Applying Noddings' ethic of care to healthcare education: How caring student-educator relationships improve psychological safety and inclusion of students within the clinical learning environment.

Lauren Gilowski

School of Education, Thompson Rivers University, Kamloops, BC

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Dr. Fred Schaub

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Abstract

My professional experiences over the last decade employed as a Registered Respiratory Therapist in a large urban teaching hospital have provided the context for this paper. Working as a clinical educator and frontline therapist allowed me to develop a caring approach to pedagogy that centers around relationship building throughout all of my educator and leadership practice. The pedagogy of a caring approach has not been traditionally utilized in healthcare education, and often does not get the respect it deserves. While my caring approach to pedagogy has often been criticized by my healthcare colleagues, I have found it to be validated by the literature, especially the work by Noddings, as an effective educational leadership philosophy during the completion of my Master of Education. This paper demonstrates the need for healthcare educators to adopt more components of Noddings' method into their own practice by describing the qualities, risks, and benefits of a caring approach towards education. I argue that implementing an ethic of care, with particular focus on building caring student-educator relationships, will improve healthcare education through increasing student psychological safety, inclusion, and overall experiences in the clinical learning environment. The implication of this pedagogical shift is bringing connection to adult learning in healthcare education at the post-secondary level, which will in turn shape the attitudes students bring into their future professional practice. A new caring pedagogy could be a cornerstone component to recent overall cultural changes within the Canadian healthcare system.

Keywords: Noddings ethic of care, caring student-educator relationships, healthcare education, psychological safety, clinical learning environment, inclusion and belonging, respiratory therapy

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Chapter 1: Introduction

My Journey from Respiratory Therapist to Educator

During my third year as an undergraduate student, I completed a strong interest assessment in order to help provide a future direction for myself. The results revealed that "respiratory therapist" and "university professor" were both in my top five matches for potential career paths that matched my profile. Fast forward 13 years later, and I find myself at a crossroads in my career, about to amalgamate both of these interests. Many years of education and professional experience have led me to this point, and I hope to explore this personal transition along with the topic of caring relationships and connection, which have become such an important part of my practice.

Respiratory Therapy Program Description and My Student Experience

I completed the Respiratory Therapy Diploma at Thompson Rivers University (TRU) for my respiratory therapist (RT) credentials, having previously earned my Bachelor of Science. The program consists of two very busy years of classes and laboratories at the university, followed by a year long practicum that takes place within three different hospitals. During these years, I experienced many different kinds of student-educator relationships, ranging from caring to antagonistic and many in between. I also have a vivid memory of sitting in a hospital classroom during student orientation and having the thought that one day I would love to be the Clinical Site Coordinator (CSC) at Vancouver General Hospital (VGH).

Education Roles as a RT

Once I graduated from TRU and began working as a RT at VGH, I was pleasantly surprised to realize that teaching is a large component of the role. Working in a large teaching hospital, I had the opportunity early on in my career to be a preceptor to RT students. This solidified my desire to one day pursue a career educating students. With this goal in mind, I began to actively seek out other educational experiences and roles that would help me to achieve this goal. I enrolled in an educator series that was offered by the VGH professional

development department and completed three levels over the course of two years to help build my educator credentials.

With the help of a couple of encouraging mentors, I took on additional leadership roles and responsibilities within the RT department, and volunteered to help with many educational initiatives within the hospital. These opportunities included RT education, patient and family education in acute and non-acute workplaces, and interdisciplinary education including co-creating a team-based high fidelity simulation program for our intensive care unit. I found purpose in creating and delivering these educational opportunities to others, and valued the relationships I was able to cultivate along the way.

My Role as Clinical Site Coordinator (CSC)

When my mentor moved on to pursue other challenges, I was able to secure the CSC (Clinical Educator) role over more senior interviewees owing to the educational experiences and courses that I had completed. This was a very concrete reminder of the value of professional development. It was also the beginning of the most challenging professional role thus far in my career, which I will describe in more detail in Chapter Three of this paper. For now, I want to connect the role with how I embraced the educator within myself. It is also the role that helped me develop my intuitive pedagogy of caring and relationship building. I was often criticized by fellow colleagues of being ‘too soft’ as a result of the caring relationships that I built with my students. Much to my chagrin, I was encouraged by some to embody the intimidating presence that has been traditionally associated with healthcare education. Though this criticism often caused me internal distress, upon reflection I knew in my heart that a pedagogy of fear would have been inauthentic to my person and detrimental to my students. As a means towards quieting this internal doubt, I began to feel the pull towards validating my educator skills and continuing with my professional development. I knew that in order to advance into further leadership roles within the hospital or to pursue other goals, such as teaching at TRU, I would need to obtain a Master degree.

The Beginning of My Master of Education Journey

Commencing the Master of Education (M.Ed.) program coincided with the beginning of my motherhood journey. Going through a very large personal transition as well as diving back into academia was initially very challenging. However, learning about myself and my personal values and how they translated into aspects of my professional practice seemed to provide just the balance I needed. At a time when parts of myself were easily lost or overshadowed by the huge new responsibility of being a mother, I learned to make sense of other parts of myself and how to fit the pieces together.

The second class that I took during my M.Ed. program was a course exploring various philosophies of education. Having never formally studied the subject before, or thought about my pedagogical approach in terms of having support from literature, it was a very liberating experience. Exploring new pedagogical approaches provided me with a newfound validation of practice that I had been searching for, and allowed me to have greater confidence in my educator abilities. I will expand on a few of the most influential philosophers and theories as they contribute to the framework of how I became interested in my topic and help to develop the significance of my paper.

My Teaching Philosophy and the Philosophers Who Influenced It

I will share an excerpt from my teaching philosophy that I wrote two and a half years ago as a way to show the sentiments that have guided my learning throughout my MEd journey:

> *I am a RT who has the privilege of educating the future generation of RTs. While developing my professional practice, I observed and reflected on my various preceptors' actions and attitudes. In becoming an educator, I have reflected on my past educational experiences. As with most philosophers who built on or modified the work done before them, I utilized what I felt to be organic to my values and ethics, and discarded methods I did not want to perpetrate. Through these reflections, I have realized that the most important aspect in my*

> *educational philosophy is creating a genuine, caring relationship with my students so that there can be mutual trust and rapport between us. If I am successful in creating these relationships, I believe that the chaotic hospital environment becomes a safe space for the students to learn.*

I strongly related to Dewey's (1897) ideas of experiential learning (Article 4, point 2) as they are highly applicable to the CSC role of helping the students develop their practical skills in the hospital. Friere's (1970/1998) views on aspects of adult education, especially the "authentic dialogue between learners and educators as equally knowing subjects" (p. 487) and valuing the adult learners previous life experiences spoke to my intrinsic pedagogy. This sentiment was echoed by Noddings (1984/2013) as she states that a one-caring educator "starts from a position of respect or regard for the projects of [the student]" (p. 176). Noddings' focus on caring and relationship building resonated the most with me, as it was the pedagogy that most closely matched my own, and it is what I used as inspiration for the topic of this paper.

