

Anonymous reporting was identified by several participants as a way to mitigate risk while still being able to voice their concerns. In clinical settings, research has shown that healthcare providers are reluctant to report adverse events to a superior (Lawton & Parker, 2002). As a result, anonymous reporting systems have been implemented in hospital settings for healthcare providers to voluntarily report errors and near misses (Suresh et al., 2004). Anonymous reporting may offer UNSs the distance needed to feel safe to report their concerns, as has been implemented in clinical settings.

5.7.1.2 Creating Spaces Outside the Lens of Judgement. There is value in creating spaces for UNSs outside the lens of judgment. Spaces outside the lens of judgment may be, but are not necessarily defined by, a physical location. Rather, they are defined by the environment and culture of safety that is created within them. As objects of power, the participants spoke at length about their experiences of being watched, judged, and evaluated. As learners, UNSs are subjected to these disciplinary technologies (Coverston, 2001) that render them visible for the purpose of classification and judgement (Smart, 2002). The participants in this study wanted spaces where they could share their moral experiences with people who were not in a position of authority to observe, judge, and evaluate them. A space where UNSs feel they are invisible or less susceptible to being seen for the purpose of judgement and examination may foster an environment where they can be themselves without fear of reprisal. This would allow UNSs to talk openly about their moral experiences during clinical placements and receive support to work through them.

Several of the participants in this study spoke about how they felt they did not have a space to openly share their moral experiences. Some felt they had nowhere to turn for support when they had experiences that challenged their values and beliefs despite the efforts of some staff and faculty to be open to students. Because of the interconnected nature of the relationships among school faculty and staff, some participants believed that speaking about the challenges they experienced during their clinical placement might enable their concerns to be circulated back to their clinical instructor or they might become labelled as a difficult UNS. The use of disciplinary technologies in education (hierarchical observation, normalizing judgement, and examination) may offer insight into the participants' desire to remain hidden within organizational systems. Their experiences of being objects of disciplinary power could be unpleasant and stressful. Holmes (2001) described a similar sentiment with patients: "The fact that patients need care does not exclude the fact that they may also feel observed, disciplined, and objectified by these new surveillance devices" (p.10). Similarly, although UNSs understand they are learners, being observed, judged, and examined are not necessarily well received. In order to mitigate the use of these disciplinary technologies, the participants sometimes made attempts not to call attention to themselves. UNSs may benefit from access to spaces where they feel free to express themselves; it is important that those creating these spaces are not involved in observing, judging, and evaluating them as learners in the clinical environment.

From this study, DGDs were most frequently identified as a space where participants chose to share their moral experiences. Although the relationship between the UNSs and their clinical instructor has been identified as the most important factor influencing learning experiences during clinical placements (Warne et al., 2010), and despite the formally designated time, such as in post-clinical debriefing, to talk about moral experiences, some participants were

still hesitant to talk because they did not feel able to speak honestly. This was because their clinical instructor had the capacity to influence whether they passed or failed the clinical placement. Conversely, the professor for each DGD group is not involved in evaluating UNSs' clinical performance. Small group team learning, such as in the DGD format, has been used successfully in nursing education, among other disciplines, to promote learner engagement, teamwork, and enthusiasm (Feingold et al., 2008). While the DGD groups do not solve the issue of a close relationship between faculty and staff, there appeared to be a certain level of comfort in sharing during the DGDs that was not seen elsewhere in the current structure of the program. This is interesting because DGDs were not explicitly designed as an outlet for the support of UNSs in this way. Therefore, it may be relevant for schools of nursing to consider allocating time during DGDs, or equivalent, for the expressed purpose of allowing UNSs to share their moral experiences in relation to clinical placements and be supported by peers and faculty members in a controlled environment.

The spaces where UNSs are willing to share their moral experiences may be linked to the ways in which relations of power unfold in those places. The concepts of “space” and “place” have been studied in research on nursing practice (Gagnon et al., 2015). Space is defined as a physical location and place refers to the social context in which power is exercised (Elwood & Martin, 2000; Herzog, 2005). Understanding how space and place influenced the participants' feeling of safety during DGDs may help explain why DGDs were perceived to be spaces outside the lens of judgement.

At the university where the study took place, the professors who lead DGD groups are not directly involved in clinical placements. It became clear during the interviews that this distance between the DGD professor and participants as well as the DGD professor's

(in)capacity to evaluate the participants was an important factor in seeing the DGD as a space where participants were willing to share their moral experiences in relation to clinical placements. Furthermore, the UNSs in the DGD groups were typically not the same as those in a clinical placement group. The DGD professor and the UNSs in the DGD group could provide feedback with little or no risk to the UNS who was sharing their moral experience. This concept of distance is vitally important, in one example, one participant chose not to share their moral experience because one of their peers was in both their DGD and clinical placement group; they did not want there to be a link between both spaces. Therefore, the creation of a place outside the lens of judgement is not necessarily linked to a specific location (space). What has emerged in this study as important is that UNSs have a place where they feel empowered to share their experiences without fear of reprisal. A sense of safety for UNSs to share their moral experiences in relation to clinical placements is created by the distance between the UNS and the listeners' capacity to influence the evaluation of their clinical placement.

5.7.1.3 Investing in Clinical Learning. The findings from this study demonstrate that navigating relationships during clinical practicums is a valuable aspect of the participants' learning. The American Association of Colleges of Nursing (2020) has recommended investing in in-person clinical learning to offer UNSs the opportunity to develop their relational skills. In order to accomplish this, they recommend developing and maintaining strong relationships between schools of nursing and their practice partners; practice partners being the organizations where clinical practicums occur, to adapt to the ongoing needs of both. The findings from this study indicate that UNSs have direct and on-going contact with the practice partners as representatives of the school of nursing and their needs within these relationships should be considered. Some of the participants described how important it was that they felt welcomed by

nurses on the clinical unit. When this did not happen, it was difficult to feel like a member of the clinical team or to turn to the nurses for support.

In addition to strengthening in-person clinical experiences through developing and maintaining relationships with practice partners, schools may also want to consider ways to ensure that UNSs have adequate time during each clinical placement. What constitutes adequate time has been debated and depends on the learning goals and objectives (Goers et al., 2022). Some researchers have shown that it may take up to seven months for an UNS to develop confidence in a clinical environment (Dubé et al., 2015), while others have suggested the timeframe may be even longer (Ellaway et al., 2013). Too-short clinical placements can produce frustration and anxiety (Ellaway et al., 2013). Conversely, studies have shown that longer clinical placements offer increased satisfaction, learning, engagement, personal growth, performance, and preparedness for practice (Dubé et al., 2015; Ellaway et al., 2013; Roberts et al., 2017). Longer clinical placements have been implemented elsewhere as an innovative response to the needs of an evolving healthcare system (Wright, 2015), and have the potential to benefit UNSs, schools of nursing, and their practice partners (Goers et al., 2022).

The structure and length of clinical placements is not universal across schools of nursing nationally or internationally (Dobrowolska et al., 2015). At the university where data collection occurred, UNSs have their first clinical placement in the second semester of their second year; their remaining clinical placements and consolidation occur in third and fourth years. Several of the participants felt they had little time to become comfortable in an environment before moving to another clinical placement. Participant 18 stated: “There should have been more clinicals, more time in the hospital. Longer clinicals, 3rd year was extremely rushed. [...] I definitely would have them [clinical placements] all semester” (P18).

It is important to review nursing education programs regularly to ensure that the curriculum responds to the needs of the students as well as the academic institution, practice partners, accreditation standards, and an evolving healthcare system (Jager et al., 2020). Research has been undertaken on the innovative ways some healthcare and educational organizations have responded to these challenges, including increasing UNS capacity at clinical sites, using non-traditional clinical sites for UNS learning, and reducing faculty costs (Niederhauser et al., 2012). One specific innovative approach is having UNSs work in pairs or dyads in clinical placements (Austria et al., 2013; Tousignant et al., 2021). Pairing two UNSs and assigning them one or more patients has been shown to be a positive experience for most, particularly as it relates to teamwork, confidence, work engagement, and autonomy (Ott & Succheralli, 2015; Trueman et al., 2014). Dyad learning offers a means for UNSs to feel empowered, creating an environment where they can discuss and debate their thoughts, ideas, or concerns with a peer with little fear of reprisal (Trueman et al., 2014). It is this type of innovative thinking that has the potential to transform clinical placement education to meet the evolving needs of UNSs, academic institutions, and their practice partners.

5.7.1.4 Clinical Instructor Feedback. Another recommendation for education is in relation to the process of giving feedback to clinical instructors. At the end of each clinical placement in the school of nursing where data collection occurred, UNSs have the opportunity to provide anonymous feedback. The participants in this study perceived themselves to be at risk of being identified by the feedback they provided. The format of the form and the small clinical group sizes meant that the participants perceived there was a reasonable chance that the clinical instructor would know who the respondents were based on their short and long question format responses, even though they were submitted anonymously.

Further, participants also noted that these forms went to the clinical instructors only and did not reach any administrators for review. They believed then that instructors could easily dismiss this feedback. If school administrators had access to this feedback, they could detect trends in clinical instructor performance, for example, and follow up with a discussion, training, corrective action, or other as appropriate. Because the participants perceived there was no “real” value to these feedback forms they did not necessarily want to risk sharing their honest feedback on the form; they either tempered their responses or neglected to fill it out at all. Schools of nursing should consider reviewing the feedback process for clinical instructors to address shortcomings in terms of UNS anonymity and follow-up with clinical instructors.

When considering ways to address the fear of identification and potential reprisal, it is important to think about how distance can be created to increase UNSs’ sense of safety. One way may be to use tools that have been developed to measure specific characteristics of clinical instructors as rated by UNSs (Madhavanprabhakaran et al., 2013). These types of tools may provide clinical instructors with empirical feedback without providing contextual details that may identify an UNS. The characteristics measured vary depending on the tool but include effectiveness of teaching and clinical instructor characteristics of excellence, for example. Some already developed are: Nursing Clinical Teacher Effectiveness Inventory (Knox & Mogan, 1985), Clinical Teacher Characteristics Instrument (Bergman & Gaitskill, 1990), and Effective Clinical Teaching Behaviors Inventory (Zimmerman & Westfall, 1988). Further, these tools could be modified as appropriate to generate information over time on UNSs’ perception of the characteristics of clinical instructors. Because clinical instructors may not receive specific training for their role, the results of the feedback obtained from these tools could help school administrators identify strengths and weaknesses both among individual instructors and clinical

instructors as a whole in order to develop training to target any areas of improvement. Using a standardized tool may reduce the risk of individual UNSs being identified through their responses, an assurance of anonymity that might encourage feedback more reflective of their experience.

5.7.1.5 Interprofessional Collaboration in Nursing Education. An area that merits further consideration is around the integration of interprofessional collaboration in undergraduate nursing education. Interprofessional collaboration is considered an essential skill needed in the everyday work of healthcare providers (Canadian Association of Schools of Nursing, 2020; World Health Organization, 2010). Further, it has the potential to improve work engagement and satisfaction as well as patient care (Kaiser et al., 2018; Peltonen et al., 2020). Many of the study participants either spoke, directly or indirectly, about a hierarchical structure that they perceived exists, with themselves at or near the bottom. Dealing with physicians was a source of stress for many of the participants, leaving them feeling intimidated or not valued. The participants may have learned in class about the role of physicians as well as patient-centered care principles that value the knowledge of all healthcare professionals. In practice however, these principles represented ideals rather than clinical reality. It has been suggested that interprofessional education improves patient outcomes through the development of interpersonal and communication skills, collaboration, and teamwork (Carey et al., 2010; Lapkin et al., 2013; Stewart, 1995). Interprofessional collaboration fostered in some capacity in undergraduate nursing education might help to challenge unequal perceptions of value within the healthcare team.

5.7.2 Implications for Practice

The findings from this research study focus on the UNS population; because of their work in clinical environments such as hospitals, long-term care homes, and community health centers, it is relevant to present implications for the practice settings in which the moral experiences of UNSs occur. The implications for practice are all related to the use of open, clear, and continuous communication between people.

Fostering open communication between the people in healthcare facilities and academic institutions, including nurses on the unit, UNSs, and clinical instructors, is important to help create a working environment that is mutually beneficial (Didion et al., 2013). Clinical nurses who work with UNSs are not necessarily trained to support them and often feel unprepared to serve in this role, yet it may be expected of them (College of Nurses of Ontario, 2002; McClure & Black, 2012). Outlining clear expectations to UNSs at the outset may help improve learning outcomes (Rowbotham & Owen, 2015). Open communication may also have a positive impact on patient care (Didion et al., 2013).

Clinical instructors and nurses who work with UNSs, such as preceptors, need to be able to develop interpersonal relationships with UNSs to promote learning (Collier, 2018; Lethale et al., 2019). Different cohorts of UNSs, and the individuals within those cohorts, will have differing experiences and each will have their own strengths and weaknesses. A blanket statement does not account for the individual differences in knowledge and performance of each UNS. When UNSs are paired with clinical nurses, the nurses are typically not the same from one shift to another, highlighting the importance of committing to ongoing communication every shift, whether it is a quick check-in or a more in-depth discussion based on what is needed at the time. Further, clinical instructors (and nurses) who are approachable, knowledgeable, and fair in

their evaluations can help create an environment that enhances UNS learning and allows room for growth to happen (Ali, 2012; Rowbotham & Owen, 2015; Sweet & Broadbent, 2017).

5.7.3 Implications for Research

Implications for research are related to areas for future exploration based on gaps remaining or identified as a result of this study. The implications for research are divided into six sections: 1. Goffman as a complementary sensitizing concept, 2. Research gaps in the moral experiences of undergraduate nursing students during clinical placements, 3. Research gaps in the moral experiences of clinical instructors during clinical placements, 4. Future research opportunity with the study participants, 5. Research with undergraduate nursing students with prior licensure, and 6. Looking at the participant characteristics in relation to the moral experiences of undergraduate nursing students.

5.7.3.1 Goffman as a Complementary Sensitizing Concept. In grounded theory, sensitizing concepts are used as a starting point to help the researcher explain the conceptualization of ideas and arguments (Charmaz, 2014). The sensitizing concepts that resonated with me and my understanding of the moral experiences of UNSs were relational ethics, nursing as a moral experience, and power. For the concept of power, I relied on the work of philosopher Michel Foucault, specifically his writing on knowledge/power and disciplinary power. However, Foucault has been criticized for failing to describe how the forms of discourse play out in the everyday lives of people and how they become part of the institutions. Hacking (2004) described Foucault's research as "top-down" arguing that he "starts with a mass of sentences at a time and place, dissociated from the human beings who spoke them, and uses them as the data upon which to characterize a system of thought, or rather, its verbal incarnation, a discursive formation" (p. 278). In other words, Foucault provides an overarching perspective of

power but fails to articulate how individuals are influenced by the social and material forces of their everyday lives (Leib, 2017).

