Mentoring student nurses and the educational use of self – A hermeneutic phenomenological study

Abstract

Background

In the United Kingdom, pre-registration nurse education relies on workplace mentors to support and assess practice learning. Despite research to clarify expectations and develop support structures, mentors nevertheless report being overwhelmed by the responsibility of mentoring alongside their clinical work. Understanding of their lived experience appears limited.

Objectives

The aim of the study was to achieve a deeper understanding of the lived experience of mentoring, searching for insights into how mentors can be better prepared and supported.

Design

The mentor lifeworld was explored utilizing a hermeneutic phenomenological methodology drawing on Heidegger.

Settings and Participants

Twelve mentors, who worked in a range of clinical settings in England were recruited via purposive and snowball sampling.

Method

Participants described their experiences of mentoring through in-depth interviews and event diaries which included 'rich pictures'. Analysis involved the application of four lifeworld existentials proposed by van Manen – temporality, spatiality, corporeality and relationality.

Findings

The essence of being a mentor was 'the educational use of self'. Temporality featured in the past self and moving with daily/work rhythms. Spatiality evoked issues of proximity and accountability and the inner and outer spaces of patients' bodies. Mentor corporeality revealed using the body for teaching, and mentors revealed their relationality in providing a 'good educational experience' and sustaining their 'educational selves'.

Conclusions

'The educational use of self' offers insight into the lived experience of mentors, and exposes the potentially hidden elements of mentoring experience, which can inform mentor preparation and support.

Key words

lifeworld; mentorship; nurse education; phenomenology; hermeneutics

1. Introduction

Mentorship can be defined as a unique reciprocal and asymmetrical learning partnership between individuals that involves support processes and which changes over time (Eby et al., 2007). Conceptually and practically, therefore, mentorship is open to diverse interpretations. In the context of this paper, 'mentorship' closely reflects the 'preceptorship model' of undergraduate nurse practice education identified by Budgen and Gamroth (2008) in which a student is assigned to a practice area for a defined period under the supervision of an experienced practitioner. Mentorship involves modelling nursing practice, selecting learning opportunities for students, articulating one's own practical and theoretical knowledge, and assessing students' competence in practice (Nursing and Midwifery Council, 2008). Implications for the United Kingdom and other nations adopting this 'preceptorship model' (within Europe, USA, Canada, and China, for example) are that pre-registration nurse

education relies on a finite supply of nurses sufficiently equipped to support and assess practice learning.

The pivotal position of mentors in nurse education internationally has implications for all stakeholders. In describing their roles, mentors emphasize including the student in their daily work (Őhrling and Hallberg, 2000) teaching clinical skills (Bray and Nettleton, 2007), giving verbal and written feedback (Clynes, 2008), and 'showing, telling, exploring' and 'acting as appropriate role-models' (Phillips et al., 2000: 41). Theoretical perspectives on workplace and practice-based learning that involve co-participation in or access to work practices (Billett, 2004, Eraut, 2006) and cognitive apprenticeship (Cope et al., 2000) can support understanding of the delicate interplay between mentor and student. Through cognitive apprenticeship, for example, mentors can facilitate a sequence of learning activity from engagement in simple tasks to increasing complexity (Collins, 2006). A key strategy in this process is to make professional thinking visible through questioning and reflective dialogue (Woolley and Jarvis, 2007).

Additionally, in assessing practice competence, Cassidy (2009) suggests that mentor reflexivity is critical for ensuring the validity of judgements. Although assessments need to include concrete evidence of professional values and behaviours (Fitzgerald et al., 2010), judgements about professional capability can also embrace mentors' personal impressions of students' enthusiasm, indifference or confidence (Shakespeare and Webb, 2008). Coupled with reports of a lack of mentor openness (Pearcey and Elliott, 2004), toxic mentors (Gray and Smith, 2000), 'failure to fail' (Rutkowski, 2007), exposure to overwhelming role demands, and lack of opportunity to update skills (Hurley and Snowden, 2008), the possibility of subjective judgements in assessment highlights the importance of appropriate recruitment, preparation and support for mentors.