Counseling Electives

The counseling electives that I chose to take were also very important in further developing my interest in caring relationships and connections. My confidence in having difficult conversations after learning about attending, emphasizing, observing, and reflecting feelings was changed - I now had language and learning to use practically to cultivate a caring atmosphere in difficult times. Studying the various works of Brene Brown, Carl Rogers, and Viktor Frankl among others, impacted how I felt about my practice and how I formed connections with my students and peers.

Why I Chose This Topic and Its Significance

The topic of building student-educator relationships and genuine connection chose me. As I have explored in the previous sections, these were the concepts that began to stand out to me throughout all my classes. I believe that exploring relationships was the most impactful part of my learning journey because I connected to the concepts on a personal level. The literature I

studied in various classes throughout my M.Ed. provided validation for my intrinsic values, as I found evidence to support connection in education, counseling, and leadership practices. Some of this scholarly evidence that pertains to this capstone paper's argument will be presented in Chapter Two, the literature review section.

At this point of my paper, I would like to introduce the following question for contemplation: Why is the topic of an ethic of care important in healthcare education? My answer for the reader is: because a caring ethic is lacking in practice within healthcare education systems, students across various programs are not experiencing the benefits of caring student-educator relationships. By implementing a more caring pedagogy into their practice, present healthcare educators will be able to build more genuine connections and relationships with their students. This in turn will affect the way that their students, once they are fully fledged professionals, will interact with their future students (Noddings, 1984/2013, p. 17), as the way healthcare students are taught influences their future clinical teaching practices (Kost & Chen, 2015, p. 20).

Presenting the Argument

"*The student is infinitely more important than the subject*" (Noddings, 1984/2013, p. 20).

In this paper, I argue that implementing an ethic of care by prioritizing the creation of caring student-educator relationships will improve healthcare education. The reasons for my claim are educators who prioritize building meaningful relationships with their students: promote inclusivity and a sense of belonging in the clinical learning environment, increase student psychological safety, and improve overall learning experiences and future patient care.

In the Literature Review chapter, I will present evidence that corroborates my argument. Healthcare students stated that caring relationships with their supervisors were essential to creating a positive learning environment and inclusive workplace (Hägg-Martinell et al., 2014, p. 20-21); showing interest in the students as a person and developing trusting, genuine relationships increases the student's sense of psychological safety (Hearst McClintock et. al.,

2022, p. 8-9); and the student-supervisor relationship is important to overall student learning experiences and satisfaction in recommending the healthcare program (Pitkänen et al., 2018, 148). For sake of a counter-argument, barriers found throughout the literature that impede caring student-educator relationships within the clinical learning environment will be identified. The consequences of absent caring student-educator relationships and lack of psychological safety within the clinical learning environment will also be explored in Chapter Two.

In the Application chapter, I will further explore the topic of meaningful student-educator relationships within the context of my own past and future professional experiences. I will strengthen my argument by connecting my lived-experiences with the literature reviewed. I will extrapolate transferable skills and knowledge from my previous experiences and from the literature in order to suggest possibilities for future training programs and professional development for clinical educators within the RT department at TRU with the intention of improving student's overall clinical education.

The Conclusion chapter will reaffirm support for my argument through summarizing and connecting the Literature Review to my lived-experiences as described in my Application chapter. The summary and findings parallel recent recommendations for healthcare leadership with the goal of improving patient care (Aranzamendez et al., 2015, p. 172 & 176). Exploring recommendations for healthcare leadership and means of improving patient care will provide an effective illustration as to how this paper's argument fits within the larger context for the future vision of the Canadian healthcare system. I will conclude by explaining the implications of the findings of this paper, followed by recommendations for healthcare educators at the post-secondary teaching level.

Chapter Two: Literature Review

This chapter will explore the literature pertaining to my argument that caring student-educator relationships are of benefit to healthcare education. An overview of Noddings' ethic of care is followed by a discussion of healthcare learning environments, belonging, and psychological safety. Literature on caring relationships will be connected to increasing healthcare student's overall learning experiences in their educational programs. The chapter will conclude with a brief summary which will comment on how the topics explored will impact healthcare student's future practice and patient care.

Noddings's Ethic of Care

"A caring relation requires the engrossment and motivational displacement of the one-caring, and it requires the recognition and spontaneous response of the cared-for" (Noddings, 1984/2013, p. 78).

As one can infer from the above quote, the ethic of care is grounded in the concept of reciprocity (Noddings, 1984/2013, p. 4). The one-caring's actions must be perceived by the cared-for as caring in order for the relationship to be complete and considered caring (Chang, 2019, p. 46). In Noddings' view, this reciprocity is not contractual for mutuality to be attained between the one-caring and the cared-for. The cared-for may not even acknowledge the one-caring's efforts in any explicit way, they might just continue on with their own projects (p. 151).

Noddings' ethic of care was first published in 1984 before care theory was largely studied in various fields (Noddings, 1984/2013, p. xiii). The biggest critique of the ethic of care was that the philosophy was seen as a feminist view to be imposed on women (Noddings, xiii; Chang, 2019, p. 47). Noddings answers this critique in the forward to the third edition by stating that 'relational' is likely a better term than 'feminine' for a descriptor (p. xiii). The text of the ethic of care denotes that the use of the term feminine or the female pronouns is merely a reflection of "[the term] feminine in the deep classical sense - rooted in receptivity, relatedness, and

responsiveness" (p. 2). While these traditionally 'feminine' characteristics are what most closely align with the ethic of caring that Noddings put forth, she is explicit several times throughout the conception of care that its sentiments are universal to all humans (Chang, p. 47; Noddings p. 172).

The universal need for human care aligns with this paper's argument that all humans can benefit from, and are capable of creating, caring relationships. Given the patient-care context in which these relationships will be discussed, it seems intuitive that a conception of caring would be a logical fit for an educational pedagogy in healthcare. Such a pedagogy of care would also align with hospital culture changes of increasing relatedness and flattening the hierarchical structure that have taken place within the last 30 years. The literature review discussion will begin by exploring the context of where the inclusion of care has been suggested to be made: the clinical environment in which caring relationships in healthcare education are built.

Learning Environments

It is this paper's view that the creation and sustaining of the relationships between the one-caring (educators) and the cared-for (students) have an incredible impact on the learning environment and the quality of the learning that takes place within that environment. As "learning in a clinical context is foundational in the training of health professionals; there is simply no alternative" (Nordquist et al., 2019, p 366), the specialized environment in which most of healthcare education takes place will be discussed from conception through development in the following section. The literature surrounding what contributes to a positive learning environment and the factors that create a negative learning environment will also be explored.

Exploring the Past to Inform the Future

The 'Flexner Report' (1910) was the first study that looked at *how and where* medical education was delivered and it was used to revolutionize the training of physicians. The report gave recommendations about how to standardize medical education across Canada and the United States with the goal of increasing the quality of teaching and learning (Harley, 2006, p.