The use of Foucault's conceptualization of power as a sensitizing concept is helpful to understand the influence of power on UNSs as a collective group within scholarly institutions – how, for example, disciplinary forms of power come to shape experiences. It does not, however, provide a way to understand how UNSs are made up in their everyday lives within these institutions. During clinical placements, UNSs are subject to the same overarching disciplinary powers but the ways in which each individual UNS interacts with the material and social world around them in this context is not explained through Foucault's description of disciplinary power. The work of Canadian sociologist Erving Goffman has been used to fill out the work of Foucault on disciplinary power. Goffman's research on power uses what Hacking (2004) describes to be a "bottom-up" approach – "always concerned with individuals in specific locations entering into or declining social relations with other people" (p. 278). Goffman's work provides a more localized account of the interactions between individuals and institutions (Leib, 2017). The use of Foucault was a good starting point and yet it proved to be incomplete when trying to understand power as it relates to the moral experiences of UNSs during clinical placements. Goffman's work on total institutions may help fill this gap and would strengthen an understanding of power in this context, and more importantly, bring conceptual foundations to UNSs' experiences and adaptation to the clinical environment. Future research on moral experiences could integrate the works of both Foucault and Goffman.

5.7.3.2 Research Gaps in the Moral Experiences of Undergraduate Nursing Students during Clinical Placements. Prior research and literature reviews on the UNS population have been conducted on specific moral concepts, such as moral distress (e.g., Sasso et al., 2016),

moral courage (e.g., Pajakoski et al, 2021), moral sensitivity (e.g., Yeom et al., 2017), and moral uncertainty (e.g., Greig et al., 2021). However, to my knowledge, no other research has been done that explores the moral experiences of UNSs during their clinical placements more broadly. The present study highlights the spectrum of moral experiences that UNSs have in the context of their clinical placements, the relational dimensions of their clinical practice, and the ways in which they incorporate their moral experiences into their learning process. Given that the present study was conducted at a single school of nursing in Canada, future research on the same types of experiences could be conducted to better understand how moral experiences may be similar or different depending on the context in which it takes place; for example, how different organizational and societal cultures influence the moral experiences of UNSs.

5.7.3.3 Research Gaps in the Moral Experiences of Clinical Instructors During Clinical Placements. Currently, the majority of the research that has been conducted with clinical instructors in nursing appears to reflect either UNSs' perceptions or evaluations of their clinical instructors (e.g., Reising et al., 2018) or measured specific characteristics, such as the effectiveness of clinical instructors (e.g., Lovrić et al., 2014). Few studies have sought to understand clinical instructors' experiences of working with UNSs, and those that do generally focus on specific types of experiences, such as moral distress (Wojtowicz & Hagen, 2014a) or managing at-risk UNSs (Rodger & Juckes, 2021). I did not identify any studies that looked at the moral experiences of clinical instructors during clinical placements more broadly. In this present study, clinical instructors were frequently identified as a key player in the moral experiences of the participants; the participants interacted frequently with their clinical instructors during their placements and the instructors were often the point of contact between the clinical environment and the institutions. Clinical instructors were seen as persons of authority because of their ability

to pass or fail the participants. Ultimately however, clinical instructors work within institutions and are themselves subject to institutional constraints as they navigate relationships within them.

Understanding the moral experiences of clinical instructors during clinical placements may help articulate the relational dimensions of their experiences as clinical instructors and the ways in which they incorporate their moral experiences into their decision-making processes. This perspective is valuable because it shifts the narrative from one of clinical instructors as oppressors to one where we understand them as being subject to similar structures of power as UNSs, who are constantly interacting with and navigating these environments. Their positioning within these structures is different from that of the UNSs due to their role, but this does not shelter them from institutional constraints. A recent study undertaken by Kellish et al. (2021) looked at moral distress and burnout in health science clinical instructors. Although the research included but was not specific to nursing clinical instructors, the findings demonstrate that clinical instructors in health science related programs experience moral injury as a result of moral distress and burnout. The authors noted an increase in the frequency and severity of moral distress when the actions of the clinical instructors were constrained, reflecting a relational approach to understanding moral experiences as well as the power dynamics within institutions.

Although less frequently, some participants did speak about clinical instructors who had a positive influence on their learning and moral experiences because they felt supported by their clinical instructor. Similarly, clinical instructors too likely experience a broad range of moral experiences, not just moral distress or burnout when working with UNSs. Understanding their range of moral experiences can help put a language to these experiences and create a dialogue around the ways in which clinical instructors can be supported in their own moral experiences and, ultimately, improve clinical learning for all.

5.7.3.4 Future Research Opportunity with the Study Participants. When I applied to the university's Research Ethics Board, I included a question in my consent form where I asked participants if they were willing to be contacted for a follow-up study if I were to conduct research on this topic in the future. The participants could then choose to agree or disagree to be contacted for this purpose although all participants agreed. The purpose of this question was to allow for the opportunity to conduct a future study with the same participants following their graduation and employment in the workforce. A future study with the same participants could take one of multiple approaches: undertaking a type of comparative analysis, looking at lessons learned, or having them reflect on their moral experiences shared during this study from their perspective as registered nurses for example. While this research is currently limited to the present study participants, other researchers may want to consider following up with their own study participants at a later date and include this clause in their Research Ethics Board application(s).

5.7.3.5 Research with Undergraduate Nursing Students with Prior Licensure. Initially, participants were excluded if they had previously or currently held any type of nursing or medical license either in Canada or outside of it. The rationale for this decision was that given their prior work in healthcare, I believed that their experiences during clinical placements would be different from those who had not worked under their own license – that they would feel more confident providing care because of previous exposure to clinical environments that UNSs without prior licensure would not have had.

Ultimately, I did interview one participant who previously held a medical license and worked as a medical doctor outside of Canada. Their interview was retained after consulting with the Research Ethics Board. The data was relevant for the study and meant that the participant

was not interviewed for nothing. Interestingly, this participant withheld their prior experience and licensure from their clinical instructors because they did not want to be targeted or held to a higher standard than their UNS colleagues. However, they struggled to draw the line between what they were allowed to do as an UNS and what they had been allowed to do as a physician. Essentially, their experience countered my expectation that those with previous or current medical or nursing licensure would excel in the clinical environment because of their experience and comfort there.

Their experience may be explained in part because they were internationally educated. There is abundant research done on internationally educated health professionals in Canada (Covell et al., 2016). Internationally educated nurses for example face many challenges when transitioning to practice in Canada that include difficulty adapting to local professional cultures and a different scope of practice (Neiterman & Bourgeault, 2015). Additionally, research on the transition from licensed practical nurses to registered nurses similarly identified some of the challenges they face during baccalaureate education (Cook et al., 2010). These students are typically an older demographic and have family or work responsibilities that can distract their focus away from school (Cook et al., 2010). With only one participant in this study who had a prior medical license and limited research in this area, firm conclusions cannot be drawn about their experiences. Future research could be conducted to better understand the experiences of UNSs who have previously held or currently hold a nursing or medical license either in or outside of the country in which they are in nursing school.

5.7.3.6 Looking at the Participant Characteristics in Relation to the Moral Experiences of Undergraduate Nursing Students. The present research study did not focus on the experiences of UNSs in relation to specific demographic characteristics such as gender, age,

and race/ethnicity. This information was collected as part of the demographic survey for the purpose of describing the population to enable other researchers to determine the transferability of the findings to their own setting. Future research could use a gendered, intersectional, or other lens to better understand the experiences of UNSs from these perspectives.

Although there was no analysis done to understand the experiences of the participants based on specific characteristics, it would be remiss to ignore that the experiences of some of the participants who did not fit the majority in some capacity seemed to have had more challenging experiences. Prior research that accounts for specific demographic features has found that minority groups encounter significant barriers in clinical education (Graham et al., 2016; Metzger et al., 2020). Given that this was not a focus of my research and that there was limited data collected that linked their identity to their moral experiences, it is not prudent to conclude that some of their challenging experiences were a result of belonging to one or multiple minority groups. Alternatively, being a part of the majority did not shelter participants from challenging experiences. There simply seems to be an indication that those who do not fit the majority in some capacity experienced some significant challenges and that further research is needed to draw any meaningful conclusions. More research is warranted to better understand the interplay of demographic characteristics and the moral experiences of UNSs during clinical placements.

5.8 Conclusion

UNSs have moral experiences during clinical placements, from the mundane to the extraordinary. Prior research conducted with UNSs, and nurses more broadly, is focused on specific moral experiences, such as moral distress, moral courage, and moral uncertainty. Yet, the diversity of UNSs moral experiences from a relational lens is not well understood. The aim of this constructivist grounded theory was to construct an understanding of the moral experiences

of UNSs, the ways in which these experiences shape them as learners, and the relational dimensions at play. Twenty-three UNSs were recruited using a two-pronged approach for semi-structured interviews. Data were analyzed inductively using Charmaz's (2014) approach.

The findings illustrate UNSs' experiences during clinical placements, as well as how they align with or challenge their values and beliefs about what is good, right, and just. Importantly, the findings reveal how these experiences represent a spectrum rather than dichotomous or disconnected experiences as previously portrayed in the literature. Further, as demonstrated by UNSs interpretations and responses to moral experiences, they are not passive learners who are independent from the world around them. Instead, they are moral beings who are developing a moral identity as they make decisions about who they are, who they want to be, and what they value as good, right, and just. Finally, UNSs are interdependent on the world around them as they navigate relationships in the clinical environment. In this way, UNSs develop meaningful relationships as they interact with others within an organizational environment.

Clinical placements are an important source of knowledge development and attainment for UNSs, during which they employ a range of actions in response to experiences that challenge their values and beliefs. This conceptualization opposes previous thinking on the topic whereby UNSs are considered or perceive themselves to be powerless or passive learners in the clinical environment. Additionally, the participants' stories did not reflect the notions of moral uncertainty and moral dilemmas, which have been portrayed in the literature. Ultimately, UNSs might benefit from spaces where they can freely share their experiences without fear of judgement. The clinical environment is fraught with thorny ethical issues and UNSs are not insulated from these challenges. While this study addresses a knowledge gap, the findings are

constructed from data collected at a single post-secondary institution in Canada. More research is needed to understand how different organizational and societal cultures influence the moral experiences of UNSs during clinical placements. I would like to finish by recognizing and thanking my participants. Without them, this research would not have been possible, and I am grateful that they entrusted me to share their stories.

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Appendix A Recruitment Posters

ARE YOU AN UNDERGRADUATE NURSING STUDENT?

If you answered YES, you may be eligible to participate in a research study looking at the moral experiences of undergraduate nursing students during clinical placements. We want to hear your stories!

Am I eligible? We are looking for English or French speaking undergraduate nursing students who have started or completed at least one clinical placement.

What will I need to do? The FIRST STEP is to grab a tab on the right side of this poster and send an email expressing your interest to Emily Marcogliese, a PhD student in nursing at the University of Ottawa. The SECOND STEP is an individual interview lasting approximately 60-90 minutes with Emily. Emily will ask you a number of open-ended questions about your clinical experiences. You will be asked to share a situation or situations and how they have influenced you and your relationships with others.

When & Where? Interviews will be scheduled at a time and place that is convenient for YOU.

Why should I participate? Your participation in this study will help us to better understand the moral experiences of undergraduate nursing students during clinical placements.

Is my time valued? Of course!! We recognize that our research isn't possible without you and we want you to know that your time is valuable. ALL participants will receive \$20 IN CASH and your parking will be reimbursed for the duration of the interview.

I'm interested!! Now what? Remember the first step. Contact Emily Marcogliese. She will give you more information and answer any questions you may have. Participants are selected on a first come first serve basis, unless there is an overwhelming response, so don't wait!

Emily Marcogliese at

Emily Marcogliese

Emily Marcogliese

Emily Marcogliese

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Emily Marcogliese

ÊTES-VOUS UN(E) ÉTUDANT(E) EN SCIENCES INFIRMIÈRES?

Si vous avez répondu OUI, vous êtes peut-être admissible à participer à une étude de recherche sur les expériences morales des étudiant(e)s en sciences infirmières de premier cycle lors des stages cliniques. Nous voulons entendre vos histoires!

Suis-je admissible? Nous cherchons des étudiant(e)s anglophones ou francophones en sciences infirmières de premier cycle qui ont commencé ou complété au moins un stage clinique.

Qu'est-ce que je dois faire? La PREMIÈRE ÉTAPE consiste à saisir un onglet sur le côté droit de cette affiche et à envoyer un courrier indiquant votre intérêt à Emily Marcogliese, étudiante au doctorat en sciences infirmières à l'Université d'Ottawa. La DEUXIÈME ÉTAPE est une entrevue individuelle avec Emily, d'une durée approximative de 60 à 90 minutes. Emily vous posera des questions ouvertes sur vos expériences cliniques. On vous demandera de partager une situation (ou plusieurs situations) et comment cet événement vous a influencé et influence vos relations avec les autres.

Quand & Où? L'entrevue aura lieu à un temps et un endroit qui VOUS convient.

Pourquoi devrais-je participer? Votre participation à cette étude nous aidera à mieux comprendre les expériences morales d'étudiants en sciences infirmières de premier cycle au cours de stages cliniques.

Mon temps est-il valorisé? Absolument!! Nous reconnaissons que notre recherche est impossible sans vous et nous voulons que vous sachiez que votre temps est précieux. TOUS les participant(e)s recevront 20\$ en ARGENT COMPTANT et votre stationnement sera remboursé pour la durée de l'entrevue.

Je suis intéressé(e)!! Maintenant quoi? Rappelez-vous la première étape. Contactez Emily Marcogliese. Elle vous donnera plus d'informations et répondra à toutes vos questions. Les participant(e)s sont sélectionné(e)s selon le principe du premier arrivé alors n'attendez pas!

Emily Marcogliese at

Emily Marcogliese

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Appendix B

In-Class Recruitment Speeches

In-class recruitment speech

Hello,

My name is Emily. I'm currently a PhD student but not long ago I was in your very shoes, an undergraduate nursing student at the University of Ottawa, with the dream of becoming a registered nurse. While my dream of becoming a nurse was real, the process of getting there was anything but. I have very strong memories about what it was like to be a nursing student. I remember feeling like the nursing program challenged me in ways that my friends who were enrolled in different programs could not understand. Although my friends and I shared in our stress of leaving home for the first time, learning to cook meals on hot plates, meeting academic deadlines, and deciding which electives to take in order to help bring up our faltering grade point averages. But for me, I felt that there was something else, there was more. When I started in my clinical placements in my second year of the nursing program I found myself responsible for another individual in ways that were unfamiliar and even uncomfortable to me. With this new responsibility came new pressures. Afraid to make a mistake, I learned everything I could to impress my clinical instructors and make my patients' feel confident in my knowledge. Nothing in my textbooks prepared me for some of the experiences I would face during my clinical placements. My personal values were challenged at times, for example, when I provided care that did not align with what I believed to be in the best interest of the patient or when I felt as though my patient's priorities or care timeframes were not in line with my clinical instructor's expectations. In contrast, there were times when I felt so proud of the positive difference that I had made in someone's life, for example, having the extra time to focus on developing a meaningful relationship with a terminally ill patient's spouse and teaching my patient being discharged home about their prescribed medications in a way that empowers them to be active participants in their own care.