In meeting the expectations and demands of the role, mentors therefore require sophisticated interpersonal and educational skills, although the literature also highlights

areas of weakness in mentoring practice. Despite the burgeoning literature, our understanding of what it actually means to be a mentor remains poorly developed. This paper extends understanding of the mentor experience.

2. Objectives

The aim of the study was to achieve a deeper understanding of the lived experience of mentoring, searching for insights into how mentors can be better prepared and supported.

3. Method

Hermeneutic phenomenology, a methodology that can both evoke and interpret lived experience (van Manen, 1997), was adopted to address the question of what it means to be a nurse who mentors students in practice. Central to this approach was Heidegger's (1962) view that people are self-interpreting entities, concernfully involved in the world by virtue of practices and equipment which they grasp as meaningful and intrinsically purposeful.

3.1 Participants

Twelve nurses working in southern England in a range of clinical settings from home nursing to intensive care, and who had mentored at least one student nurse, were recruited in 2008 by purposive (Ritchie et al., 2003) and snowball (Patton, 1990) sampling. Contact with potential participants occurred by email to mentors and by invitations for the researcher to attend mentor meetings, initially mediated through clinical placement facilitators in their organizations. Comprehensive information on the purpose of the study was supplied and invitation leaflets distributed to clinical areas. Participants were all female, and at various stages in their career, and represented a wide spectrum of both nursing and mentoring experience. Recruitment ceased at a point of data saturation.

3.2 Data gathering

Each mentor participated in one to three in-depth face-to-face interviews (n = 29) at a location convenient for them, and most supplied written diary accounts of mentoring-related events (n = 29). Overall, six 'rich pictures' (Checkland, 2000) of particular mentoring events were created. The extent of participation in interviews and diary keeping varied according to the timings of student allocations and practical constraints and preferences of the participants. Although an interview schedule was piloted, interviews were subsequently conducted in an open-ended format following an opening question 'What is it like for you being a mentor?' Pseudonyms were immediately assigned to each participant. The interviews, which were each between one and three hours long, were audio recorded and transcribed verbatim. Data were stored and organized electronically within NVivo 8.

3.3 Ethics and trustworthiness

Ethical approval for the study was granted by the sponsoring university, National Health Service research ethics committee, and the mentors' employing organizations. During the entire research process consideration was given to non-coercion, informed consent, and maintaining participant anonymity. Hermeneutic phenomenological research aims to represent the experience under investigation as close as possible to how it was encountered by the participant, while recognizing the interactions and overlapping horizons between researcher and participant. Therefore, trustworthiness was fostered through critical reflection (Kahn, 2000) and an open and transparent decision trail (Whitehead, 2004).

3.4 Analysis

Themes were determined through a gradual process of developing understanding through immersion in the data, and asking what each aspect could convey about the meaning of being a mentor. Initial first-order themes were discussed with participants for verification and clarification. The interpretive process also involved production of vocative texts (Nicol, 2008) and phenomenological descriptions (van Manen, 1997). The focus in this

paper is on the analysis of the essence of mentorship conducted by applying the lifeworld existentials 'temporality', 'spatiality', 'corporeality', 'relationality' (van Manen, 1997).

Temporality, or lived time, is experienced as a sense of time passing: a 'succession of presents' with a past and a future (Gibbs, 2009 p.115). In corporeality, a person experiences the world through the senses, movement, and through bodily awareness. The body mediates our communication in the world and, as embodied beings, we experience space in relation to our bodies, standing in a living, dynamic relationship with time, and we see others as embodied and lived others (Dahlberg et al., 2001, Heidegger, 1962). Spatiality refers to the experience and meaning of place and space, and relationality refers to the experience of lived relations (van Manen (1997).

4. Findings

Mentorship was an intensely personal and meaning-laden enterprise. The mentors described distinct styles of engagement – ways of being an educational agent that contributed to their sense of purpose and identity. 'The educational use of self' was an overarching theme representing the 'essence' of being a mentor, which is the focus of discussion in this paper.