1428). The report resulted in many program closures to reduce the "over-production…of cheaply made doctors" (Flexner, 1910/1972, p. 14) resulting from the shift of an apprenticeship model to didactic lectures that had occurred in the previous 150 years. What is important to this paper's argument is how, even over a century ago, Flexner noted that "*personal contact between teacher and student*…was lost [italics added]" (p. 9). He implied that the new educational model of large numbers of students obtaining their cognitive learning in the university classrooms and laboratories as opposed to the patient-care environment did not create a space where a caring relationship could be made between student-educator or student-patient. Flexner therefore advocated for medical education programs to be associated with a hospital, that "the medical student returns to the patient, whom…he left when he parted with his preceptor" (20). Thus, the clinical learning environment (CLE) came into existence.

The CLE has continued to be a subject of study for several decades in healthcare education (Nordquist et al., 2019, p. 367). In 1993, the General Medical Council (GMC) in the UK published "Tomorrow's Doctors: Recommendations on Undergraduate Medical Curriculum;" this was another catalyst that sparked changes in curriculum and standards for healthcare educators around the world (Palmgren, 2016, p. 14; Nordquist et al., p. 367). The GMC report highlighted the problems with the hierarchical clinical environment, mainly that healthcare students were not being treated respectfully and that greater focus needed to be placed on "creat[ing] environments that are apt for learning" (Palmgren, p. 14).

While strides have been made in the past 30 years to improve the CLE for healthcare students, recent studies show that in some cases, not much has changed. The hierarchical structure of the clinical environment remains a large barrier in some instances for learning (Hägg-Martinell et al., 2014, p. 19). Hearst McClintock and colleagues (2022) found students reported the "behaviors of attendings [doctors] and senior residents as being understandable 'given their position,' as though it is an accepted part of the culture to mistreat or ignore

students" (p. 11). Clearly there remains room for improvement in the cultivation of caring relationships and personal connection between healthcare educators and their students.

Future Goals for Healthcare Learning Environments

A qualitative study done by Hägg-Martinell and colleagues (2014) illustrated healthcare students' experiences in their own words through interviews and questionnaires. Supervisors who were enthusiastic, engaged, and took the time to build relationships contributed strongly to a positive learning environment (p. 20). The authors also discussed the importance of the organization supporting a positive learning environment by planning for effective patient-based education (p. 21). A large part of creating a positive learning environment was allowing the practitioners who educate time and space to supervise and educate the students (p. 19). Staff who have the support of their supervisors and colleagues to spend time building relationships with their students alongside their patient-care responsibilities will create a more effective learning environment. This is a culture change that is needed moving forward.

Other changes in the CLE culture that need to be made were discussed at a global conference held in October 2018 by the Royal College of Physicians and Surgeons of Canada (Nordquist et al., 2019, p. 370). The literature regarding CLEs was "deconstruct[ed]" (p. 370) in order to create both short-term and long-term goals towards overall improvement. This conference resulted in six lenses, or "avenues" (p. 370) through which to better understand and explore the many parts of the CLE: architectural, digital, diversity and inclusion, education and measurement, psychological, and sociocultural. Several of these 'avenues' will be further discussed in the following sections within the context of how caring relationships will improve these aspects of the CLE.

Inclusion, Belonging, and Connectedness: Why Do They Matter?

The discussion on inclusion and sociocultural avenues of improving the CLE as described above will begin with a review of Maslow's original hierarchy of needs. The third stage includes 'belongingness,' or the need for interpersonal relationships, connectedness, and

inclusion in a group (McLeod, 2007/2022). A sense of belonging has been described as one of our basic human needs and is an explanation of what motivates the formation of interpersonal relationships (Baumeister & Leary, 1995, p. 497). The deprivation of belonging to a social group, or having damaged social bonds, can have detrimental emotional effects on individuals such as depression and anxiety (p. 505-506). Belonging and inclusion, then, are vital to an individual's wellbeing.

Closely related to belonging is connection. Brown (2010/2020) defines connection as: "the energy that exists between people when they feel seen, heard, and valued; when they can give and receive without judgment; and when they derive sustenance and strength from the relationship" (p. 29). The first two parts of this definition nicely connect (no pun intended) our previous discussion on the importance of positive CLEs with psychological safety, the concept that will be explored in the next section. However, the literature on belonging and caring relationships within the healthcare context will be expanded on first.

Belonging, Caring Relationships, and Healthcare Education

Students will learn more effectively if they perceive that they belong, as belongingness contributes to a positive learning environment by producing positive emotions (Baumeister & Leary, 1995, p. 505). The work by Walton and Brady (2017) connected the theory of belonging to specific learning environments which led to their suggestion that individual students need to feel that they are included and accepted within their clinical learning environments. The discovery that learners need to feel included within their clinical learning environments has been corroborated in many studies. For example, Hägg-Martinell and her team (2014) found that student's confidence increased if they sensed they belonged to the community of practice at their workplace: "[the students'] learning. . .is facilitated if competent and enthusiastic [educators] give them opportunities…[and] their own responsibilities in this community" (p. 22). Likewise, students reported increased engagement in their learning when their educators gave them "a legitimate role on the team and in patient care" (Hearst McClintock et al., 2022, p. 10).

Conversely, students who felt excluded from the team and not invited to participate in patient care reported negative consequences to their learning such as disengagement and self-isolation (pp. 12-13). Clearly a sense of belonging to the healthcare team, thus verifying that the student fits into the CLE, impacts student's learning in a positive way.

How do students achieve this sense of belonging within the clinical learning environment? The answer: through the provision of caring student-educator relationships. The educator cares to include the student in the dialogue and actions of the team. In examining the examples from the previous paragraph, each one was facilitated by specific actions taken by the educator to either include or exclude the student in meaningful learning opportunities within the CLE. Clinical educators are the equivalent of team leaders (Hearst McClintock et al., 2022, p. 16), and thus have an enormous impact on the culture of inclusion and psychological safety within the CLE (Rosenbaum, 2019, p. 786; Aranzamendez, 2015, p. 173).

The next section will investigate Nordquist and colleagues (2019) psychological avenue to improving the CLE through the concept of psychological safety, how psychological safety stems from belonging, and how a caring clinical educator is integral to the development of psychologically safe learning environments.