I share this story with you today because I hope that you will be willing to share your stories with me. I'm here today to invite you to participate in my thesis research project that seeks to understand the experiences of undergraduate nursing students during clinical placements. I am looking for individuals enrolled in the undergraduate nursing program who have started or completed at least one clinical placement. Your participation will consist of one individual interview with me and will last about 60-90 minutes. During that time, I will ask you a number of open-ended questions about your clinical experiences. Your participation in this research study is voluntary and anonymous and will not influence your academic standing in any way. Eligible participants will be selected on a first come first serve basis so if you're interested, please contact me as soon as possible!

If you are interested in participating in this study or would like more, I ask that you send me an email at [REDACTED] (will write on the white board/chalk board at the front of class and will spell it out loud). You can also find a letter of invitation with my name and my contact information as an announcement on Brightspace for this course.

Thank you for your time today and I hope to hear from you.

Bonjour,

Je m'appelle Emily. Je suis présentement étudiante au doctorat, mais ça ne fait pas longtemps que j'ai été à votre place, étudiante de premier cycle en sciences infirmières à l'Université d'Ottawa, rêvant de devenir infirmière autorisée. Bien que mon rêve de devenir infirmière fût réel, le processus pour y arriver fut parfois plutôt comme un cauchemar. J'ai des souvenirs très clairs de la vie étudiante en sciences infirmières. Je me souviens d'avoir eu l'impression que le programme de sciences infirmières m'avait mis au défi d'une manière que mes amis inscrits à différents programmes ne pouvaient pas comprendre. Bien que mes amis et moi ayons partagé notre stress de quitter la maison pour la première fois, apprendre à cuisiner des repas sur des plaques chauffantes, respecter les échéances académiques et décider quels cours au choix à prendre pour nous aider à relever notre moyenne chancelante. Mais pour moi, je sentais qu'il y avait autre chose, il y en avait un peu plus que ça. Lorsque j'ai commencé mes stages cliniques en deuxième année du programme, je me suis retrouvé responsable d'une autre personne d'une manière inconnue et même parfois inconfortable. Cette nouvelle responsabilité a entraîné de nouvelles pressions. Craignant de me tromper, j'ai appris tout ce que je pouvais pour impressionner mes instructeurs cliniques et donner confiance à mes patients en mes habilités. Rien dans mes manuels scolaires ne m'a préparé à certaines des expériences auxquelles je ferais face lors de mes stages cliniques. Mes valeurs personnelles ont parfois été remises en cause, par exemple lorsque je prodiguais des soins qui ne correspondaient pas à ce que je croyais être dans l'intérêt du patient ou lorsque je me sentais comme si les priorités de mon patient ne correspondaient pas aux attentes de l'instructeur clinique. À l'opposé, j'ai parfois été tellement fier de la différence positive que j'avais faite dans la vie de quelqu'un, par exemple, lorsque j'ai pris le temps de développer une relation significative avec le conjoint d'un patient en phase terminale ou lorsque j'ai enseigné à mon patient qui a obtenu son congé la prise de ses médicaments prescrits de manière à lui permettre de participer activement à ses propres soins.

Je partage cette histoire avec vous aujourd'hui parce que j'espère que vous voudrez partager vos histoires avec moi. Je suis ici aujourd'hui pour vous inviter à participer à mon projet de thèse qui cherche à comprendre les expériences des étudiants en sciences infirmières de premier cycle au cours de stages cliniques. Je recherche des individus inscrits au programme de sciences infirmières de premier cycle qui ont commencé ou terminé au moins un stage clinique. Votre participation consistera d'une entrevue individuelle avec moi qui durera environ 60 à 90 minutes. Pendant ce temps, je vous poserai des questions ouvertes sur vos expériences cliniques. Votre participation à cette étude de recherche est volontaire et anonyme et n'influencera en aucune manière votre statut académique. Les participants éligibles seront sélectionnés selon le principe du premier arrivé, premier servi. Si vous êtes intéressé, contactez-moi dès que possible!

Si vous êtes intéressé à participer à cette étude ou si vous voulez plus d'information, vous pouvez m'envoyer un courriel à [REDACTED] (je vais écrire mon adresse courriel sur le tableau blanc / le tableau noir devant de la classe et l'expliquez à haute voix). Vous pouvez également trouver une lettre d'invitation avec mon nom et mes coordonnées sous forme d'annonce sur Brightspace pour ce cours.

Merci pour votre temps aujourd'hui et j'espère entendre de tous ceux et celles qui sont intéressés.

Appendix C Interview Guides

Semi-structured interview guide

Note: this interview guide is intended to be used flexibly and questions may be asked out of order or skipped at the discretion of the researcher. The interview questions will be reviewed on an ongoing basis throughout the study. The questions may be modified by the principal investigator, as appropriate, based on feedback from her thesis co-supervisors and committee members. The ongoing review and modification of interview questions is consistent with the constructivist grounded theory methodology guiding this study.

Interview questions:

Could you tell me what it's like to be a nursing student for you?

Could you tell me about what it's like to be an undergraduate student during your clinical placements?

Show the definition of moral experience to the student – ask the student to explain, for them, what it means in their practice.

Definition of moral experience that will be shown to the participant:

“Moral experience encompasses a person's sense that values that he or she deems important are being realized or thwarted in everyday life. This includes a person's interpretations of a lived encounter, or a set of lived encounters, that fall on spectrums of right-wrong, good-bad or just-unjust” (Hunt & Carnevale, 2011, p. 659).

Could you tell me about a time when something happened in clinical that was meaningful to you either positively or negatively.

If the story is not perceived to be moral in nature (for example the participants tells about a time they were happy to be able to have given their first medication), then I will ask the question again in this way:

- Could you tell me about a time when something happened in clinical that was meaningful to you because it challenged or supported your values or beliefs.

Prompting questions if needed:

- Can you describe where this occurred? (*prompts examples if needed: description of the unit, description of the hospital, description of the city*)
- Can you describe what happened?
- Was your response to the situation, based on what you wanted to do? Please explain.
- Were there any factors that influenced how you responded to the situation (individual, organizational or other)?
- How did your response to the situation make you feel?
- What about this experience has stayed with you the most?

How has this experience (or has it) influenced your relationships with _____?
Prompt (as appropriate) that speak to power, hierarchy, dual allegiances, role, context, etc.):

- yourself
- classmates
- clinical instructors
- clinical nurses
- other healthcare providers (*prompting examples if needed: physiotherapists, social workers, physicians*)
- the University of Ottawa / Algonquin College (whichever applies)
- the hospital unit where your placement was taking place
- the hospital as a whole
- the healthcare system
- the nursing profession
- society at large (the sociopolitical context)
- other (please describe)

Reflecting back, do you think this experience has changed you as a person and/or nurse? If so, how?

Reflecting back, do you think this experience has affected how you provide patient care? If so, how?

Concluding question:

Is there any information you would like to add?

Guide d'entrevue semi-structuré

Notez: ce guide d'entrevue a été conçu pour être utilisé de manière flexible et les questions peuvent être posées dans un ordre différent ou ignorées à la discrétion du chercheur. Les questions d'entrevue seront examinées régulièrement tout au long de l'étude. Les questions peuvent être modifiées par la chercheuse principale, lorsque approprié, en fonction des commentaires des co-superviseurs de thèse et des membres du comité. L'examen et la modification continue des questions de l'entrevue sont conformes à la méthodologie de théorisation ancrée tel que conçue par Charmaz (2014) guidant cette étude.

Questions d'entrevue:

Pouvez-vous me dire ce que c'est être un(e) étudiant(e) en sciences infirmières pour vous?

Pouvez-vous me dire ce que signifie être un(e) étudiant(e) de premier cycle pendant vos stages cliniques?

Montrez la définition de l'expérience morale au participant – demandez lui/elle d'expliquer ce que cela signifie dans leur pratique lors des stages cliniques.

Définition de l'expérience morale qui sera montrée au participant:

L'expérience morale englobe le sentiment d'une personne que les valeurs qu'il/elle juge important(e)s sont réalisées ou entravées dans la vie quotidienne. Cela inclut les interprétations par une personne d'une rencontre vécue, ou d'un ensemble de rencontres vécues, qui tombent dans le spectre du vrai-faux, du bon-mauvais ou juste-injuste (Hunt & Carnevale, 2011).

Pouvez-vous me parler d'un moment ou d'une situation en stage clinique qui a été très significatif pour vous, que ce soit positif ou négatif.

Si la réponse du participant n'est pas perçue par le chercheur comme étant de nature morale (par exemple, le participant raconte qu'il était heureux de pouvoir donner son premier médicament), je poserai à nouveau la question de la manière suivante:

- Pouvez-vous me parler d'un moment ou d'une situation en stage clinique qui a été très significatif pour vous parce que cela mettait en cause ou soutenait vos valeurs ou vos croyances comme personne.

Questions de suivi si nécessaire:

- Pouvez-vous décrire où cela s'est produit? (*donner des exemples au participant si nécessaire: description de l'unité, description de l'hôpital, description de la ville*)
- Pouvez-vous décrire ce qui s'est passé?
- Votre réponse à la situation était-elle basée sur ce que vous vouliez faire? S'il vous plaît, élaborer.
- Y a-t-il eu des facteurs qui ont influencé votre façon de réagir à la situation (individuelle, organisationnelle ou autre)?
- Que pensez-vous maintenant de votre réaction à la situation?

- Qu'en est-il de cette expérience qui vous a le plus marqué?

Comment est-ce que cette expérience a-ta-elle (ou non) influencée vos relations avec _____?

Questions de relations (lorsque approprié) qui parlent de pouvoir, de hiérarchie, de double allégeance, de rôle, de contexte, etc.):

- vous même
- vos camarades de classe
- vos instructeurs cliniques
- les infirmières cliniques
- d'autres prestataires de soins de santé (*donner des exemples au participant si nécessaire: physiothérapeutes, assistants sociaux, médecins*)
- l'Université d'Ottawa / Collège Algonquin (selon le cas)
- l'unité hospitalière où votre placement a eu lieu
- l'hôpital dans son ensemble
- le système de santé
- la profession d'infirmière
- la société en général (le contexte sociopolitique)
- autre (veuillez élaborer)

En réfléchissant, pensez-vous que cette expérience vous a changé en tant que personne et / ou infirmière? Si oui, comment?

En réfléchissant, pensez-vous que cette expérience affecte la manière dont vous prodiguez des soins aux patients maintenant? Si oui, comment?

Question de clôture:

Y a-t-il des informations que vous voudriez ajouter?

Appendix D Sociodemographic Questionnaires

Sociodemographic information

1. What is your age? (please check one)
 - ☐ Under 18
 - ☐ 18 to 24
 - ☐ 25 to 34
 - ☐ 35 to 44
 - ☐ Over 44
2. What is your marital status? (please check one)
 - ☐ Married
 - ☐ Living common law
 - ☐ Never married
 - ☐ Separated
 - ☐ Divorced
 - ☐ Widowed
3. How would you define your gender? _____
 - Some examples: female, male, transgender, non-binary, pangender
4. Which race/ethnicity best describes you? (please check one)
 - ☐ Aboriginal (Inuit, Métis, North American Indian)
 - ☐ Arab/West Asian (e.g., Armenian, Egyptian, Iranian, Lebanese, Moroccan)
 - ☐ Black (e.g., African, Haitian, Jamaican, Somali)
 - ☐ Chinese
 - ☐ Filipino
 - ☐ Japanese
 - ☐ Korean
 - ☐ Latin American
 - ☐ South Asian
 - ☐ South East Asian
 - ☐ White (Caucasian)
 - ☐ Other _____
5. Which year of study are you in? (within the nursing program – please check one)
 - ☐ 2
 - ☐ 3
 - ☐ 4
 - ☐ 5
 - ☐ Over 5
6. Have you previously completed any post-secondary certificates, diplomas, or degrees?
 - ☐ No
 - ☐ Yes
 - If yes, please specify which program _____
7. Have you previously worked in the healthcare sector?
 - ☐ No
 - ☐ Yes
 - If yes, please specify your role _____

Données sociodémographiques

1. Quel âge avez-vous? (veuillez cocher une réponse)
 - ☐ Moins de 18 ans
 - ☐ 18 à 24
 - ☐ 25 à 34
 - ☐ 35 à 44
 - ☐ Plus de 44 ans
2. Quel est votre état matrimonial? (veuillez cocher une réponse)
 - ☐ Marié
 - ☐ Vivant en union libre
 - ☐ Jamais marié
 - ☐ Séparé
 - ☐ Divorcé
 - ☐ Veuf/Veuve
3. Comment définissez-vous votre genre? _____
 - a. Quelques exemples: féminin, masculin, transgenre, non-binaire, pangendre
4. Quel race/ethnicité vous décrit le mieux? (veuillez cocher une réponse)
 - ☐ Autochtone (Indien(ne) d'Amérique du Nord, métis, Inuit/Esquimau)
 - ☐ Arabe/Asiatique occidental (p. ex. Arménien, Égyptien, Iranien, Libanais ou Marocain)
 - ☐ Noir(e) (p. ex. Africain, Haïtien, Jamaïquain, Somalien)
 - ☐ Chinois(e)
 - ☐ Philippin(e)
 - ☐ Japonais(e)
 - ☐ Coréen(ne)
 - ☐ Origine d'Amérique latine
 - ☐ Sud-asiatique
 - ☐ Asiatique du Sud-est
 - ☐ Blanc(he) (Caucasien(ne))
 - ☐ Autre _____
5. En quelle année d'étude êtes-vous? (dans le programme de sciences infirmières - veuillez cocher une réponse)
 - ☐ 2
 - ☐ 3
 - ☐ 4
 - ☐ 5
 - ☐ Plus de 5
6. Avez-vous déjà obtenu un certificat, un diplôme ou un grade post-secondaire?
 - ☐ Non
 - ☐ Oui
 - Si oui, s'il vous plaît spécifiez quel programme _____
7. Avez-vous déjà travaillé dans le secteur de la santé?
 - ☐ Non
 - ☐ Oui
 - Si oui, s'il vous plaît spécifiez votre rôle _____

Appendix E
Research Ethics Board Documents

Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

H-08-19-4704 - REG-4704 - Certificat d'approbation éthique / Certificate of Ethics Approval

(English message follows)

Cher/Chère Emily Marcogliese,

Veuillez trouver ci-joint le certificat d'approbation éthique pour le projet intitulé «The moral experiences of undergraduate nursing students: A constructivist grounded theory».