4.1 The educational use of self

The 'educational use of self' reflected common desires of trying to '*make sure*' students learn, or to '*get them to understand'*. Mentors pursued these goals by organizing, being vigilant, leading by example, engaging students in activity, repetition, problem solving, and inspiring students in some way. They wanted students to '*stop and think what's going on'*, and to question why they were doing things. Despite the imperative to '*push*' students to learn, it was also clear that '*letting them have the freedom to go out there and think for themselves*' was equally important. Analysis is organized according to the four lifeworld existentials.

Mentor temporality

Mentor temporality showed in their orientation not only to facilitating learning, but also to the students as individuals. Mentors enlisted their past selves, especially in situations they perceived to be ambiguous, such as being unsure of a student's feelings. Such reminiscence provided quality checks and motivated mentors to produce empathic responses to students. In situations where it was difficult to grasp the most appropriate mentoring approach, mentors often drew on how they had felt as students:

> I sometimes feel that I don't necessarily know what the student expects of me. Having been a student not so long ago, […] maybe I feel ... I can relate how *I* would have expected a mentor to react. (Emma)

In a working day, mentors were enmeshed in the temporal rhythms and pace of the workplace and there was little time solely for mentoring. Work was structured around mealtimes, doctors' rounds, medicine rounds, shifts, day of the week, or appointment systems. Sometimes, participants successfully assimilated mentoring into the existing temporal frame:

> You're doing the drug round and I just – we go through the drugs that we're using, I ask – I check them first, I ask them if they know, I tell them to ask me if they come across something they don't know, we go through [pharmaceutical text] [...] when I'm doing an ECG on a patient they come with me and I show them how to do it, talk them through it [...]. We do it while we're working. (Anna)

By contrast, mentoring could also disrupt work rhythm and pace, and attempts to support learners within the normal flow of work could cause frustration:

> Drugs round here should be able to be done within, say, 20 minutes half an hour at the most. […] Of course when you're having to check everything every time, dates and everything, then *they're* having to check them and they don't know where to find them and they're having to pass them to you to make sure you've seen them as well, and they're taking a long time to find the stuff and then they don't know what it's for so they're having to look it up, it's so slow. (Angel)

Mentor spatiality

Mentor spatiality revealed the salience of the physical environment in mentoring and the patient's body itself as a mentoring space. The ward was an area of public performance, where mentors and students were exposed to the gaze of patients, the public, visiting staff and close colleagues, but nevertheless it was still the nurses' domain. By contrast, mentors working in community settings were guests in patient's homes. Spatiality also featured in considerations of distance, in the sense that the 'educational self' needed to maintain proximity to students in order to be an effective and accountable educator.

Maintaining proximity enabled mentors to account for their students' learning and practice through close supervision, although students could sometimes get too close:

> I had two students standing either side of me and then all of a sudden [...] I felt ever so claustrophobic, [...] She said Am I getting too close? [...] and then [...] I went to wash my hands and she put her hands in the sink while I was washing my hands and she just laughed and she said I've done it again haven't I! (Emma)

The ward environment offered a flexible space in which a mentor could keep inexperienced students close by, and allocate experienced students a contained area in which to work:

> I run all over the place doing various things – just follow me and see what I do, and I mean they do that initially and then from that if there's a job to be done, they can go off and do that, but I'll say as soon as you've finished that come back to me again […] if a student is more experienced [...] I encourage them to [...] look after the patients in the bay, and just come to me with anything that ... they are unsure about and that needs observing, and then go back in and just make sure that everything's done, because at the end of the day I'm personally accountable for the student. (Trudy)

A ward was a relatively confined space, in contrast with a neighbourhood. A home nurse's feelings of responsibility for her student's safety in public, outdoor spaces, led to efforts at mitigating any dangers the student might encounter:

> I gave her a carrier bag in the end that didn't look like a nurse's bag, it didn't feel so conspicuous and she put her coat on – […] you do worry about their safety. I'd hate

anybody to jump into her and say give me your bag, you've got syringes in there [...] She had [...] everybody's work mobile number, the surgery number and everybody's private number. (Flossie)

Both hospital ward and neighbourhood illustrate the interconnectedness of spatiality and accountability in mentoring and the mentors' efforts to reduce distance, either by physical means, or by facilitating telephone contact.