Psychological Safety

> *When a teacher asks a question. . .and a student responds, she receives not just the "response" but the student. What he says matters, whether it is right or wrong, and she probes gently for clarification, interpretation, contribution. She is not seeking the answer but the involvement of the cared-for* (Noddings, 1984/2013, p. 176)

Psychological safety (PS) was a concept that was first introduced in the 1960s which has now morphed into an essential component for effective learning in high-stakes, interpersonal environments, such as healthcare and education (Edmondson et al., 2016, p. 65). PS has been highly researched in recent healthcare literature; for example, 60 of the included 88 studies in

Ito and colleagues (2021) review article last year on PS and healthcare applications were published between 2016 and 2020. Of those studies, 51 cited the definition of PS from Edmondson (1999):

> Psychological safety is defined as a shared belief that the team is safe for interpersonal risk taking. . .the term is meant to suggest neither a careless sense of permissiveness, nor an unrelentingly positive affect but, rather, a sense of confidence that the team will not embarrass, reject, or punish someone for speaking up. This confidence stems from mutual respect and trust among team members (p. 354)

This definition mirrors Noddings' (1984/2013) thoughts on caring receptivity:

> The receptivity of the one-caring need not lead to permissiveness nor to an abdication of responsibility for conduct and achievement. Rather, it maintains and enhances the relatedness that is fundamental to human reality and, in education, it sets the stage for the teacher's effort in maintaining and increasing the [student's] receptive capacity (p. 59-60)

Caring student-educator relationships are needed in order to create this mutual respect, trust, and mutual receptivity discussed in aforementioned definitions. PS has also been described as "how safe one feels to take a risk and 'be wrong' without being shamed, blamed, or ignored" (Hearst McClintock et al., 2022, p. 4), and as a state in which one feels included in the team and safe in the environment to learn, contribute, and ask questions "without fear of being embarrassed, marginalized, or punished in some way" (Clark, 2020, p. 2). PS is an essential link between positive CLEs and the student's overall sense of inclusion and belonging. A major factor dictating whether PS is established in the CLE is whether supportive student-educator relationships are present (Hearst McClintock et al., p. 8), which the following sections will explore more thoroughly.

When Psychological Safety and Caring Relationships are Not Present

Clark (2020) places the concept of PS as the balance between respect and permission to participate within relationships created in team learning environments (p. 126). He discusses how a lack of respect creates a relationship of exploitation, while a lack of permission pushes the dynamic of the relationship towards paternalism, or simply "telling you what to do" (p. 127). Of interest considering this paper's topics, healthcare and higher education settings are both examples that he used in this section. Clark (2020) speculates that the reasons for the continued trend towards paternalism in these institutions stems from traditional authoritarian systems (p. 128). This claim is corroborated by several other studies reviewed that have found that hierarchical structures are barriers to psychological safety (Hearst McClintock et al., 2022, p. 4, 13; Edmondson et al., 2016, p. 78; Hägg-Martinell et al., 2014, p. 19).

A phenomenon that is widely discussed in the healthcare education literature as a means to enforce hierarchy and which is detrimental to the formation of caring relationships and PS is a form of public questioning referred to as 'pimping.' As most healthcare educators lack formal training in pedagogical techniques, pimping is a generational transfer of instruction that occurs when educators ask a series of questions "with the intent to cause discomfort in the learner as a means of maintaining medical hegemony" (Kost & Chen, 2015, p. 21). This "practice of humiliating" (Hoskison & Beasley, 2019, p. 1078) healthcare students described by these authors as being commonplace over 30 years ago when they were in medical school, is unfortunately still present in CLEs today. As Hearst McClintock and colleagues (2022) found in their study, questioning repeatedly on topics that were identified as unfamiliar to the students was reported often by participants (p.13). Not only did the practice of asking demanding and pointed questions create an unsafe CLE and destroy PS, it was detrimental to the building of caring educator-student relationships as it "was often cited as a form of public humiliation [that] and highlight[ed] power dynamics within a team" (Hearst McClintock et al., p. 13), rather than an attempt to further the student's learning through dialogue.

Other behaviors that healthcare educators engaged in that impaired PS in the CLE are cited as: providing brief answers to questions, providing insufficient supervision, failing to acknowledge students by name, acting annoyed by the student's presence, and displaying disrespectful body language such as not paying attention while the student was talking (Hearst McClintock et al., 2022, p. 12). Organizational culture such as hierarchy, lack of inclusiveness, and blame culture were identified in multiple studies as correlating with low PS (Grailey et al., 2021, p. 9). As previously established, educator clinicians are considered leaders in the healthcare environment, therefore their actions and attitudes determine the amount of PS present in the CLE (Rosenbaum, 2019, p. 786; Hearst McClintock et al., p. 16).

Antecedents of Psychological Safety in Healthcare Education

Multiple studies on PS in healthcare environments have attempted to describe the specific actions and behaviors that educators and leaders engage in in order to create a safe learning and working environment. Leader inclusiveness was among the behavioral antecedents that contribute to PS as described by Aranzamendez and colleagues (2015). Nembhard and Edmondson (2006) define leader inclusivity as: "words and deeds…that indicate an invitation and appreciation for others' contributions" (p. 947), which complements the previous discussion on the creation of a sense of belonging within the CLE. Nembhard and Edmondson go on to state that it "captures attempts by leaders to include others in discussions and decisions in which their voices and perspectives might otherwise be absent" (p. 947). Is this not a true sentiment behind caring student-educator relationships?

A contributing factor to PS is that students must perceive the educator as an advocate for student learning to improve the CLE (Edmondson et al., 2016, p. 78). This finding may remind readers of Noddings' (1984/2013) concept of reciprocity (p. 69). This reciprocity concept was illuminated by Pitkänen and team's (2018) study whereby the students that reported more positive relationships with their supervisors, as measured by one-on-one reflection time per week, were "brave enough to participate in discussions on the work unit" (p. 148). This finding

indicates that the presence of a caring student-educator relationship not only directly increased the student's confidence in the CLE, but improved their subsequent clinical performance.

Hägg-Martinell and colleagues (2014) had students comment indirectly in their study about PS, stating that the instances when they could ask questions and get a respectful reply increased their feelings of support from their supervisor in the CLE (p. 19). Similarly, Hearst McClintock's team (2022) reported that PS was increased by clinical educators when they responded productively to student's questions. Productive responses included acknowledging student input, giving constructive feedback, and emphasizing learning opportunities instead of blaming when mistakes were made or students did not know the answers to questions (p. 10). Responding to student's questions with patience and kindness as described above speaks to the educator's ability to create a caring relationship with their students. Students feel safe to express their questions and make mistakes while learning knowing that their caring educator prioritizes "work[ing] cooperatively with the student in his struggle towards competence in that world [with which she is in contact]" (Noddings, 2013, p. 178). Collaboration between student and educator therefore improves the student's overall learning experience.

Overall Learning Experiences

Effective and caring student-educator relationships have been discussed in the context of creating a positive learning environment, promoting inclusion and belonging, and increasing the student's perception of psychological safety. Taken together, these aforementioned concepts add up to creating a positive overall learning experience for healthcare students. This was corroborated by Pitkänen's team (2018), who reported that students who had a positive relationship with their supervisor reported better overall experiences of their clinical time and would recommend the program to others over students who reported a poorer relationship with their supervisor (p. 148). Though it is inevitable that students will encounter "both good and bad role models" (Hägg-Martinell et al., 2014, p. 20), it is clear that educators who cared to make

connections with their students resulted in increased positive learning outcomes for the students.

Summary of Literature and Connection to Patient Care

The previous sections discuss the overall concepts of the clinical learning environment, belongingness and inclusion, and psychological safety within the context of how each contributes to improving the quality of healthcare education. Though the literature was arranged and analyzed in separate sections, ideally by this point the reader has been able to grasp:

1) All of these concepts are interconnected.
2) Together, the concepts improve the quality of healthcare education.
3) The presence of caring student-educator relationships strengthen all concepts.