Le certificat est valide jusqu'au : 24-09-2020

Recherche financée : veuillez faire suivre une copie du certificat au [Service de gestion de la recherche](#).

Si vous avez des questions, n'hésitez pas à communiquer avec le Bureau d'éthique à ethique@uottawa.ca ou en composant le 613-562-5387.

Vous pouvez voir votre demande en vous connectant à votre compte [eReviews](#).

Cordialement,

Riana Marcotte
Responsable d'éthique en recherche

Ceci est une réponse automatisée, merci de ne pas répondre à ce courriel.

Dear Emily Marcogliese,

Please find attached the certificate of ethics approval for your research project titled "The moral experiences of undergraduate nursing students: A constructivist grounded theory".

This certificate is valid until: 24-09-2020

Funded research: A reminder that you must provide a copy of this certificate to [Research Management Services](#).

If you have any questions, please contact the Ethics Office at ethics@uottawa.ca or by telephone at 613-562-5387.

You can view your project at any time by logging into [eReviews](#).

Best regards,

Riana Marcotte
Protocol Officer

This is an automated message. Please do not reply directly to this email.

Attachement(s) / Attachment(s)
[approvalLetter1569424014185.pdf](#)

Université d'Ottawa

Bureau d'éthique et d'intégrité de la recherche

University of Ottawa

Office of Research Ethics and Integrity

H-08-19-4704 - ANN1-4704 - Certificat d'approbation éthique renouvelé / Certificate of Ethics Approval Renewed*(English message follows)*

Cher/Chère Emily Marcogliese,

Merci d'avoir soumis une demande de renouvellement pour le projet de recherche intitulé «The moral experiences of undergraduate nursing students: A constructivist grounded theory».

Veuillez trouver ci-joint le certificat d'approbation éthique renouvelé, valide jusqu'au 24-09-2021.

Recherche financée : Veuillez faire suivre une copie du certificat renouvelé au [Service de gestion de la recherche](#).

Si vous avez des questions, n'hésitez pas à communiquer avec le Bureau d'éthique à ethique@uottawa.ca ou en composant le 613-562-5387.

Vous pouvez voir votre demande en vous connectant à votre compte [eReviews](#).

Cordialement,

Marc Alain Bonenfant
Coordonnateur de l'éthique

Ceci est une réponse automatisée, merci de ne pas répondre à ce courriel.

Dear Emily Marcogliese,

Thank you for submitting a renewal request for your research project titled "The moral experiences of undergraduate nursing students: A constructivist grounded theory".

Please find attached the renewed certificate of ethics approval, valid until 24-09-2021.

Funded research: A reminder that you must provide a copy of this certificate to [Research Management Services](#).

If you have any questions, please contact the Ethics Office at ethics@uottawa.ca or by telephone at 613-562-5387.

You can view your project at any time by logging into [eReviews](#).

Best regards,

Marc Alain Bonenfant
Ethics Coordinator

This is an automated message. Please do not reply directly to this email.

Attachement(s) / Attachment(s)[approvalLetter1600910851976.pdf](#)

Université d'Ottawa

Bureau d'éthique et d'intégrité de la recherche

University of Ottawa

Office of Research Ethics and Integrity

H-08-19-4704 - ANN2-4704 - Certificat d'approbation éthique renouvelé / Certificate of Ethics Approval Renewed*(English message follows)*

Cher/Chère Emily Marcogliese,

Merci d'avoir soumis une demande de renouvellement pour le projet de recherche intitulé «The moral experiences of undergraduate nursing students: A constructivist grounded theory».

Veuillez trouver ci-joint le certificat d'approbation éthique renouvelé, valide jusqu'au 24-09-2022.

Recherche financée : Veuillez faire suivre une copie du certificat renouvelé au [Service de gestion de la recherche](#).

Si vous avez des questions, n'hésitez pas à communiquer avec le Bureau d'éthique à ethique@uottawa.ca ou en composant le 613-562-5387.

Vous pouvez voir votre demande en vous connectant à votre compte [eReviews](#).

Cordialement,

Safaa Lamhoujeb
Coordonnateur de l'éthique

Ceci est une réponse automatisée, merci de ne pas répondre à ce courriel.

Dear Emily Marcogliese,

Thank you for submitting a renewal request for your research project titled "The moral experiences of undergraduate nursing students: A constructivist grounded theory".

Please find attached the renewed certificate of ethics approval, valid until 24-09-2022.

Funded research: A reminder that you must provide a copy of this certificate to [Research Management Services](#).

If you have any questions, please contact the Ethics Office at ethics@uottawa.ca or by telephone at 613-562-5387.

You can view your project at any time by logging into [eReviews](#).

Best regards,

Safaa Lamhoujeb
Ethics Coordinator

This is an automated message. Please do not reply directly to this email.

Attachement(s) / Attachment(s)[approvalLetter1631880409433.pdf](#)

Université d'Ottawa

Bureau d'éthique et d'intégrité de la recherche

University of Ottawa

Office of Research Ethics and Integrity

H-08-19-4704 - ANN3-4704 - Fermeture de dossier / Project Closure*(English message follows)*

Cher/Chère Emily Marcogliese,

Merci d'avoir soumis une demande de fermeture pour votre projet de recherche intitulé «The moral experiences of undergraduate nursing students: A constructivist grounded theory». Ce projet est maintenant fermé.

Recherche financée : Veuillez faire suivre cette confirmation de fermeture au [Service de gestion de la recherche](#).

Si vous avez des questions, n'hésitez pas à communiquer avec le Bureau d'éthique à ethique@uottawa.ca ou en composant le 613-562-5387.

Vous pouvez voir l'historique de votre demande en vous connectant à votre compte [eReviews](#).

Cordialement,

Safaa Lamhoujeb
Coordonnateur de l'éthique

Ceci est une réponse automatisée, merci de ne pas répondre à ce courriel.

Dear Emily Marcogliese,

Thank you for submitting the project closure request for your research project titled "The moral experiences of undergraduate nursing students: A constructivist grounded theory". The project has now been closed.

Funded research: A reminder that you must provide a copy of this confirmation to [Research Management Services](#).

If you have any questions, please contact the Ethics Office at ethics@uottawa.ca or by telephone at 613-562-5387.

You can view your project history at any time by logging into [eReviews](#).

Best regards,

Safaa Lamhoujeb
Ethics Coordinator

This is an automated message. Please do not reply directly to this email.

Attachement(s) / Attachment(s)

Appendix F
Free Mental Health Support Business Cards

Free mental health support

uOttawa

Student Academic Support Services

<https://sass.uottawa.ca/en/personal>
613-562-5200

Algonquin College

Access Counselling Services

<https://www.algonquincollege.com/counselling/home/>

613-727-4723 ext. 7200

Distress Centre of Ottawa

Distress: 613-238-3311

Crisis: 613-722-6914 or 1-866-996-0991

Services en santé mentales gratuites

Université d'Ottawa

Service d'appui au succès scolaire
<https://sass.uottawa.ca/fr/personnel>
613-562-5200

Collège Algonquin

Access Counselling Services (anglais seulement)
<https://www.algonquincollege.com/counselling/home/>
613-727-4723 ext. 7200

Centre de détresse d'Ottawa

Détresse: 613-238-3311
Crise: 613-722-6914 ou 1-866-996-0991



Université d'Ottawa
Faculté des sciences
de la santé
École des sciences
infirmières

University of Ottawa
Faculty of Health
Sciences
School of Nursing

Appendix G Consent Forms

Consent Form

Title of the study: The moral experiences of undergraduate nursing students: A constructivist grounded theory

Student Investigator:

Emily Marcogliese, RN, BScN, PhD (candidate)
School of Nursing, Faculty of Health Sciences
University of Ottawa
[REDACTED]

Under the supervision of:

Dr. Amanda Vandyk, RN, PhD
Associate Professor
School of Nursing, Faculty of Health Sciences
University of Ottawa
[REDACTED]
[REDACTED]

Dr. Jean Daniel Jacob, RN, PhD
Associate Professor; Assistant Director, Undergraduate Nursing Program
School of Nursing, Faculty of Health Sciences
University of Ottawa
[REDACTED]
[REDACTED]

Invitation to Participate: I am invited to participate in the research study titled “The moral experiences of undergraduate nursing students: A constructivist grounded theory”, conducted by Emily Marcogliese in the context of a PhD thesis, under the supervision of Dr. Amanda Vandyk and Dr. Jean Daniel Jacob.

Purpose of the Study: The purpose of the study is to better understand the moral experiences of undergraduate nursing students during clinical placements.

Participation: My participation will consist essentially of one individual in-person interview lasting approximately 60-90 minutes during which I will be asked about my experiences in my clinical placements. The interview has been scheduled for a time and location at my convenience. I understand that the interview will be audio-recorded for future transcription. I will be asked to complete a sociodemographic survey at the end of the interview; this should take no more than 5 minutes. In addition, I will be asked if I would like to be contacted by email at a later date to be offered the opportunity to read the interview transcript.

Risks: My participation in this study will entail that I describe experiences that occurred during one or multiple clinical placements, and this may cause me to feel



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Sciences
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emotional discomfort if these experiences were negative. I have received assurance from the researcher that every effort will be made to minimize these risk, including offering to skip a question, pausing or stopping the interview. At the end of the interview, I will be provided with a card that has information about free mental health services available to you. These services are:

uOttawa

Student Academic Support Services

<https://sass.uottawa.ca/en/personal>

613-562-5200

Algonquin College

Access Counselling Services

<https://www.algonquincollege.com/counselling/home/>

613-727-4723 ext. 7200

Distress Centre of Ottawa

Distress: 613-238-3311

Crisis: 613-722-6914 or 1-866-996-0991

Benefits: My participation in this study will help us better understand the moral experiences of undergraduate nursing students during clinical placements. This understanding will give undergraduate nursing students a way to describe their moral experiences and provide insight for educators regarding the moral realities of their students.

Confidentiality and anonymity: I have received assurance from the researcher that the information I will share will remain strictly confidential. I understand that the contents will be used only for data analysis and that my confidentiality will be protected through the removal of my personal information in the transcripts. I understand that the transcripts from this interview, with all personal information removed, may be conserved indefinitely and used in the future for secondary projects.

Anonymity will be protected in the following manner: I will be assigned a coded study number that will be used on all my study records. A code sheet that links my identity with my code will be kept in a locked cabinet separate from any identifying documents. A code will be used and no identifying information will be disclosed during the presentation of any research results. I understand that the researcher, Emily Marcogliese, is a Registered Nurse and member of the College of Nurses of Ontario. As a result, she has an obligation to report any incident in which she believes a healthcare professional has sexually abused a client. If any event of this nature is described during the interview, Emily Marcogliese will pause the interview and notify me that she will have to report the event to the College of Nurses of Ontario. The reporting of this event may compromise the protection of my identity.

Conservation of data: The data collected, including audio recordings, transcripts, and the signed consent form, will be kept in a secure manner – written documents will be kept in a locked filing cabinet in a locked office at the University of Ottawa. Electronic documents will be kept in a password-secured external hard drive in a locked office at the University of Ottawa. Only the research team will have access to the code sheet with identifiers, consent forms, audio recordings, and full transcripts.

613 562-5473
613 562-5443

451 Smyth
Ottawa ON K1H 8M5 Canada

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Compensation: I will be provided with \$20 cash and, if applicable, my parking costs will be paid for the duration of the interview. If I choose to withdraw from the study, I will still receive this compensation.

Voluntary Participation: I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If I choose to withdraw, all data gathered until the time of withdrawal will be destroyed – paper documents will be shredded and electronic files will be securely deleted.

Acceptance: I, _____, agree to participate in the above research study conducted by Emily Marcogliese of the School of Nursing, Faculty of Health Sciences, University of Ottawa, under the supervision of Dr. Amanda Vandyk and Dr. Jean Daniel Jacob.

In addition to providing consent to participate (please circle your response clearly):

1. I **do** / **do not** agree to be contacted via email by the primary investigator (Emily Marcogliese) to be offered the opportunity to read my interview transcript.
2. I **do** / **do not** agree to be contacted via email by the primary investigator (Emily Marcogliese) to be offered the opportunity to clarify any elements of my interview that may be unclear to her (Emily Marcogliese) during the transcription and analysis of my interview data.
3. I **do** / **do not** agree to be contacted for a follow-up study should the researcher conduct further research on this topic in the future.

If I have any questions about the study, I may contact the researcher or his supervisor.

If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5
Tel.: (613) 562-5387 Email: ethics@uottawa.ca

There are two copies of the consent form, one of which is mine to keep.

Participant's signature:

Date:

Researcher's signature:

Date:



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Formulaire de consentement

Titre du projet: Les expériences morales d'étudiants de premier cycle en sciences infirmières : Une théorisation ancrée constructiviste

Chercheuse étudiante:

Emily Marcogliese, Inf., B.Sc.Inf., Ph.D. (candidate)
École des sciences infirmières, Faculté des sciences de la santé
Université d'Ottawa

Sous la supervision de:

Dre. Amanda Vandyk, Inf., Ph.D.
Professeure agrégée
École des sciences infirmières, Faculté des sciences de la santé
Université d'Ottawa

Dr. Jean Daniel Jacob, Inf., Ph.D.
Professeur agrégé; Directeur adjoint, Études du premier cycle
École des sciences infirmières, Faculté des sciences de la santé
Université d'Ottawa

Invitation à participer: Je suis invité(e) à participer à la recherche nommée ci haut qui est menée par Emily Marcogliese dans le contexte d'un projet de thèse au doctorat, Dre. Amanda Vandyk et Dr. Jean-Daniel Jacob.

But de l'étude: Le but de l'étude est de mieux comprendre les expériences morales des étudiants en sciences infirmières de premier cycle lors des stages cliniques.

Participation: Ma participation consistera essentiellement à rencontrer la chercheuse principale, Emily Marcogliese, pour une entrevue individuelle qui se fera face à face et qui sera audio enregistrée. Lors de l'entrevue qui durera environ 60 à 90 minutes, la chercheuse vous demandera quelques questions sur vos expériences vécues au cours d'un ou plusieurs stages cliniques. La session se fera à un temps et lieu qui me convient. On me demandera de compléter un questionnaire sociodémographique à la fin de l'entrevue, cela ne devrait pas prendre plus de 5 minutes. Finalement, on me demandera si je souhaite être contacté ultérieurement par courrier électronique afin de pouvoir lire le compte rendu de mon entrevue.