The physical space of patients' bodies formed an equally fundamental aspect of mentors' work. Detailed engagement with patients' bodies required mentors to work in confined spaces with students, frequently involving intimate areas. Moreover, visual representations, such as diagrams or anatomical models, were used by mentors to promote student understanding of the internal spaces of the body:

Draw a diagram. Here's a picture of your larynx, this is what you do with that, this is what you do with that. (Shrimpy)

Mentor corporeality

Being bodily in the world, mentors could use their bodies actively as a teaching tool by demonstrating and modelling practice, using body language such as hand gestures or facial expressions for deliberate communication and by using the voice. Talk during clinical work was essential for explaining practice or giving students procedural guidance. This level of supervision clearly requires the physical presence of a mentor as instructor alongside the student. Not only were voice and hands indispensible educational tools, but also mentors applied situational judgements for using their body to manage students' emotions:

I'll have my approachable face on so people can come and find me. (Lisa).

Mentors working alongside a student, sharing the work, engaging in conversation, modelling practice and explaining things, all had corporeal implications. Sometimes, exposure to a student's critical gaze, or a direct challenge, provoked anxiety about how their own practice was perceived:

You're also aware that they are watching *you* very closely (Angel)

It was also possible for corporeality to be so tacit that it was a challenge to articulate the habitual knowledge attached to embodied skills. In supporting a student's first attempt at inserting a urinary catheter, 'Romayne' revealed the importance of touch and dexterity for procedures breaching external body boundaries:

> At some points [I] physically assisted her, cos this was her very, very first attempt and at one point when we finally inserted the catheter it was probably both my hands and hers. (Romayne)

Arguably, the ultimate in 'the educational use of self' is offering up one's own body for a student to practise nursing skills as 'Shrimpy' reported, on an occasion when she collapsed at work and colleagues rallied to help:

> The doctors came to my aid, taking my pulse and asking for a blood sugar. I offered my finger, then I stated that the student nurse could take it. […] [I thought] "Oh, here's a learning opportunity for my student – she can take my blood glucose." (Shrimpy, event diary)

Mentor relationality

Relationality permeates discussions of temporality, spatiality and corporeality, where all the mentoring scenarios involved, in some way, lived relations with others. Mentors existed in a world of different roles that contributed to and helped to sustain the educational landscape. 'The educational use of self' appeared in supporting, teaching and assessment interactions with students, cooperating with and obtaining help from colleagues, and in protecting and respecting patients.

Inconsistencies across the wider network of collegial relationships had the potential to foster resentment, typically if a student had not learnt skills that were signed off by a previous mentor:

> Sometimes you get someone who comes along and the mentors, previous ones, just tick boxes […] not pick up something, problems. (Lisa)

The participants also worked in lived relation to a regular circle of contacts. A key aspect of relating to colleagues was in facilitating student exposure to specialist services, which would increase the breadth and depth of their learning:

> We have the dietician, we have colorectal nurses, people that link in, and these people add a valued experience to the student's learning and the students – I encourage the students to contact these people and arrange to meet up with them and may spend a half day of their placement time […] – I mean the pain team, they're fantastic. (Trudy)

In this way, the mentors held a pivotal position in helping and encouraging their students to make links with specialist nurses and other professionals. Colleagues from other disciplines and professions could also inform mentors about the progress and performance of a student.

The mentors relied on good two-way communication to maintain relationships with their students. Without a conversational flow, rapport was impossible and students could become difficult to fathom. Not only did it place the teaching dialogue in jeopardy but, crucially, it also rendered students unable to interact effectively with patients and colleagues:

> You just have to keep encouraging them. Like you say 'oh when you go into that house, ask them how they're feeling, ask them how that dressing's been, how's that wound feeling and just keep talking to the patient'. […] if you've got a shy student I think that's the most difficult thing, cos they don't get the rapport with you, they don't get the rapport with the patient and I don't think you're truly able, maybe, to assess them. (Gina)