The final piece that will be discussed in this literature review section is included in order to situate the importance of the argument within the overall healthcare goal of increasing the quality of patient care. It has been established that creating caring student-educator relationships improves the CLE, the sense of belonging and inclusion, and the presence of PS. These concepts have also been linked to improved patient outcomes in the healthcare literature. For example, Nordquist's team (2019) conclude their study with:

> . . .further study and efforts to improve the CLE are critical to the learning, professional socialization and well-being of trainees as they learn and participate in patient care, and to the future quality of care they will deliver over decades of practice following graduation (p. 370)

The presence of PS has also been linked to overall positive performance outcomes in the healthcare arena, because if the culture is safe then team members are comfortable "speaking up. . .[and this] in turn can lead to improved patient safety (Aranzamendez et al., 2015, p. 172).

If the reader accepts the above points, then one can reasonably conclude that promoting caring student-educator relationships will not only improve healthcare

education, but will improve the overall quality of patient care. These conclusions will be explored further in the next chapter, where these research findings will be examined in terms of their practical applications in the real life healthcare education experiences of this author.

Chapter Three: Application

The previous chapter's Literature Review explored my argument that caring student-educator relationships will improve healthcare education through promoting inclusion and a sense of belonging. This leads to the creation of psychological safety (PS), which contributes to an overall positive clinical learning environment (CLE). In this chapter, I intend to relate the findings from the Literature Review to my real-life experiences as a Respiratory Therapist in the CLE from the viewpoint of a student, a preceptor, and a clinical educator. Through my examples of the caring and non-caring relationships that I experienced in the CLE in a variety of roles, I will strengthen my argument that caring relationships improve healthcare education and overall student experiences. The conclusion of this chapter will be an exploration into my new educator role at Thompson Rivers University (TRU) outside of the CLE. I will extrapolate my experiential transferable skills and connect them to the literature in order to explore how I may continue to encourage the creation of caring student-educator relationships in the CLE as well as at the university.

What is a Respiratory Therapist?

The Canadian Society of Respiratory Therapists (CSRT) states that Respiratory Therapists (RTs) are "important members of [healthcare] teams that provide care in hospitals, in clinics, in the community, and in people's homes" (Who are RTs?, para 1). For the purpose of this paper's argument, the practical setting that is meant by the term 'clinical learning environment' pertains to the hospital role of RTs, as this is the setting where the majority of student RT practical training takes place. Within hospitals, RTs provide care to patients of all ages, from newborns to elderly adults, who need respiratory support due to critical illness or injury; RTs are responsible for maintaining a patient's airway and breathing, providing various breathing treatments, and engaging in educational conversations with their patients regarding the management of their respiratory diseases (CSRT, Who are RTs?, para 2-4). RTs are an integral part of the healthcare team, and have played a vital role in the recent COVID-19

pandemic, highlighting a need for additional support and training for healthcare professionals other than doctors and nurses (CSRT, 2022, p.1-2).

With regards to doctors and nurses, the research that has been reviewed thus far throughout this paper has been gathered through studies of nursing students, medical students, and residents. As RTs make up only a small percentage of the healthcare team, and a minute percentage of researchers, finding literature pertaining strictly to RT specific education programs and relationships with their clinical educators was nearly impossible. The one relevant study found on the RT CLE reported similar findings to previous nursing studies (Alghamdi et al., 2019, p. 166). Though the practical training differs in terms of skills, competencies, and learning outcomes, all healthcare professions share the CLE and therefore share similar successes and barriers to effective education practices, such as building caring student-educator relationships. This will become evident as I connect my lived-experiences as an RT training and working in the CLE with the supporting literature.

My Experiences as a Student

The following section will examine excerpts from my own experience as a RT healthcare student. These experiences occurred between June 2013 - April 2014 across four clinical hospital sites on Vancouver Island and in the city of Vancouver. For character and academic reference, I was a mature student compared to many of my classmates at the time having already completed my Bachelor of Science[1], and graduated my didactic university classes with a GPA of 3.78 (Anesthesia got the better of me, hence why I do not work in the operating room!).

[1] This has changed in more recent years. Most students now have a previous Bachelor degree upon entry to the TRU RT program. This shifting demographic is important to note in terms of adult learning principles of taking into account the previous experiences of the current students that I will be teaching at the university. I definitely noticed a difference in the hospital over the past few years.

Role Description

The role of a RT student varies depending on individual preceptor and educator opinion. In general, RT students are expected to work three 12-hour shifts or five 8 hour shifts a week at their clinical site hospitals. They are under the direct supervision of a Registered RT preceptor for every shift as they rotate through different clinical care areas, most of which are critical care. The scheduling of rotations and assignment of daily preceptors is done by the Clinical Site Coordinator (in most hospitals). The amount of responsibility that is assigned to a RT student gradually increases throughout their clinical year, starting with one patient to take care of in tandem with their preceptor to taking on a full patient load independently by the end of the placement. The learning curve and professional growth of RT students is truly amazing during this year!

On top of their clinical shifts, students are expected to complete individual and group research projects, attend class days, seminars, and simulations, and study for cumulative exams. RT students are expected to be on time and come prepared for their shifts, having reviewed theory pertaining to the specific rotation they are assigned to that week. Some areas have site pre-readings and quizzes or assignments to complete prior to their shifts in specific rotations (intensive care unit, respiratory wards, cardiac care unit, etc.) to encourage baseline knowledge acquisition and review. The students are expected to participate in as much patient care as possible. They are given a notebook with guided reflections to fill out at the end of each shift as well as space to receive written feedback from their preceptors. These collections of reflections and feedback are used to gauge growth over time as well as whether the student is meeting the learning outcome criteria for formal evaluations twice per semester.

Challenges of the Clinical Learning Environment

As is evident from the above description, student life is busy. Added on top of the academic challenges are the CLE challenges. The preceptor model differs greatly from other healthcare disciplines and poses possibly the greatest challenge to students. Instead of being

matched with a specific preceptor for an extended period of time, the RT students work with a new preceptor everyday. Students reported that having too many supervisors can be difficult to navigate as it means building a new relationship and having to “demonstrate the same knowledge and skills again and again” (Hägg-Martinell et al., 2014, p. 20). I distinctly remember the disappointment, trepidation, or fear that I would sometimes feel after seeing my assignment for the day. Some staff members disliked having students, and acted annoyed or irritated at the prospect of having a student for the day, among displaying other behaviors previously described in Chapter Two as creating a psychologically unsafe learning environment (Hearst McClintock et al., 2022, p 12); I recall several mornings where I was not greeted or acknowledged by name by my preceptor, consistent with these authors’ findings amongst medical students.

Another challenge of the CLE in an RT education program is that the number of staff in a department is small. The hospitals I worked at represented both smaller departments - four to five RTs per shift - and larger departments - 15 to 20 RTs per shift. Consistent with the findings of Hearst McClintock and colleagues (2022), reputations of students and preceptors alike were often made on a first impression basis (p. 9, 14). Preceptors shared who were the stronger and weaker students, creating an environment of judgment and insecurity, and treated the students differently depending on what they had heard. For example, preceptors would often ask questions throughout the day based off of the pre-reading and quizzes that were mentioned above. The purpose of this questioning was meant to assess preparedness, although some preceptors utilized the opportunity to ‘rapid-fire test’ the student and establish the hierarchy of the CLE as discussed in the literature review section on ‘pimping.’ For the weaker students, this was a source of humiliation (Hoskinson & Beasley, 2019, p. 1078), and for the stronger students, it was a reminder of the existence of hegemony in the CLE (Kost & Chen, 2015, p. 21). Both cases illustrate an environment devoid of psychological safety (PS), as well as indifference to creating a caring student-educator relationship.