Risques: Je comprends que puisque ma participation à cette recherche implique que je décrive des expériences survenues au cours d'un ou plusieurs stages cliniques, il est possible qu'elle crée un inconfort émotionnel si ces expériences étaient négatives. J'ai reçu l'assurance de la chercheuse que tout se fait en vue de minimiser ces risques, notamment en offrant de sauter une question, de suspendre ou d'arrêter l'entrevue si celui-ci était trop pénible sur le plan émotionnel. À la fin de l'entrevue, une carte avec

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de l'informations sur les services en santé mentales gratuites me sera fournie. Ces services sont :

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Service d'appui au succès scolaire

<https://sass.uottawa.ca/fr/personnel>

613-562-5200

Collège Algonquin

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<https://www.algonquincollege.com/counselling/home/>

613-727-4723 ext. 7200

Centre de détresse d'Ottawa

Détresse: 613-238-3311

Crise: 613-722-6914 ou 1-866-996-0991

Bienfaits: Ma participation à cette recherche aura pour effet de contribuer à l'avancement de nos connaissances des expériences des étudiants en sciences infirmières de premier cycle lors des stages cliniques. Cette compréhension donnera les étudiants en sciences infirmières de premier cycle un moyen de décrire leurs expériences et offrira les éducateurs une vision des réalités vécues par leurs élèves.

Confidentialité et anonymat: J'ai l'assurance de la chercheuse que l'information que je partagerai avec elle restera strictement confidentielle. Je m'attends à ce que le contenu ne soit utilisé que pour la rédaction de la thèse, la présentation des résultats et la publication de travaux scientifiques. Ma confidentialité sera protégée en tout temps par l'omission de toute information qui m'identifierait. Je comprends que les transcriptions de cette interview, avec toute information identifiant omis, peuvent être conservées indéfiniment et utilisées dans le futur pour des projets secondaires.

L'anonymat est garanti de la façon suivante : je serai assigné un code à la place d'information qui m'identifierait qui sera utilisée pour documentation de recherche qui m'est associé. Une feuille avec le code qui relie votre identité au code sera gardée dans un bureau sous clef, séparée de tout autre document qui contient de l'information identifiant. Un code sera utilisé et aucune information qui m'identifierait ne sera divulguée lors de la présentation des résultats de la recherche. Je comprends que la chercheuse, Emily Marcogliese, est une infirmière autorisée et membre de l'Ordre des Infirmières et Infirmiers de l'Ontario. En conséquence, elle a l'obligation de signaler tout incident dans lequel elle pense qu'un professionnel de la santé a abusé sexuellement d'un client. Si un événement de cette nature est décrit au cours de l'entrevue, Emily Marcogliese va suspendre temporairement l'entrevue et m'informer qu'elle devra signaler l'événement à l'Ordre des Infirmières et Infirmiers de l'Ontario. Je comprends que le signalement de cet événement peut compromettre la protection de mon identité.

Conservation des données: Les données recueillies, y compris les enregistrements audio, les transcriptions et le formulaire de consentement signé, seront conservées de façon sécuritaire. Les documents papiers seront conservés dans un classeur verrouillé dans un bureau verrouillé de l'Université d'Ottawa. Les documents électroniques seront conservés sur un disque dur externe sécurisé par mot de passe dans un bureau verrouillé à l'Université d'Ottawa. Seule l'équipe de recherche aura accès à la fiche de code avec

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identifiants, formulaires de consentement, enregistrements audio et transcriptions complètes.

Compensation: Je recevrai 20\$ en argent comptant et, au besoin, mes frais de stationnement seront payés pour la durée de l'entrevue. Si je choisis de me retirer de l'étude, je recevrai quand même cette compensation.

Participation volontaire: Ma participation à la recherche est volontaire et je suis libre de me retirer en tout temps, et/ou refuser de répondre à certaines questions, sans subir de conséquences négatives. Si je choisis de me retirer de l'étude, les données recueillies jusqu'à ce moment seront détruites – les documents papiers seront déchiquetés et les documents électroniques seront supprimés de manière sécurisée.

Acceptation: Je, _____, accepte de participer à cette recherche menée par Emily Marcogliese, de l'école des sciences infirmières, Faculté des sciences de la santé, Université d'Ottawa, sous la supervision de Dre. Amanda Vandyk et Dr. Jean Daniel Jacob.

En plus de donner votre consentement à participer (veuillez entourer clairement votre réponse):

1. **J'accepte / n'accepte pas** que la chercheuse principale (Emily Marcogliese) communique avec moi par courriel afin de me donner la possibilité de lire la transcription de mon entrevue.
2. **J'accepte / n'accepte pas** d'être contacté par courriel par la chercheuse principale (Emily Marcogliese) pour me donner l'opportunité de clarifier tout élément de mon entrevue qui n'est pas être clair pour elle (Emily Marcogliese) lors de la transcription et l'analyse des données de l'entrevue.
3. **J'accepte / n'accepte pas** d'être contacté(e) pour une étude de suivi sur ce sujet à l'avenir si c'est effectué par la chercheuse principale.

Pour tout renseignement additionnel concernant cette étude, je peux communiquer avec le chercheur ou son superviseur.

Pour tout renseignement sur les aspects éthiques de cette recherche, je peux m'adresser au Responsable de l'éthique en recherche, Université d'Ottawa, Pavillon Tabaret, 550, rue Cumberland, pièce 154, (613) 562-5387 ou ethics@uottawa.ca.

Il y a deux copies du formulaire de consentement, dont une copie que je peux garder.

Signature du participant:

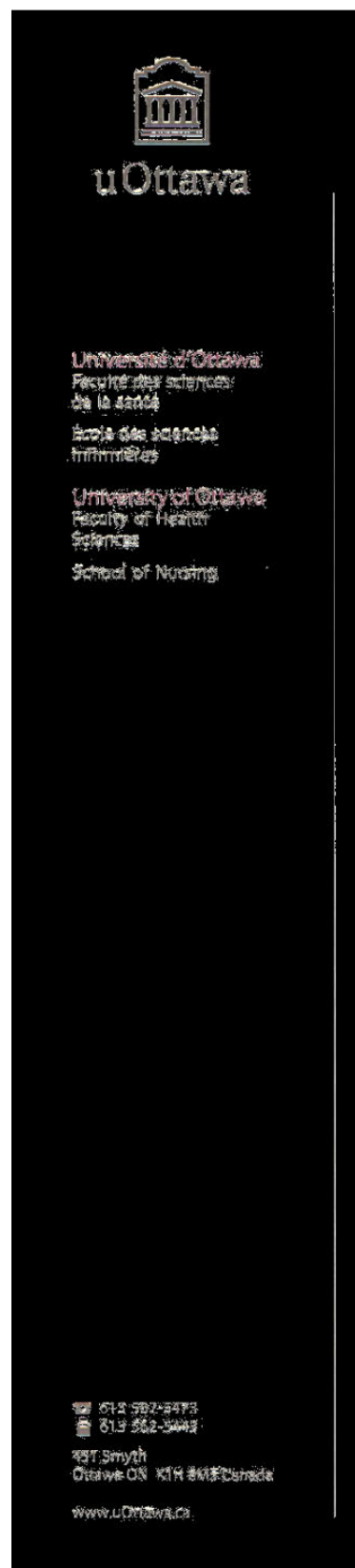
Date:

Signature du chercheur:

Date:

Appendix H

Letters of Information



Information letter

Invitation to participate in the research project titled:

“The moral experiences of undergraduate nursing students: A constructivist grounded theory”

Dear undergraduate nursing student,

Your participation is being requested for a research project conducted by Emily Marcogliese, a registered nurse and PhD student at the University of Ottawa. This Information letter will provide you with an overview of the research to help guide your decision to participate, or not, in this research.

PURPOSE OF THE STUDY:

The purpose of the study is to better understand the moral experiences of undergraduate nursing students during clinical placements.

PARTICIPATION:

Interested participants must meet **all** of the following criteria

- Be currently enrolled in the Bachelor of Science in Nursing program;
- Have started or completed at least one clinical placement;
- Be able to speak, read and understand English or French; and
- Be willing to speak about your experiences within the context of your clinical placements.

Note: Individuals who currently or have previously held any type of nursing or medical license will be excluded.

Your participation will consist of:

- One individual audio-recorded **interview** with Emily Marcogliese
 - *What* You will be asked a number of open-ended questions about your clinical experiences. You will be asked to share a situation or situations and how they have influenced you and your relationships with others.
 - *Duration* approximately 60-90 minutes
 - *Location and time* Scheduled for a time and location at your convenience

COMPENSATION:

You will receive \$20 cash and, if applicable, your parking costs will be paid for the duration of the interview.

Participants will be selected on a first come first served basis. Please feel free to contact Emily Marcogliese, the primary investigator, if you have any questions or would like more information by email at [REDACTED]. The ethical aspects of this project have been approved by the University of Ottawa Research Ethics Board.

Thank you for your time and interest.

Sincerely,

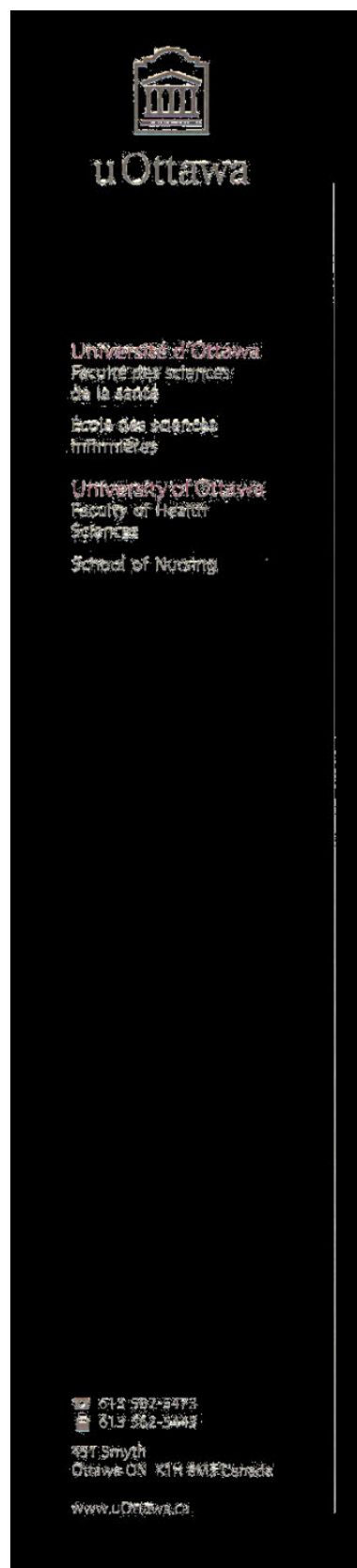
Student Investigator:

Emily Marcogliese, RN, BScN, PhD (candidate)
School of Nursing, Faculty of Health Sciences
University of Ottawa
[REDACTED]

Under the supervision of

Dr. Amanda Vandyk, RN, PhD
Associate Professor
School of Nursing, Faculty of Health Sciences
University of Ottawa

Dr. Jean Daniel Jacob, RN, PhD
Associate Professor; Assistant Director,
Undergraduate Nursing Program
School of Nursing, Faculty of Health Sciences
University of Ottawa



Lettre d'information

Invitation à participer à un projet de recherche intitulé:

Les expériences morales d'étudiants de premier cycle en sciences infirmières : Une théorisation ancrée constructiviste

Cher étudiant(e) infirmier/infirmière,

Nous vous invitons à participer au projet de recherche mené par Emily Marcogliese, infirmière autorisée et étudiante au doctorat à l'Université d'Ottawa. Cette lettre d'information vous donnera un aperçu de la recherche pour vous guider dans votre décision de participer ou non à cette étude.

BUT DE L'ÉTUDE:

Le but de l'étude est de mieux comprendre les expériences morales des étudiants en sciences infirmières de premier cycle lors des stages cliniques.

PARTICIPATION:

Les participants intéressés doivent répondre à **tous** les critères suivants

- Être actuellement inscrit au programme de baccalauréat en sciences infirmières;
- Avoir débuté ou complété au moins un stage clinique;
- Être capable de parler, lire et comprendre l'anglais ou le français; et
- Soyez disposé à parler de vos expériences dans le cadre de vos stages cliniques.

Notez: Les personnes qui détiennent ou ont déjà détenu tout type de permis sous le titre d'infirmier ou autre profession médicale seront exclues.

Votre participation consistera:

- D'une **entrevue** individuel enregistré avec Emily Marcogliese
 - o *Quoi* Elle vous posera des questions ouvertes sur vos expériences cliniques. Elle vous demandera de partager une situation ou des situations et comment elles vous ont influencé et influencent vos relations avec les autres.
 - o *Durée* environ 60 à 90 minutes
 - o *Lieu et heure* planifié pour un temps et un lieu qui vous convient

COMPENSATION:

Vous recevrez 20\$ en argent comptant et, lorsque approprié, vos frais de stationnement seront payés pour la durée de l'entrevue.

Les participant(e)s seront sélectionné(e)s selon le principe du premier arrivé, premier servi. N'hésitez pas à contacter Emily Marcogliese si vous avez des questions ou souhaitez obtenir plus d'informations par courriel à [REDACTED]. Les aspects éthiques de ce projet ont été approuvés par le comité d'éthique de la recherche de l'Université d'Ottawa.

Merci pour votre temps et considération.