At the other extreme, students who were constantly questioning and demanding attention were equally challenging. It could be mentally and physically draining to mentor a student for several weeks on a daily basis. Support networks at work or at home were important for mentors to sustain their 'educational selves', and the support of colleagues was highly valued:

> There is a big team that you can talk to, and if you get frustrated or annoyed we are conferring with each other and supporting each other an awful lot. (Angel)

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Colleagues in the higher education partner organization were also an essential, although sometimes low profile, source of support:

> I think when I first started mentoring I just didn't feel – even though the support was there I didn't always feel that it was, so it was probably me just paddling a canoe in circles. (Romayne)

Additionally, many mentors described how they focused on the needs of patients and their own lived relation to patients in order to sustain their mentoring drive. Ultimately, mentors sustained themselves through the rewards of seeing students learn:

> It's having the ability, the power, the ... oomph and the desire to be able to bring somebody on and to give them a bit of what you've got, to help them to develop their skills and turn somebody into a really good nurse. That's nice. (Shrimpy)

5. Discussion

'The educational use of self' encompassed mentor involvement in assessing learning needs and possibilities, facilitating student exposure to learning experiences, teaching, and assessing, and accounting for their mentoring practice. This discussion draws on the contribution made by the lifeworld analysis to deepen understanding of this essence of mentoring, and offer new insights into mentorship and workplace learning. The hermeneutic phenomenological methodology adopted offers a *possible* interpretation of lived experience rather than wholly generalisable findings, and the subsequent recommendations are made in acknowledgment of these limitations.

The functional and meaningful implications of existing in time, space, body, and relationships offered an insightful interpretational framework to the experiences of mentoring identified in this study. The lens of 'temporality' exposed a pervasive past self and the salience of the temporal flow of work in practice learning situations. 'Spatiality' showed environmental practicalities shaping mentoring strategies to maintain proximity to their students, and the meaning of place, which included the educational opportunity pertaining to a patient's body. The 'relationality' lens revealed the significance of mentor networks for both

direct educational purposes and personal support. The lens of corporeality embraced Merleau-Ponty's (1962 p.82) conceptualization of the lived body as our 'vehicle for being in the world'. As embodied beings, mentors used hands and voice for teaching and guiding students, seemed only occasionally conscious of their physical presence, and at times were aware of performing emotional labour (Hochschild, 1983).

Significant implications can be drawn from this exploration of the mentor experience. The study affirms previous work highlighting mentoring activities of teaching clinical skills, giving feedback, and including students in their work (Bray and Nettleton, 2007, Clynes, 2008, Őhrling and Hallberg, 2000). It also emphasizes the fundamental importance of dialogue in mentoring (Woolley and Jarvis, 2007). Additionally, this in-depth exploration of lived experience offers further explication of what it means to be a mentor.

'The educational use of self' implies that mentors are somehow tools in the business of educating student nurses, although in contrast to inanimate tools, mentors are subject to human issues including trust, guilt and exhaustion. (See 'Author and Co-author' (2011) for a discussion of the trust issues raised in this study's data.) Research that has identified problematic mentoring relationships from the student viewpoint (Gray and Smith, 2000, Pearcey and Elliott, 2004) promotes a common view that mentors are sometimes unwilling or unable to support students (RCN, 2006). This might partly be explained by the extraordinary, and perhaps unsustainable, effort that the 'willing' mentors in this study actually invested in the role. Moreover, professional use of self can give rise to unwelcome emotions (Ward, 2008), which perhaps demands greater recognition. Therefore, the recruitment and preparation processes for mentors ideally should include opportunities for candidates to reflect on mentorship in relation to their own experiences as learners and their aspirations as nurses.

The participants often compensated for extra demands both by working faster and working without breaks. They often stayed on after their shifts had ended to finish their work.