Why Caring Relationships Matter

While the above incidents may seem trivial to a reader, what is incredible is the amount of emotional baggage that I find still attached to those memories almost 10 years later. This proves that feelings of exclusion create powerful negative emotions (Beaumister & Leary, 1995, p. 505). Undoubtedly my student experience in the CLE was clouded by some instances of low psychological safety, all pertaining to the atmosphere that was created by my preceptor-of-the-day. However, what (sometimes) helped on the tough days was the relationship I had with my Clinical Site Coordinator (CSC).

I created six different student-educator relationships with CSCs throughout my clinical year[2]. I experienced both caring and non-caring relationships with the people in these roles. Retrospectively, I can now say that the distinguishing factor between the two types of relationships was the person's ability to create a psychologically safe environment. In the presence of some CSCs I felt comfortable enough to "ask for help, admit errors, and discuss problems" (Edmondson, 1999, p. 352) "or simply say, 'I don't know'" (Rosenbaum, 2019, p. 786), all interpersonal risks that are described as being a part of a high PS environment. With others, I felt the hierarchical culture of the hospital reflected in their pedagogical approaches. It seemed to me that they were more interested in maintaining their expert image through fear or intimidation, instead of projecting a caring personality that I could rely on to help make sense of a chaotic learning environment.

My Experiences as Clinical Site Coordinator (CSC) aka. Clinical Educator

I 'survived' my clinical year and made it to graduation despite the many challenges of the clinical learning environment, instances of poor psychological safety, and experiences of both inclusion and exclusion depending on the kind of relationship that was created with my preceptors and CSC. I carried forward the feelings of discomfort and intimidation I had

[2] This is an unusually high amount. Two of my hospitals had staff sharing the position and there was a change of personnel halfway through one of the semesters. The average RT student would have four CSCs throughout their clinical year.

experienced as a student into my own practice. The memory of these unpleasant feelings were what motivated me to care for my students and do my best to always create PS as a preceptor, and later as a CSC. I frequently engaged in behaviors that contributed to psychologically safe environments such as: created clear learning expectations, invited questions, and treated the students as equal participants in patient care (Hearst McClintock et al., 2022, p. 8).

Despite not having the terminology at the time, I identified in my practice the desire to embody Noddings' (1984/2013) concept of 'engrossment,' or seeing from the student's perspective in order to determine how to meet their needs (p. 66-67). It took me a couple of years to explore 'motivational displacement': to meet the student where they were at in order to help them achieve their goals, rather than project my own agenda (Noddings, p. 205). These concepts remained a work in progress as I transitioned from frontline therapist/preceptor to CSC, and indeed are still areas of my educating practice that I continue to develop.

The following sections will describe the CSC role and examine reflections on my professional practice as CSC from October 2017 to August 2021, when I commenced my current maternity leave. The hospital where I was employed was a large urban teaching center for all disciplines of healthcare students.

Role Description

The role of Clinical Site Coordinator is multifaceted. It combines the role of educator, manager, human resources, counselor, cheer-leader, performance evaluator, and conflict manager. The role is unique in that a CSC is an employee of the healthcare authority as well as a member of Thompson Rivers University faculty. This meant that I was obliged to report to two different managers regarding different aspects of the students educational experience. In the teaching hospital where I worked, I was responsible for two separate groups of 15-17 students for the duration of their clinical placements from the beginning of June to the end of the following April.

Typical duties of a CSC include: creating the students' rotation schedule; facilitating clinical orientation; indirectly supervising the students as they work with their individual preceptors each day; advocating for and creating educational experiences for students in the CLE; developing and delivering classroom-based and simulation-based education, written activities and assessments, and clinical seminars; ensuring that clinical learning outcomes are meeting national competency standards; working as part of a team to design and implement curriculum; formally evaluating students performance twice per semester; creating developmental plans to support student learning; resolving conflicts between students and their preceptors, RT staff, and interdisciplinary staff; and facilitating removal from the RT program in consultation with TRU if learning competencies are lacking or if there are incidents of patient safety.

Challenges of the Clinical Learning Environment

A large challenge of completing my role as CSC in the hospital where I worked was that the role is not fully understood by staff RTs. Many of the staff criticized my 'soft' approach to the students. They failed to recognize the importance of creating a psychologically safe environment in which to help the students learn, because the reality of acute care is that it is not always a psychologically safe workplace. I had numerous conversations with different staff members about my approach, justifying my actions, which is understandable in a leadership role to some extent. The difficulty lies in the fact that the CSC is a liaison between the university and the hospital, the students and the staff. The CSC is ultimately responsible for advocating for student learning while also balancing patient safety. Part of my Masters of Education journey that was so beneficial was gaining validation for my pedagogical approach and having literature to support my practice.

Another large challenge that I faced in the clinical learning environment as a CSC was creating a caring relationship while also providing formal feedback on whether learning objectives are being successfully met. It is a fine balance between delivering constructive

feedback and maintaining a caring approach. Noddings (1984/2013) addresses this in her chapter on moral education:

> For the one-caring as teacher, the sort of attributions that are made in evaluating raise difficulty. The teacher as one-caring and the student as cared-for both have difficulty in the matter of evaluation. *The teacher has no unusual difficulty in evaluating the student's work for the sake of the student and his progress* [italics added]. Problems that arise here arise everywhere in caring; they require appropriate thought, sensitivity, and open communication. The great difficulty is in grading, which is an intrusion upon the relationship between the one-caring and the cared-for (p. 193)

Noddings' overall message is that the evaluation of the student is not difficult, as assessment is part of maintaining a caring relationship and having open and honest conversations about the student's goals in their learning. This is corroborated in many studies that found a positive relationship between students receiving regular feedback and their overall satisfaction with their clinical experience and perceived caring student-educator relationships (for example, Hägg-Martinell et al., 2014, p. 20; Pitkänen et al., 2018, p. 146). The part that can be more detrimental to the caring relationship is the grading part, the determining of whether the student passes to graduate and become a practicing RT or whether they do not. This grading power is an additional barrier to overcome when creating caring student-educator relationships as it emphasizes, again, the hierarchy that is present in the healthcare and educational environments.

Why Caring Relationships Matter

I will provide an example from my practice as CSC to illustrate how building a caring student-educator relationship helped to overcome all of the CLE challenges that were described in the previous section. I received a student in December to complete their second-half of clinical training at my hospital. They were on a developmental plan indicating that they had not

yet fully achieved the learning competencies of the first semester with a time limit of six weeks to meet the outstanding objectives or they would be removed from the program. This is not an ideal situation, but it happens once in a while.