Sincèrement,

Chercheuse étudiante:

Emily Marcogliese, Inf., B.Sc.Inf., Ph.D. (candidate)
 École des sciences infirmières, Faculté des sciences de la santé
 Université d'Ottawa
 [REDACTED]

Sous la supervision de

Dre. Amanda Vandyk, Inf., Ph.D.
 Professeure agrégée
 École des sciences infirmières,
 Faculté des sciences de la santé
 Université d'Ottawa

Dr. Jean Daniel Jacob, Inf., Ph.D.
 Professeur agrégé; Directeur
 adjoint, Études du premier cycle
 École des sciences infirmières,
 Faculté des sciences de la santé
 Université d'Ottawa

Appendix I
French to English Translated Participant Quotes

Page #	French (Original)	English (Translated)
75	“Puis j’ai eu des félicitations de l’équipe de nursing puis de mon prof clinique. Mon prof a dit ‘Tu as fait ce qu’il fallait faire’” (P14).	"Then I received congratulations from the nursing team and my clinical instructor. My instructor said 'You did what you had to do'" (P14).
79	“Bien j’aimerais penser que les profs de stage ont confiance en toutes leurs étudiants jusqu’à temps que quelque chose arrive pis qu’ils leur prouvent différemment” (P21).	"Well, I'd like to think that clinical instructors have confidence in all their students until something happens and they are proven otherwise" (P21).
81	Moi je trouve c’est tellement important. So là je n’ai pas peur de rentrer en stage puis avoir la mauvaise réponse. Comme je viens tout le temps préparé, je fais ma recherche de mes médicaments, les différentes conditions de mes patients et tout ça. Mais si jamais il y a quelque chose, comme on va dire je ne sais pas pourquoi que ce patient-là prends ce médicament-là Mes profs ils n’étaient jamais comme “Voyons donc, pourquoi que tu dis ça, c’est pas ça, c’est obviously ça.” Mes profs ils ne faisaient jamais ça, ils étaient tout le temps comme “Ah c’est une bonne hypothèse mais ce n’est pas ça, c’est ça.” Puis là tu vas le savoir pour la prochaine fois. So de cette façon-là, je n’avais pas peur d’essayer de faire des hypothèses par moi-même puis de leur dire. (P21)	I think it's so important. So now I'm not afraid of going into clinical placement and having the wrong answer. I always come prepared, I do my research on my medications, my patients' different conditions and all that. But if ever there's something, like I don't know why this patient is taking this particular medication My clinical instructors were never like "Come on, why are you saying that, it's not that, it's obviously that." My clinical instructors never did that, they were always like "Ah that's a good hypothesis but it's not that, it's that." Then you'll know for the next time. So that way, I wasn't afraid to try and make hypotheses on my own and then tell them. (P21)
83	Ouais, évidemment les infirmières n’ont pas autant de temps. Puis ce n’est pas leur faute, ils ont tellement de patients puis ils ont tellement de choses à faire. Puis si tu as quelqu’un qui est en crise d’asthme puis il a besoin d’un puffer, la priorité ça ne va pas être le monsieur qui est anxieux. (P15)	Yeah, obviously the nurses don't have as much time. And it's not their fault, they have so many patients and so many things to do. If you have someone who's having an asthma attack and needs a puffer, the priority isn't going to be the anxious patient. (P15)
83	Puis je pense que les besoins émotionnels, they’re not taskable things ... but to me it’s the base of all nursing care. ... on travaille dans un système où le soutien émotionnel et le fait de connaître ton	And I think emotional needs, they're not taskable things ... but to me it's the base of all nursing care. ... we work in a system where emotional support and knowing your patient ... - it's not taskable, it's

	patient ... – it's not taskable, it's almost like it's not expected anymore. ... Yeah, ça me frustre vraiment. (P19)	almost like it's not expected anymore. ... Yeah, it really frustrates me. (P19)
87	Et puis ouais, j'étais très optimiste, le jour du jumelage j'étais jumelé à une infirmière, elle m'a beaucoup expliquée. J'ai dit "Est-ce que je peux essayer ça, est-ce que je peux essayer l'autre" – "Oui, vas-y administrer les médicaments dilués en poudre par la sonde nasogastrique." J'ai dit "Est-ce que je peux pousser", elle dit "Tu fais." Et elle dit "Je dois prendre un prélèvement de sang." J'ai dit "Est-ce que je peux vous aider?" Elle a dit "oui, pourquoi pas." Et il paraît que la prof a tout vu, tout entendu, elle m'a appelé, elle a dit que tu n'as pas ton assignation demain. J'ai dit "Pourquoi?" "Tu as dépassé tes limites, tu es trop proactif." Mais j'ai dit "Qu'est-ce que j'ai fait?" Elle a commencé à crier sur moi ... "Pourquoi tu as fait ça, tu n'avais pas le droit?" Elle a dit que "Toi tu es dangereuse là." Elle m'a dit que je suis dangereuse, elle a dit que "Non, tu es une étudiante dangereuse, tu ne connais pas tes limites." Et depuis mon calvaire est commencé, donc elle m'a suivi, elle me pointait à chaque erreur etcetera. (P20)	And then yeah, I was very optimistic, the day of the pairing I was paired with a nurse, she explained a lot to me. I said "Can I try this, can I try that" - "Yes, go ahead and administer the crushed medication through the nasogastric tube." I said, "Can I push?" she says, "You do." And she says, "I need to take a blood sample." I said "Can I help you?" She said, "Yeah, why not." And apparently the clinical instructor saw everything, heard everything, called me, said you don't have a patient assignment tomorrow. I said "Why not?" "You've overstepped your boundaries, you're too proactive." But I said, "What did I do?" She started yelling at me ... "Why did you do that, you had no right?" She said that "You are dangerous." She told me I'm dangerous, she said that "No, you are a dangerous student, you do not know your limits." And from then on my suffering began, so she followed me, she pointed out every mistake etcetera. (P20)
88	Donc, c'est ça, j'aurais mieux aimé que cette erreur là – puis t'sais moi j'étais dans tous mes états, je me sentais tellement mal, en plus un enfant on dirait ça l'empire. Puis t'sais une situation comme ça, j'avais besoin du support ou que quelqu'un me rassure ou quelqu'un qui me dise c'est pas grave, moi aussi j'en ai faite des erreurs. Puis finalement on avait juste réajusté les temps pour la prochaine dose puis toute était pour être correcte mais je n'ai pas eu ce support de ma professeure. Non. (P10)	So, that's it, I'd have liked it better if that mistake - you know, I was in such a state, I felt so bad, and what's more, it was a child which seems to make it worse. And you know, a situation like that, I needed support or someone to reassure me or tell me it's okay, I've made mistakes too. Then in the end we just readjusted the times for the next dose and everything was okay, but I didn't have the support of my clinical instructor. No. (P10)
89	Comme nous en santé mentale, on avait tous des problèmes avec notre prof, puis c'était super awkward à cause que la coordinatrice est venue puis notre prof elle n'est pas partie de la chambre. Puis on	Like us in mental health, we all had problems with our clinical instructor, then it was super awkward because the coordinator came and our clinical instructor didn't leave the room. Then we

	était comme “On va pas commencer à la ‘trasher’ quand que t’es drette là,” c’est pas évident. Alors là on était juste comme “Oui ça va super bien.” (P23)	were like "We're not going to start 'trashing' her while you're here," it's challenging. Then we were just like "Yeah, it's going great." (P23)
91	“Dans notre groupe de stage on était toute terrifiée. Oui, terrifiée de lui [clinical instructor]. C’était vraiment de l’enseignement par intimidation” (P19).	"In our clinical group we were all terrified. Yes, terrified of him [clinical instructor]. It was really teaching by intimidation" (P19).
92	... mais en tant qu’étudiante infirmière c’était dur pour moi. Ça c’est un moment que je me sentais comme “I should have spoken up.” J’aurais dû dire comme “On pourrais-tu utiliser un calibre un peu plus petit? Il [patient] est super irrité à cause de bla-bla-bla, il a spina bifida.” Puis je n’ai pas speak-er up. Ça c’est quelque chose que moi personnellement je regrette de pas avoir fait. (P15)	... but as a nursing student it was hard for me. This is a moment that I felt like "I should have spoken up." I should have said like, "Could we use a slightly smaller gauge? He [patient] is super irritated because of blah-blah-blah, he has spina bifida." Then I didn't speak up. That's something I personally regret not having done. (P15)
93	J’avais un professeur de stage qui a été assez rough avec nous au début et c’était à cause qu’une des journées on était en retard pour l’orientation. ... Elle nous faisait des petits commentaires comme “Essayez de pas être en retard cette fois-ci.” Juste pour nous rappeler qu’on était en retard la journée de l’orientation même si ce n’était pas notre faute. On a expliqué le e-mail, on lui a lu cette phrase puis on a interprété ça comme si vous n’avez pas la formation de 8 à 12h, vous pouvez venir à midi. ... So à un moment donnée elle a dit comme – c’était je pense deux semaines après que le stage a commencé et elle avait dit “Don’t be late this time” encore. Et puis là j’étais comme “Are you still on that?” (P16)	I had a clinical instructor who was pretty rough with us at first and it was because one day we were late for orientation. ... She'd make little comments like "Try not to be late this time." Just to remind us that we were late on orientation day even though it wasn't our fault. We explained the e-mail, we read her this sentence and then we interpreted it as if you don't have the 8 to 12 o'clock training, you can come at noon. ... So at one point she said like - it was I think two weeks after the course started and she had said "Don't be late this time" again. And then I was like "Are you still on that?" (P16)
94	Mais j’avais une patiente qui avait sickle cell disease Puis pour elle, à cause qu’elle en avait eu tellement [pain crisis], ça a causé un manque d’oxygène à son bébé puis là son bébé avait des gros problèmes. ... Ils ont dû faire un avortement ... puis là ça ne s’est pas bien passé. Je l’avais [patient] une couple de jours aussi, je l’ai eu comme quatre jours de suite. Elle saignait beaucoup beaucoup,	I had a patient who had sickle cell disease And for her, because she'd had so many [pain crises], it caused a lack of oxygen to her baby, and then her baby had big problems. ... They had to do an abortion ... which didn't go well. I had her [patient] for a couple of days too, I had her for like four days straight. She was bleeding a lot, a lot more than normal. I'd never seen a post-abortion before. But

	plus que la normale. Moi je n'avais jamais vu un post-avortement. Mais de ce que j'ai vu dans les normes, elle saignait beaucoup plus que la norme. Puis beaucoup des infirmières disaient comme "Ah, elle vient d'avoir un avortement, c'est normal qu'elle saigne" mais j'étais comme "Oui, mais elle saigne beaucoup. Puis elle ne se sent vraiment pas bien." Puis sure enough on a fait des prises de sang puis son hémoglobine était comme 60 qui est super bas. Puis elle était super pâle et sweaty, alors j'étais comme "Elle va pas bien la madame." Finalement elle a été transférée à ICU mais ça ... c'était une situation que moi j'ai vraiment speak-er up. Ça c'était le soir, il était comme huit heure le soir, elle n'était pas dû pour des prises de sang avant le lendemain matin puis c'est moi qui a poussé d'en prendre. (P15)	from what I saw in the guidelines, she was bleeding a lot more than normal. Then a lot of the nurses were like "Ah, she just had an abortion, it's normal for her to bleed" but I was like "Yes, but she's bleeding a lot. And she really doesn't feel well." Then sure enough we did blood work and her hemoglobin was like 60 which is super low. Then she was super pale and sweaty, so I was like "She's not doing well." Eventually she was transferred to ICU but that ... that was a situation I really spoke up. That was in the evening, it was like eight o'clock in the evening, she wasn't due for blood tests until the next morning and then I was the one who pushed to have it taken. (P15)
96	Moi, je faisais toujours ce charting à l'ordi parce que ça se fait vraiment rapidement. Mais ma prof était comme "Why do you do it on the computer, do it on the machine," and I'm like "Well I like doing it on the computer" so elle m'a dit de penser à le faire sur la machine [portable charting machine] but in my head I'm like "It doesn't make a difference as long as I do it." So I smile and nod and then I'm not going to do it that way [on the portable charting machine] parce que c'est pas ça que je veux faire. J'ai le même result, I'm charting it, it's getting done, ça ce fait plus rapidement – when I do it later, I sit down and I focus on it and I do my head to toe assessment and I make sure everything's right, but right now I'm rushing and I don't want to do it now and in the end it's the same result. (P19)	Me, I always charted on the computer because it's really quick. But my clinical instructor was like "Why do you do it on the computer, do it on the machine," and I'm like "Well I like doing it on the computer" so she told me to think about doing it on the machine [portable charting machine] but in my head I'm like "It doesn't make a difference as long as I do it." So I smile and nod and then I'm not going to do it that way [on the portable charting machine] because that's not what I want to do. I have the same result, I'm charting it, it's getting done, I can do it faster - when I do it later, I sit down and I focus on it and I do my head to toe assessment and I make sure everything's right, but right now I'm rushing and I don't want to do it now and in the end it's the same result. (P19)
97	C'est tellement un programme [School of Nursing] petit aussi, que comme y a des avantages et y a des désavantages. Mais au moins on peut s'entraider un petit peu en connaissant les ins and outs. Puis maintenant il y a un groupe qui ont	It's such a small program [School of Nursing] too, so there are advantages and disadvantages. But at least we can help each other a little bit by knowing the ins and outs. And now there's a group that started a club called "Beating Burnout"

	commencé un club qui est “Beating Burnout” puis eux autres ils font toute la santé mentale avec nursing puis toute. Alors il y a quand même des étudiants vraiment motivés qui veulent changer certains aspects, qui est bon. Mais le fait que sa prends ça, c’est aussi pas une bonne chose. (P23)	and they're doing all this mental health with nursing and everything. So there are some really motivated students who want to change certain aspects, which is good. But the fact that this is what it takes is also not a good thing. (P23)
98-99	Je ne me rappelle pas des commentaires, je me rappelle juste de m’être senti si petite dans ce stage-là. Je voulais éviter cette enseignante-là dans les couloirs et je voulais qu’elle me laisse essayer faire mon travail toute seule. Parce que je savais que dès qu’elle allait regarder quelque chose, elle allait critiquer quelque chose et que j’allais me sentir plus pire. C’était pas comme parfois elle me donne des compliments, parfois elle me donne des critiques. C’est plus si elle me dit quelque chose, c’est pour me critiquer, c’est pour me dire que j’aurais dû mieux faire ou j’aurais dû faire quelque chose d’autre. Ça c’était la seule communication que j’avais avec cette personne-là donc je l’évitais physiquement, j’allais dans l’autre couloir à cause que je voulais pas qu’elle me voit parce que je savais que si elle me voyait, ça allait être quelque chose de négatif. (P16)	I don't remember the comments, I just remember feeling so small during that clinical placement. I wanted to avoid that clinical instructor in the hallways and I wanted her to let me try to do my work on my own. Because I knew that as soon as she looked at something, she was going to criticize it and I was going to feel worse. It wasn't like sometimes she gives me compliments, sometimes she gives me criticism. It's more like if she tells me something, it's to criticize me, it's to tell me I should have done better or I should have done something else. That was the only communication I had with that person, I avoided her physically, I went to the other corridor because I didn't want her to see me, because I knew that if she did, it would be something negative. (P16)
100	... moi personnellement je préfère parler à mes propres amis. Comme disons [...] que j’ai vraiment besoin de parler de quelque chose, ça aide pour moi que j’ai beaucoup d’amis en nursing, surtout mes meilleures amies parce que eux autres me connaissent puis je peux vraiment les reconforter puis vice versa. Whereas t’as un groupe de gens que je connais juste parce qu’ils sont dans le même programme, je ne le connais pas davantage, c’est dure de reconforter quelqu’un, pas dure mais c’est juste c’est plus facile quand c’est tes meilleurs amis puis tu les connais super bien. (P15)	... I personally prefer to talk to my own friends. Let's say [...] I really need to talk about something, it helps that I have a lot of nursing friends, especially my best friends because they know me and I can really comfort them and vice versa. Whereas with a group of people I know just because they're in the same program, I don't know them well, it's hard to comfort someone, not hard but it's just easier when it's your best friends and you know them really well. (P15)
105	Moi en tant que personne je ne suis pas vraiment quelqu’un qui est capable de	As a person, I'm not really capable of confrontation. I've never been able to