Studies indicating that nurses work extensive unpaid hours and forego breaks (Care Quality Commission, 2009; Santry, 2011) reinforce these mentor accounts, as do studies indicating that mentors are often unable to spend as much time as they would like with their students (for example, Murray and Williamson, 2009). The time constraints on mentors are well known, although it remains less clear whether time pressures are a factor in 'toxic' mentoring (Gray and Smith, 2000), and there may be other more important factors such as general disposition or aptitude for mentorship, which is now receiving critical attention in nursing (Robinson et al 2012). There is evidence to suggest that 'failure to fail' is linked to the time implications, as mentors whose time with their student is limited have reduced opportunities to assess their practice, and additionally this study concurs with literature identifying the considerable amount of extra time taken up with a student who is failing (Duffy, 2003;Rutkowski, 2007).

Mentors need to make sensitive and appropriate responses to individual students' needs, and this study indicates that these needs are best identified in the midst of practice. Therefore, students need to be aware of workplace interpersonal dynamics, and engage actively with their mentors and the practical work. This raises three issues relating to visibility. First, learning involves internal processes of willing, remembering, imagining, sensing, feeling, reasoning, and intuiting (Mulligan, 1993) as well as producing tangible outputs such as skill performance, reflective writing, or offering a rationale for one's practice (Stuart, 2007). It also requires personal transformations as part of a deeper learning journey (Daloz, 1999). It follows that a student needs to make their learning *efforts* visible to their mentor and reveal the *products* of learning for consideration and judgement. Both mentor and student require awareness and skills in managing this process.

Second, the mentors commonly aspired to be skilled in the management of emotions although they might reveal to students only their calm exterior. Scholars have previously claimed that student nurses should be taught emotional labour skills (Theodosius, 2008), although nurses might be unable to verbalize the emotional labour skills they actually employ

(Staden, 1998). Despite the challenges, mentor programmes should ideally promote awareness of emotional labour, enabling mentors to reveal to students their management of authentic feelings. This reflects processes of cognitive apprenticeship that make professional 'thinking' visible (Cope et al., 2000). Third, a key recommendation for consideration by higher education organizations is that their practice liaison staff who are extrinsic to mentors' everyday working relationships need to be visible and available.

Much of the work concerning corporeality in nursing draws attention mainly to understanding the lived body of patients (Lawler, 1997, Twigg et al., 2011). Consequently, this study offers an extra dimension to corporeality in nursing, by identifying the centrality of a mentor's lived body as part of the educational use of self. Conceptualizing the patient's body as a learning space also prompts formal recognition of, and reflection on, a patient's status in clinical mentoring activities. There is a need for further research in these areas.

A key message for employers is the importance of facilitating an atmosphere that values, inspires, and supports mentors. Employers are urged to support mentors to confide in colleagues by promoting psychological safety in teams (Edmondson, 1999), being openly supportive towards individuals, minimizing conflict, and nurturing potential and a 'sense of community' (Schaubroeck et al., 2011). Since opportunities for recovery and rest are vital and even short breaks in the working day can help people to recover these depleted resources (Trougakos et al., 2008), it is important to ensure mentors have sufficient opportunities to take breaks in a shift and obtain respite from mentoring in the longer term.

6. Conclusion

The educational use of self, the overarching essence of the mentor experience, has been illustrated through lenses of 'temporality', 'spatiality', 'corporeality' and 'relationality'. Mentors evoked their past selves in ambiguous situations, and the temporal frame of work had direct implications for how they could support learning. The 'educational self' needed to

maintain proximity to students in order to be effective and accountable, a mentor's body being instrumental in the educational process. Participating in a web of relationships, mentors existed in a world of roles that contributed to and helped to sustain the educational context. The findings raise awareness of the potentially hidden elements of experience, which can inform mentor and student preparation and support. Recognizing the limitations of the methodology, this study engages with qualitative approaches to facilitating good mentorship.

A nurse who is reluctant or ambivalent about mentorship might be unlikely to engage and invest at the personal level revealed in this study. There is a danger that standards of education and assessment cannot be maintained if mentors are seriously overstretched or if some mentors are only reluctantly engaged in the work. Future studies could focus on the time implications for mentorship and explore models of nurse education that allow mentors to work most productively with their students. There appears to be a growing imperative for higher education organizations and clinical services to consider how they can work together more effectively to support nurse education.

Acknowledgements

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