During orientation, a large portion of my time is spent having a one-on-one meet and greet with the students to get to know them a little better and determine their strengths and weaknesses so that we may work together to help them reach their clinical goals. This would meet criteria for Noddings' (1984/2013) concept of engrossment (p. 30). During the meeting with this student, it became evident that they were very anxious to have my support to complete their clinical objectives and have the developmental plan removed. As with all my incoming struggling students, I assured them that I "attribute the best possible motive consonant with reality to the cared-for" (Noddings, p. 193). Noddings would consider this conversation a form of 'confirmation,' wherein I "reveal to [them] an attainable image of [themselves] that is lovelier than that manifested in [their] present acts" (p. 193).

Over the next six weeks, working closely with the student, I did not share the same concerns about their clinical performance as my colleague had previously. I began to suspect that an uncaring relationship and lack of psychological safety were the bigger contributors to the student's perceived poor skill set rather than an actual deficit of skills. The student confided in me that they had experienced many behaviors from the former CSC that made them feel excluded and unwelcome in the clinical learning environment, such as pimping (Kost & Chen, 2015, p. 20) and indifference (Hearst McClintock, 2022, p. 12), and experiences of fear that they were not permitted to ask questions or make mistakes, both of which we have previously established are detrimental to PS in the CLE.

The reason that these behaviors were divulged to me is that the student was comparing their surprise at my overall educational pedagogy to the other person. I recognized in that moment that I had managed to create a caring student-educator relationship with the student and instill in them the sense of inclusion and connection that they had yet to feel in the clinical

environment, seven months into their eleven month practicum. This concept was humbling, as well as proof that a caring approach in healthcare education can make all the difference for students.

By building a caring student-educator relationship, I was able to overcome the challenges of criticism for my 'soft' approach not benefitting the students as psychological safety in the form of encouragement, advocacy, and confidence in their abilities was all that was needed for this student to flourish. Finding the balance between evaluating, providing feedback, and grading was also achieved through the relationship that was built. By providing well thought out, sensitively worded feedback and establishing open communication (Noddings, 1984/2013, p. 193), I was able to protect the caring relationship and have performance review meetings with the student that did not result in them trembling as they walked into my office.

This particular student went on not only to graduate, but to be employed at our hospital where they have grown into a very caring RT, great colleague, and supportive preceptor. I have experienced first hand how caring student-educator relationships can have lasting benefits for healthcare students and their future practice (Nordquist et al., 2019, p 370). I will now depart from the CLE that I know well and have many experiences of how caring relationships improve education, to an environment that remains unknown to my professional practice: the university.

My Future as an Assistant Professor

The final section of this chapter will be used to explore how I might be able to apply my knowledge from my past experiences in the CLE in the hospital to my new role as a university instructor in order to promote an ethic of caring for future healthcare students. I will briefly describe the role as I understand it now through conversations with my colleagues and personal observation. Following that, I will explore a few more of the barriers of creating caring student-educator relationships mentioned by clinical instructors in the literature in order to predict how I may be able to positively influence those barriers as a university instructor.

Role Description

In my role as university lecturer, I will be responsible for teaching undergraduate respiratory therapy students in a variety of settings including classroom, laboratory, and simulation settings. I will be responsible for ensuring that the curriculum covered in my lectures and labs is relevant and current, in keeping with best practice, and meeting the expected National Competency Framework guidelines (The National Alliance of Respiratory Therapy Regulatory Bodies, 2016). I will be creating and delivering formal written examinations and laboratory evaluations. In addition to my teaching obligations, I will participate in faculty initiatives, university committees, and service work to promote both the profession and the university. Hopefully, there will be future opportunities for research within the department.

What Will Caring Relationships Look Like at the University?

> *I do not need to establish a deep, lasting, time-consuming personal relationship with every student. What I must do is to be totally and non-selectively present to the student - to each student - as he addresses me. The time interval may be brief but the encounter is total* (Noddings, 1984/2013, p. 180).

One of the largest challenges that I foresee for myself with this transition of careers besides the complete change of environment, is creating caring relationships with classes of 80-100 students instead of 15. That is an incredible number of students to get to know compared to what I am used to! In reflecting on the above passage from Noddings' work, it brings me comfort and is likely to be a good reminder to myself as I begin working with larger amounts of students. Caring student-educator relationships are going to look different in my practice now, but it does not mean that they will be any less impactful.

My Sphere of Influence

I consider myself to now be in a privileged position wherein I may be able to elicit a more global (in terms of the clinical teaching sites associated with TRU) influence on promoting an ethic of caring in the clinical learning environment. When discussing the barriers of creating

student-educator relationships and creating a positive CLE, findings suggested that many clinicians were unaware of the university curriculum and this made them less confident teachers (Peadon et al., 2010, p. 649). As lack of time is already a great hurdle to relationships and teaching in general in the CLE, reviewing curriculum is not a high priority to clinical educators (Peadon et al., p. 649). This barrier may be removed somewhat by the university increasing communication of the desired learning outcomes and essential parts of, or changes to, the curriculum. In an ideal model, practice would be shared both ways, with clinicians suggesting changes to the school curriculum based on practice changes.

Many articles also mention the barrier of no formal educator training for healthcare professionals, yet teaching is an accepted part of their role (Kost & Chen, 2015, p. 20; McLean et al, 2008, p. 559). As such, several authors have suggested the development and implementation of training programs to highlight those teaching behaviors that can be used to create psychologically safe CLEs and build more caring relationships with their students (Bennet & Higgins, 2016, p. 47; Charnell et al., 2018, p. 1103; McLean et al., p. 560). If professionals were given confidence and some strategies to use along with their clinical knowledge and expertise (Charnell et al., p. 1103), this could contribute to better overall learning experiences and outcomes for future students as practitioners (McLean et al., p. 560).

In my role at Thompson Rivers University, I could be an advocate for training programs that focus on building caring student-educator relationships and promoting psychologically safe clinical learning environments to be implemented for the clinical teaching instructors at the various hospitals. It could be viewed as professional development and team building cross-site between the hospitals and TRU. A good time of year for the implementation of such training programs would be the month of May as this is the month when incoming clinical students are on their break and are absent from the hospitals. It could be a refresher for the type of environment that the program is hoping to create for the RT students, both at the university and in the clinical learning environment.

Chapter Summary

Throughout this chapter, I have illustrated that the benefits of caring student-educator relationships that were outlined in the Literature Review chapter are relevant to current healthcare education. It was my intention to emphasize to the reader the importance of building caring relationships, connecting, and creating psychological safety by providing examples from my own experiences as a student, preceptor, and educator within the clinical learning environment. I have then extrapolated from the literature how I may continue to promote caring relationship development in the CLE through my new role as a university instructor in the RT department at TRU. My capstone paper will conclude with a revisitation of my initial argument, followed by stating implications and recommendations for future practice based on the research presented, as well as make final connections between my Master of Education journey and the formation of caring student-educator relationships.