	confronter. Je n'ai jamais été capable d'aller voir le problème face à face puis de le dire, comme c'est pas correct ce que tu me dis, c'est pas correct les commentaires que tu me dis. Je me suis jamais senti que j'aurais pu et en même temps je savais que ça serait juste plus facile de rien faire et c'est toujours plus facile de rien faire. (P16)	confront the problem head on and then say it, like it's not right what you're saying to me, it's not right the comments you're making. I never felt like I could and at the same time, I knew it would just be easier to do nothing and it's always easier to do nothing. (P16)
106	"Moi je suis une personne que j'ai beaucoup de valeurs personnelles qui orientent vraiment la façon que je donne mes soins ou que j'agis avec une personne surtout en soins infirmiers" (P15).	"I'm a person who has a lot of personal values that really guide the way I provide care or the way that I act with a person especially in nursing" (P15).
109	... j'ai eu plusieurs commotions cérébrales durant mon bac [baccalaureate]. J'ai aussi été très malade, j'ai eu plusieurs chirurgies. ... Mais tout ça pour dire que moi j'ai passé beaucoup de temps, surtout les derniers quatre ans là dans les hôpitaux aussi. ... Alors ça m'a permis de vraiment voir beaucoup de choses des deux côtés. (P15)	... I had several concussions during my baccalaureate. I was also very sick, I had several surgeries. ... All that to say that I spent a lot of time, especially the last four years in hospitals too. ... So it really allowed me to see a lot of things from both sides. (P15)
111-112	Je sais pas, ça a juste sorti, j'étais pu capable on dirait. C'était juste comme tout le monde [UNS clinical group], on s'était parlé puis on était comme, "je comprends pas pourquoi elle [clinical instructor] est encore fâchée." Puis ça faisait comme une couple de shifts donc quand elle a dit ça, j'ai juste – pis moi pis cette enseignante là on avait eu des jokes parfois, alors je me suis senti comme si j'étais correct de dire un petit commentaire comme ça avec la relation que j'avais construit avec elle pendant les derniers shifts. Mais je ne sais pas si ça aurait été la même chose pour mes autres collègues, c'est juste que je me suis senti comme si ce n'est pas moi qui le disait, il y avait personne d'autre qui l'aurait dit. (P16)	I don't know, it just came out, I couldn't take it anymore it seems. It was just like everyone [UNS clinical group], we talked and then we were like, "I don't understand why she [clinical instructor] is still mad." Then it was a couple of shifts later when she said that, I just - me and that clinical instructor we'd joke sometimes, so I felt like I was okay to say a little comment like that with the relationship I'd built with her over the last few shifts. But I don't know if it would have been the same for my other colleagues, it's just that I felt like if it wasn't me saying it, there was nobody else who would have said it. (P16)
114	Il y a toujours cette idée que – puis c'est vrai que maintenant je connais beaucoup plus que je connaissais en deuxième année. C'est vrai qu'en deuxième année je connaissais beaucoup moins puis	There's always this idea that - and it's true that now I know a lot more than I knew in second year. It's true that in my second year I knew a lot less, and probably I'll look back in four years and I'll say "Wow,

	probablement je vais regarder dans quatre ans, puis je vais dire "Wow, en quatrième année de l'université je connaissais beaucoup moins que maintenant." (P15)	in fourth year of university I knew a less than I do now." (P15)
114-115	Puis si ça arriverait encore je pense que je mentionnerai mon opinion, "Regarde ça a de l'aire comme un vraiment gros calibre [cathéter urinaire], veux-tu que j'aile voir s'il y en a des petits?" Parce qu'essentiellement, le problème, j'avais entendu la résidente dire au téléphone qu'elle aussi pensait qu'elle devrait en avoir un plus petit mais sur notre unité on en avait pas. Puis c'est plus pour ça que ça m'a fait penser que c'était plus la paresse de pas vouloir aller sur une autre unité, ou ne pas vouloir aller en chercher un autre plus petit. C'était juste comme "Oh, j'en ai un gros, je vais juste prendre ça même si ce n'était pas nécessairement la bonne pratique." C'est ça qui m'avait vraiment frustré surtout à ce moment-là, que c'est ça que moi j'avais en tête, je l'ai entendu vraiment valider ce que je pensais. J'aurais dû dire quelque chose. Je n'ai pas aimé me sentir comment je me suis senti après, et je n'ai pas aimé voir comment le patient se sentait après non plus. Donc je pense que si une situation comme ça arriverait encore, je prendrai la chance puis je dirais ce que je pensais. (P15)	And if it happened again I think I'd mention my opinion, "This looks like a really big gauge [urinary catheter], do you want me to go see if there are smaller ones?" Because basically, the problem, I had heard the resident say on the phone that she also thought she should have a smaller one but we didn't have any on our unit. And that's why it made me think it was more laziness, not wanting to go to another unit, or not wanting to go and get a smaller one. It was just like, "Oh, I've got a big one, I'll just take that even though it wasn't necessarily the good practice." That's what really frustrated me especially at that point, that that's what I had in mind, hearing that really validated what I was thinking. I should have said something. I didn't like how I felt afterwards, and I didn't like seeing how the patient felt afterwards either. So I think if a situation like that came up again, I'd take the chance and say what I was thinking. (P15)
116-117	C'est beaucoup de confort puis de support à la famille mais aussi la confidentialité. Dans le centre de naissance, ... moi je ne peux rien dire [à la famille], je ne peux pas dire ce qui se passe, je ne peux pas dire que j'ai entendu un bébé, je ne peux pas dire qu'ils ont crié "It's a girl", je ne peux pas dire ça. ... Donc ça m'a aussi aidé à l'hôpital pendant mes stages parce que tu ne peux pas dire les résultats ou quelque chose à un patient. Il faut vraiment que tu dises rien mais en même temps les rassurer donc dire "on fait ce qu'on peut, tu vas le savoir aussitôt que possible." (P16)	It's a lot of comfort and support for the family, but also confidentiality. In the birthing center, ... I can't say anything [to the family], I can't say what's going on, I can't say I heard a baby, I can't say they shouted "It's a girl", I can't say that. ... So it also helped me in the hospital during my clinical placements because you can't tell a patient their results or anything. You really can't say anything, but at the same time reassure them, so say "we're doing what we can, you'll find out as soon as possible." (P16)

117	Je n'ai pas beaucoup de problème de santé mentale dans ma famille. Alors c'est quelque chose que je ne savais pas trop quoi faire. Surtout en arrivant en santé mentale, ça c'était mon pire stage. Je ne savais pas quoi faire, ... je ne savais pas comment agir, réagir face à ça. Puis ça c'est quelque chose qui a vraiment été difficile pour moi. (P15)	I don't have a lot of mental health issues in my family. So it's something I didn't really know what to do with. Especially when I arrived in mental health, that was my worst clinical placement. I didn't know what to do, ... I didn't know how to act or react to that. And that was something that was really difficult for me (P15).
118	Puis aussi on va dire que si tu as des expériences en stage, ça me reste plus. Comme une lecture en classe, je vais apprendre quelque chose, je vais l'apprendre pour le test mais si jamais je ne la vois pas en stage, on dirait que ça ne reste pas. (P21)	And I'll also say that if you have experiences during clinical placements, it stays with me more. Like a lecture during class, I'll learn something, I'll learn it for the test, but if I don't see it during the clinical placement, it doesn't seem to stay with me. (P21)
119	Au début du stage, mes relations avec les patients n'étaient pas aussi bonnes qu'à la fin du stage. J'ai dû apprendre par dire quelque chose puis voire comment la personne réagit puis espérer que j'ai dit la bonne chose. Puis certaines fois ça n'a pas nécessairement fonctionné puis j'ai appris de mes erreurs puis j'ai changé un peu. Puis chaque personne est différente aussi donc certaines personnes vont réagir mieux à quelque chose que tu vas dire puis d'autres ne vont pas aimer ça. Donc je ne sais pas comment j'ai appris ça, je n'ai pas regardé des vidéos ou lu des livres, j'ai juste essayé de voir comme si moi je serais dans cette situation-là, comment est-ce que je me sentirais puis comment est-ce que je voudrais que quelqu'un m'approche. Puis des fois ça fonctionne, des fois ça ne fonctionne pas. Mais [...] à force d'avoir plusieurs interactions avec des patients ça te permet de mieux te développer puis mieux les aider aussi. (P15)	At the beginning of the clinical placement, my relationships with patients weren't as good as they were at the end. I had to learn how to say something, then see how the person reacted, then hope I'd said the right thing. Sometimes it didn't necessarily work, and I learned from my mistakes and changed a bit. And each person is different too, so some people will react better to something you say and others won't like it. So I don't know how I learned that, I didn't watch videos or read books, I just tried to figure out what it would be like if I were in that situation, how I'd feel, and how I'd want someone to approach me. Sometimes it works, sometimes it doesn't. But [...] by interacting with multiple patients, you're able to improve yourself and help them better too. (P15)
122-123	OK, par rapport aux professeurs cliniques, la plupart d'entre eux sont d'excellentes personnes du côté professionnel. Mais aussi, comme partout dans la vie, il y en a quelques un qui honnêtement, moi je dirais qu'ils ne devraient pas être des enseignants, ils devraient faire autre	OK, when it comes to clinical instructors, most of them are excellent people from a professional standpoint. But also, like everywhere in life, there are a few who honestly, I'd say they shouldn't be clinical instructors, they should be doing something else. ... But you shouldn't dwell

	chose. ... Mais il ne faut pas s'attarder à ces personnes, il faut s'attarder aux profs qui sont vraiment très compétent, qui m'ont marqué pendant mon séjour puis que je les trouve vraiment très compétent et qui sont des personnes sévères dans le sens qu'ils sont exigeants, des personnes exigeantes dans leur domaine, mais juste. Je n'ai pas de problème avec les exigences ainsi que le travail fort, mais j'ai un peu de problème avec l'injustice par rapport aux étudiants. (P14)	on these people, you should dwell on the clinical instructors who are really very competent, who made an impression on me during our time together because I find them really very competent and who are strict people in the sense that they are demanding, demanding people in their area of expertise, but fair. I don't have a problem with the expectations and the hard work, but I do have a bit of a problem with the unfairness towards students. (P14)
128	Il y avait une fois, c'était le semestre passé, j'avais un patient palliatif. ... Mon patient il était in and out - je lui changeais la couche, puis je lui disais "on va tourner". Oui, ça lui prenait 20 secondes de plus de se tourner qu'un patient régulier, mais je trouve que c'était plus sensible de le laisser se tourner lui-même au lieu de lui garocher. ... Alors là on [patient and participant] travaillait bien ensemble toute la journée. Après ça, ... moi puis l'infirmière [qui est venu aider] on est en train de changer le patient puis elle [l'infirmière] lui tourne très rapidement, elle faisait sa tâche le plus vite possible. Puis là il [patient] commence à frapper [l'infirmière], mais obviously il va te frapper, moi aussi si tu commences à me manipuler toutes sortes de façons je te frapperais aussi. (P23)	There was this one time last semester, I had a palliative patient. ... My patient was in and out - I'd change his diaper, then say to him "we are going to turn". Yes, it took him 20 seconds longer to turn than a regular patient, but I thought it was more sensible to let him turn himself instead of throwing him around. ... So then we [patient and participant] worked well together all day. After that, ... me and the nurse [who came to help] were changing the patient, then she [the nurse] turned him very quickly, she did her job as quickly as possible. Then he [patient] starts hitting [the nurse], but obviously he's going to hit you, I'd hit you too if you started manipulating me in all sorts of ways. (P23)
133	[EM] Puis comme tu dis, elle [clinical instructor] a beaucoup de pouvoir. [P10] Ah oui, non c'est certain. Puis on ressent ça comme étudiant. Pas avec tous les profs mais avec certains on sait qu'on se fait regarder. On est tout le temps de se faire évaluer en stage. C'est certain qu'on a du stress, on le ressent. (P10)	[EM] As you say, she [clinical instructor] has a lot of power. [P10] Ah yes, no that's for sure. And you feel that as a student. Not with all clinical instructors, but with some you know you're being watched. We're always being evaluated during clinical placements. We definitely have stress, we feel it. (P10)
136	Alors, elle [clinical instructor] m'a beaucoup appris et elle a booster mon ego avec les bains du bébé parce qu'elle n'arrêtait pas de rentrer à chaque fois puis elle amenait mes collègues dans la chambre juste pour qu'ils voient comment	So, she [clinical instructor] taught me a lot and she boosted my ego with the baby baths because she kept coming in and then she'd bring my colleagues into the room just so they could see how to give baths. It was really fun and the babies were really

	donner des bains. C'était vraiment le fun puis les bébés étaient vraiment cute. Je pensais que j'étais un bébé whisperer! (P16)	cute. I thought I was a baby whisperer! (P16)
140	Donc il faut changer ça aussi, il faut changer les trucs de pouvoir absolu, le fameux contrat d'apprentissage. ... Peut-être il y a une logique derrière ça, peut-être la logique elle est bien fondée, mais la façon que certains profs utilisent le contrat d'apprentissage, je ne pense pas que ça va en lien avec ce qu'ils [the university] veulent faire avec un contrat d'apprentissage. ... Fait tout dans ton pouvoir pour ne pas avoir un contrat d'apprentissage parce que si tu as un contrat d'apprentissage, tu es à moitié mort. Ton stage c'est presque fini pour toi. C'est ça l'idée. Tout le monde a peur du contrat, le fameux contrat d'apprentissage. C'est un outil de châtiment. ... C'est un outil de coercition là. C'est un outil de punishment. (P14)	So we have to change that too, we have to change this absolute power stuff, the famous learning contract. ... Maybe there's a logic behind it, maybe the logic is well-founded, but the way some clinical instructors use the learning contract, I don't think it's in line with what they [the university] want to do with the learning contract. ... Do everything in your power not to be put on a learning contract because if you're on a learning contract, you're half dead. Your clinical placement's basically over for you. That's the idea. Everyone's afraid of the contract, the famous learning contract. It's a tool of retribution. ... It's a tool of coercion. It's a tool of punishment. (P14)
141	"Ce n'est pas par rapport à tes connaissances que tu vas être évalué, c'est par rapport à si ton prof de stage, il t'aime ou il ne t'aime pas" (P14).	"It's not your knowledge that's going to be evaluated, it's whether your clinical instructor likes you or not" (P14).
141-142	Et puis elle [clinical instructor] a tellement crié dans le bureau de la coordinatrice. ... En tout cas, j'ai eu le contrat d'apprentissage et puis ils ont dit "tu dois écrire des stratégies pour améliorer." ... La coordinatrice dit que "Voilà, si tu tiens les trois derniers shifts tu passeras." Et puis la prof a tout fait bien sûr pour que j'échoue, elle a dit "À quoi sert le calcium pour ce patient?" J'ai dit "Pour maintenir le niveau de calcium parce que c'était bas pour prévenir la perte." Elle a dit "Non, c'est pas pour ça, tu as tes cartes?" Et puis moi je n'avais pas les cartes de médicaments écrit à la main. Elle a dit "Ton stage est fini, quitte." Voilà, c'est comme ça j'ai échoué. Et puis ce n'est pas le fait que j'ai échoué, parce que la vie, en tout cas ma vie m'a donné beaucoup de	And then she [clinical instructor] yelled so much in the coordinator's office. ... Anyway, I was put on a learning contract and then they said "You have to write strategies to improve." ... The coordinator said, "There you go, if you can manage for the last three shifts you'll pass." And then the clinical instructor did everything she could to make sure I failed, she said "What's the calcium for for this patient?" I said, "To maintain the calcium level because it was low, to prevent loss." She said "No, that's not why, do you have your cards?" And I didn't have the handwritten medication cards. She said "Your clinical placement's over, leave." So that's how I failed. And it's not the fact that I failed, because life, at least my life, has given me a lot of surprises, a lot of changes, a lot of