Chapter Four: Conclusion

This final chapter of my capstone paper will begin with a summary of my argument investigating how the prioritization of caring student-educator relationships within the clinical learning environment positively impacts healthcare education. Next, I will describe how my findings and research are situated within the larger context of the changing culture of the Canadian healthcare system. I will state the theoretical and practical implications of my findings, and utilize these ideas to make recommendations on how implementing an ethic of care might be achieved in healthcare education. I will conclude with a final reflection on my learning throughout my Masters of Education, and the effect that writing this capstone paper has had on my professional aspirations as I embark upon a new career path in adult education.

Summary of the Argument

In the previous three chapters, I have explored the beneficial impact that caring student-educator relationships have on creating a psychologically safe clinical learning environment and a sense of inclusion and belonging within healthcare education. Support for the argument of implementing a caring approach wherein “the student is infinitely more important than the subject” (Noddings, 1984/2013, p. 20) is well established in the literature. Not only do caring relationships impact the student’s overall learning experiences (Pitkänen et al., 2018, p. 148), but caring relationships lead to improved future practice and patient care (Nordquist et al., 2019, p. 370). Examples from my own practical experiences as a Respiratory Therapy student and a clinical educator have been utilized to add real-life application to the literature reviewed on the subject.

This paper has successfully advanced my argument by connecting literature from well known benefits to learning, such as a positive environment, inclusion and belonging, and psychological safety, to the less studied concept of how caring student-educator relationships influence each of these concepts. By identifying and analyzing a common underlying theme of various studies in healthcare education, not only have I managed to find support for my intuitive

pedagogical approach, but I have been able to situate the importance of a caring approach within the wider healthcare goal of improved patient care.

Considering the Larger Context

In terms of planning for the future, Iphofen (2000) declares that "organizations that exist to cultivate caring skills should practice caring themselves" (p. 91). As much as the General Medical Council report sparked changes for safety culture within medical education (Palmgren, 2016, p.14), there was also a call for organizational movements to improve the caring and safety culture within the healthcare organizations themselves in the past 20-30 years (O'Donovan et al., 2019, p. 871). Recent research on healthcare teams has focused on the formation of psychological safety (PS) within the healthcare system (O'Donovan et al.; Ito et al., 2022). Findings that leadership behaviors that promote building relational inclusiveness and trustworthiness (Aranzamendez et al., 2015, pp. 173-174) lead to psychologically safe environments where team members are comfortable asking questions and reporting errors (Ito et al., p. 471) mirror the previous discussion on the effects of PS in healthcare education. This corroboration illustrates that the concepts discussed in terms of creating caring student-educator relationships are the same values that are being studied within the larger realm of healthcare culture in general terms of creating staff-leadership or interdisciplinary relationships.

An additional parallel to the discussion on healthcare education is the finding that increasing psychological safety within healthcare teams can help "to overcome the inhibiting effects of the hierarchical health care system" (O'Donovan et al., 2019, p. 879). Creating a healthcare team that cultivates an environment of psychological safety is high on the priority list of healthcare leaders throughout the system, as it has been shown to improve patient care (Aranzamendez et al., 2015, p. 172), which is the ultimate goal of healthcare quality improvement initiatives. Implications for caring relationships that promote psychological safety

are therefore relevant to both healthcare education and the overall healthcare system, and will be discussed below.

Implications

It is fascinating that most of the studies report the benefits of a caring approach to healthcare education in terms of promoting psychological safety, inclusion, and a sense of belonging within the clinical learning environment, yet few have actually formally studied that particular concept. It is reported inadvertently as a result which I noticed by searching through my particular lens. Only one other article that I found in my literature review commented on Noddings' ethic of care in medical education from the perspective of how experiencing caring student-educator relationships could help the students learn to care for their patients (Balmer et al., 2016, p. 1619), but does not mention improved quality of the learning experience which has been my focus. This lack of existing literature leads me to believe that my previous professional experiences and learning throughout my Master's journey may have led me inadvertently to identifying a gap in the literature. Therefore, the theoretical implication of my research is that my argument could point to a direction for future studies within healthcare education research.

Through connecting caring student-educator relationships to improved learning, more confident future professionals, and increased quality of patient care, the findings of my research have the potential to have multiple practical implications within healthcare education. While I speak from the viewpoint of a Respiratory Therapist, most of the research in the field of healthcare education is conducted with nursing and medical students and residents. Therefore, the concept of adopting a caring approach will have interdisciplinary ramifications. Ideally, this will impact the professional development of a variety of healthcare educators, and thus have positive benefits for all disciplines of healthcare students who share the clinical learning environment.

Recommendations

Healthcare is all about evidence-based practice. If “healthcare professionals are committed to evidence-based practice in healthcare, they should be equally committed to drawing upon the evidence base in the management of health professional education” (Iphofen, 2000, p. 96). Based on the findings from the research done for this capstone paper, I propose that providing professional development opportunities for clinical educators to help them learn what best practice is in terms of teaching strategies. While barriers to continuing education such as time and financial constraints have been identified, the overall value to the clinical educator’s professional development of training programs is undeniable (Koskimäki et al., 2021, p. 675).

The goal of the proposed professional development would be to change the inherited culture of ineffective methods (Kost & Chen, 2015, p. 20). Short training courses have been developed for medical residents with the intention of “empower[ing] new doctors as teachers by providing some basic training in clinical teaching” (Charnell et al., 2018, p. 1). This could easily be translated into courses for all healthcare disciplines that utilize the traditional apprenticeship model. Part of these courses could be an introduction to the benefits of a caring approach to teaching, and how creating a caring student-educator relationship affects how the student learns in the clinical learning environment. Simple reflection exercises to illustrate positive and negative examples of psychological safety, inclusion and belonging from their own experiences as students or professionals (similar to my reflections in Chapter Three) may be useful reminders to clinical educators.

In addition to clinical educator professional development, further research on the benefits of an ethic of caring, specifically the effects of a caring student-educator relationship, should be conducted to add validation to the philosophical pedagogical approach. Within these recommendations, there may be room for increased collaboration between the university faculty and clinical faculty members to help promote a caring culture throughout all aspects of healthcare education.

The End of My Master of Education Journey

The intention of this capstone paper was to explore the literature pertaining to the pedagogical approach to caring that I have identified strongly with throughout my studies in the Master of Education program as well my professional practice as a clinical educator in the Respiratory Therapy program at Thompson Rivers University. Finding literature that supported my professional practice was an extremely liberating and validating part of my Master of Education journey. Throughout my past three years of graduate studies, I have begun to lean into the 'educator' part of my professional identity, something that I had previously struggled with for various reasons, some which had to do with the perception of choosing education as inferior to clinical practice. This professional identity crisis is apparently not uncommon amongst medical educators (van Lankveld, et al, 2017, p. 609-610).

By surrounding myself with like-minded educators, and becoming more confident in my own practice and values, I have begun to feel like I have found my place. I am thankful for the people I have met along the way that encouraged me to get to this point. I know that my acquired knowledge and skills that have been discussed throughout various parts of this capstone paper will serve me well in the coming years as I transition from teaching in the acute care environment of the hospital to teaching in the university setting. To echo Noddings (1984/2013) one last time, caring relationships are what matter (p. 161).

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