	surprises, beaucoup de changements, beaucoup de défis. ... Au dernier jour d'évaluation, on vient toujours pour 15 minutes relire la dernière fois pour envoyer l'évaluation [CEO/ECL]. Et c'était ce jour, c'est toujours dans le bureau de [name of the clinical coordinator] coordinatrice et puis cette prof [clinical instructor], elle a commencé encore pourquoi elle m'a fait échouer. Chaque horreur elle a passé trois fois, cinq fois, chaque horreur – deux heures sont déjà écoulés, j'étais en retard pour mon cours d'éthique. ... C'est comme si elle voulait se justifier pendant deux heures. (P20)	challenges. ... On the last day of evaluation, we always come for 15 minutes to reread the evaluation [CEO/ECL] one last time before sending it. And it was that day, it's always in the office of [name of the clinical coordinator] coordinator and then this prof [clinical instructor], she started telling me again why she made me fail. Every horror she repeated three times, five times, every horror - two hours went by, I was late for my ethics class. ... It's like she wanted to justify herself for two hours. (P20)
145	[EM] Avez-vous un exemple d'injustice ? [P14] Il y en a plusieurs, il y en a plusieurs. C'est juste que les étudiants, ils ne vont pas te parler parce qu'ils ont peur de pas passer à travers. Parce qu'ils sont encore des étudiants puis ils ont peur de ne pas pour voir finir leurs études. Mais oui, c'est une réalité qui existe ici dans la faculté. Mais en tant qu'étudiante on a peur, honte de parler de ces genres de choses ici. On sait tous qu'il existe, ... on a passé tous par des situations comme ça. Pas tous, plusieurs personnes. Mais on essaye de ne pas parler trop, de continuer pour finir puis sortir avec le petit papier [diploma] puis se trouver un travail. [EM] Pourquoi pensez-vous qu'il y a cette peur en tant qu'étudiant? D'en parler? [P14] Parce que ici à l'université on se connaît tous, tout le monde connaît tout le monde. [EM] Comme entre étudiants ou... [P14] Entre les profs, donc si tu as un problème avec un instructeur clinique, tous les autres ils vont être au courant. Puis donc dès que tu vas faire ton prochain stage ça pourrait te nuire. Donc on ne parle pas. On se dit entre nous "Ok, fait attention à ça" puis tu continues. (P14)	[EM] Do you have an example of injustice? [P14] There are many, there are many. It's just that students, they're not going to talk to you because they're afraid of not getting through it. Because they're still students and they're afraid they won't be able to finish their studies. But yes, it's a reality that exists here in the faculty. But as a student, we're afraid and ashamed to talk about these kinds of things here. We all know it exists, ... we've all been in situations like that. Not all of us, but many of us. But we try not to talk too much, we keep going until we get the little paper [diploma] and find a job. [EM] Why do you think there's this fear as a student? To talk about it? [P14] Because here at the university we all know each other, everyone knows everyone. [EM] Like between students or... [P14] Between clinical instructors, so if you have a problem with a clinical instructor, all the others will know about it. Then when you go to your next clinical placement, it could affect you. So we don't talk. We say to each other, 'Okay, be careful about that', and then you carry on. (P14)

145-146	On ne parle pas de ça avec les autres profs. Même juste en parlant maintenant durant l'entrevue, je sais c'est une entrevue anonyme mais ça génère aussi une certaine réticence. ... La plupart des gens se disent "écoute, j'ai beaucoup de choses à passer à travers, j'ai ma famille, j'ai mes choses, j'ai mis beaucoup d'argent, d'effort, des pleurs, du stress à passer à travers l'université, ... je ne peux pas perdre tout ça." Donc ... on essaye de finir puis on essaye d'oublier. ... Le support c'est entre les étudiants, on n'est pas si brave to go to talk to someone else because we are afraid. Parce que c'est beaucoup d'effort, beaucoup d'argent, puis le risque c'est très important. (P14)	We don't talk about it with other professors. Even just talking about it now during the interview, I know it's an anonymous interview but it also generates a certain reluctance. ... Most people say to themselves "look, I've got a lot to get through, I've got my family, I've got my things, I've put a lot of money, effort, tears, stress into getting through university, ... I can't lose all that." So ... we try to finish and then we try to forget. ... Support is between students, we're not so brave to go to talk to someone else because we are afraid. Because it's a lot of effort, a lot of money, and the risk is very high. (P14)
149	C'est certain qu'au début, les premières semaines – si je donne l'exemple des soins complexes ... on n'avait pas beaucoup de patients, on en avait un ou deux. Puis t'as vraiment le temps de connecter avec ton patient puis comprendre ton patient au complet... (P10)	It's certain that at the beginning, the first few weeks - if I give the example of complex care ... we didn't have many patients, we had one or two. Then you really have time to connect with your patient and fully understand your patient... (P10)
149	Oui, parce qu'eux [nurses] ils n'ont pas le temps. Puis j'ai peur, ça c'est quelque chose que j'ai peur, si je me trouve dans une job où que j'ai quatre, cinq, six patients, je ne vais plus avoir le temps de faire ça [connect with patients]. Puis c'est tellement important pour moi – I would be in moral distress to be in this job and to not be doing the parts I like about it everyday. ... C'est comme ça que je me sens pis je ne sais pas comment que tu peux avoir une charge de quatre, cinq, six patients – comme comment est-ce que t'apprends à connaître les gens quand t'as six patients? I don't know, c'est beaucoup. I think it's asking too much. (P19)	Yes, because they [nurses] don't have the time. And I'm afraid, that's something I'm afraid of, if I find myself in a job where I have four, five, six patients, I'm not going to have the time to do that [connect with patients]. And it's so important to me - I would be in moral distress to be in this job and not to be doing the parts I like about it everyday. ... That's how I feel and I don't know how you can have an assignment of four, five, six patients - like how do you get to know people when you have six patients? I don't know, it's a lot. I think it's asking too much (P19)
155	On a beaucoup de relations comme ça en sciences infirmières, les relations de pouvoir. [name of the university] c'est une business, c'est puissant. C'est comme ils ont vraiment ce pouvoir là sur nous des fois. (P10)	We have a lot of relationships like that in nursing, power relations. [name of the university] it's a business, it's powerful. It's like they really have this power over us sometimes. (P10)

156	Pour revenir à l'exemple tantôt de la professeure avec l'histoire qu'on est parti [du stage] plus tôt. On se disait "Oh on pourrait aller voir [name of administrator] puis parler de cette histoire-là." Parce qu'[il/elle] est vraiment rejoignable [name of administrator], je trouve qu'[il/elle] est terre à terre puis [il/elle] est jeune puis on dirait qu'on se sent plus confortable avec. Puis tu sais ça, les autres filles disaient "Oh on devrait aller voir [name of administrator]" mais en même temps on se dit "Peut être que ça ne va rien changer parce que c'est déjà terminé puis au moins on a déjà passé." Mais c'est certain qu'on dirait que [...] l'[name of the university] c'est un gros géant comparé à nous comme étudiants. (P10)	To go back to the earlier example about the clinical instructor with the story that we left [from the clinical placement] early. We said to each other "Oh, we could go and see [name of administrator] and talk about that story. Because they're really approachable [name of administrator], I think they're down-to-earth, and they're young, and we seem to feel more comfortable with them. You know, the other girls were saying "Oh, we should go and see [name of administrator]", but at the same time we said to ourselves "Maybe it's not going to change anything because it's already over, and at least we already passed". But it sure seems like [...] the [name of the university] is a giant compared to us as students. (P10)
159	J'ai toujours un feeling – pas je me cache un peu, mais je reste – comme des fois je ne dis pas certaines choses ou je pense quelque chose mais je ne le dis pas à cause que je me dis "Eux autres savent ce qu'ils font, ce n'est pas ma place de leur dire ce que je pense." Puis ça c'est quelque chose que ma professeure en soins complexe nous disait, "Regardes, vous êtes presque infirmière, c'est le temps que vous commencez à advocate pour vos patients parce qu'éventuellement ça va être vous." C'est important de commencer en soins complexe tout de suite avant votre consolidation, de s'habituer à vraiment "speak up" puis surtout quand que c'est quelque chose important. (P15)	I always have this feeling – not that I hide a little, but I stay - like sometimes I don't say certain things or I think something but I don't say it because I think, "They know what they're doing, it's not my place to tell them what I think." And that's something my complex care clinical instructor used to tell us, "Look, you're almost a nurse, this is the time to start advocating for your patients because eventually it's going to be you." It's important to start in complex care right before your consolidation, to get used to really "speaking up" especially when it's something important. (P15)
160	Je me sens un peu mal à l'aise des fois. Surtout quand les médecins faisaient l'évaluation, j'étais juste là puis je n'étais pas sûre. Il me demandait des questions puis là, je n'étais pas sûre si j'avais fait la bonne chose. Puis c'était un peu intimidant des fois aussi, surtout dans les situations un peu plus urgentes. (P15)	I feel a bit uncomfortable sometimes. Especially when the doctors were doing their assessment, I was right there and I wasn't sure. They'd ask me questions and I wasn't sure if I'd done the right thing. It was a little intimidating sometimes too, especially in more urgent situations. (P15)
162-163	Quand j'ai appliqué en 11e année, je ne savais pas le montant de responsabilité que	When I applied in grade 11, I didn't know the amount of responsibility nurses had. I

	les infirmières avaient. Je pensais vraiment comme on les présentait dans les shows à la télévision ... ils n'ont pas vraiment de décisions à prendre, ils font juste suivre tous les ordres. Mais avec mes stages et avec mes classes puis tout ça, j'ai vraiment réalisé que les infirmières ont un gros mot à dire, on est vraiment avocat pour les patients. Donc c'est vraiment nous qui faisons des grosses décisions quand même puis on supporte la famille. (P21)	really thought they were like the way they are portrayed in TV shows... they don't really have any decisions to make, they just follow all the orders. But with my clinical placements and with my classes and everything, I really realized that nurses have a big say, we're really advocates for patients. So it's really us who make big decisions and we support the family. (P21)
163	"Moi je suis une personne influençable par les autres, surtout les profs [clinical instructors] qui sont au-dessus de toi par hiérarchie, par leur position. Je ne suis qu'une étudiante" (P20).	"Me, I'm a person who is influenced by others, especially profs [clinical instructors] who are above you in the hierarchy, by their position. I'm just a student" (P20).
163	[EM] Qu'est ce qui est différent si ..., tu sais un professeur clinique qui est vraiment ... bon puis un avec qui on s'entends moins bien avec. C'est quoi la différence pour toi? [P10] Les relations de pouvoir. Quand que les professeurs cliniques ont vraiment cette relation top down, c'est comme, ça ne fonctionne pas avec moi parce que quand il y a du stress, je ne vais pas bien réussir. Mais quand vraiment je peux comprendre – pas qu'on est des amis, mais plus comme collègue, pas vraiment collègue, je sais que t'es ma professeure, mais une approche douce puis une approche non-stressante. Puis ça c'était ma professeure de soins complexe, pas de stress. Puis elle nous posait des questions mais si on ne connaît pas la réponse ce n'est vraiment pas la fin du monde puis on va juste faire un peu de recherche après. Donc moi ce que j'ai de la misère c'est quand je ressens que mon professeur a un pouvoir sur moi, c'est stressant. (P10)	[EM] What's different ..., you know a clinical instructor who's really ...good and one you don't get along with as well. What's the difference for you? [P10] Power relations. When clinical instructors really have this top-down relationship, it's like, it doesn't work with me because when there's stress, I'm not going to succeed. But when I can really understand - not that we're friends, but more as a colleague, not really a colleague, I know you're my clinical instructor, but a gentle approach and a non-stressful approach. And that was my complex care clinical instructor, no stress. She asked us questions, but if we didn't know the answer, it wasn't the end of the world and we would just go and do a little research after. So what I have trouble with is when I feel my clinical instructor has power over me, it's stressful. (P10)
168-169	Si vous avez un étudiant qui est stressé, il a peur, il ne peut pas apprendre, c'est clair comme de l'eau. Il ne va pas apprendre, il va juste faire les choses pour que vous, en tant que professeur, que vous soyez ok avec lui. Mais il ne peut pas apprendre.	If you have a student who's stressed, he's scared, he can't learn, it's as clear as day. He's not going to learn, he's just going to do things so that you, as the clinical instructor, are okay with him. But he can't learn. To learn, you have to be in good

	Pour apprendre il faut être en esprit. C'est sûr que le travail comme nursing c'est stressant, oui, c'est sûr. Mais il ne faut pas donner trop de stress à l'étudiant, l'étudiant il ne va pas performer. ... Parce que lui là, il va falloir qu'il applique toutes les connaissances qu'il n'a jamais eu parce qu'il était stressé à donner des pilules et pas stressé à réfléchir comme il faut, avoir la pensée critique. (P14)	spirits. It's true that nursing work is stressful, yes, it is. But you can't put too much stress on the student, because he's not going to perform. ... Because he's going to have to apply all the knowledge he never got because he was stressed giving pills rather than stressed about thinking properly, thinking critically. (P14)
169	Pis il y a certains profs de stage où ce que leur environnement d'apprentissage est tellement plus convenable à l'apprentissage que d'autres profs. L'apprentissage par intimidation on dirait ce n'était vraiment pas mon affaire, je ne sais pas qui aimerait ça, mais c'était super difficile. J'avais de la difficulté à manger, ... je commençais à avoir des rêves, comme "Ah! J'ai donné de l'insuline à un patient sans prendre sa glycémie pis là je l'ai tué." Des affaires comme ça. Parce que j'avais tellement de stress relié à mon stage pis là ce n'était pas une bonne expérience d'apprentissage. (P19)	And there are some clinical instructors where their learning environment is so much more conducive to learning than other clinical instructors. Learning by intimidation really wasn't my thing, I don't know who would like that, but it was super difficult. I had trouble eating, ... I started having dreams, like "Ah! I gave insulin to a patient without taking their blood sugar and now I've killed them." Things like that. Because I had so much stress related to my clinical placement and it wasn't a good learning experience. (P19)