Doctor of Education

‘Caring in therapeutic radiography – an exploration of academic educator perceptions and experiences’

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"There can be no greater gift than that of giving one's time and energy to help others without expecting anything in return." **- Nelson Mandela**

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"If you find it in your heart to care for somebody else,
you will have succeeded." - Maya Angelou

Abstract

Caring is frequently espoused in healthcare. It is embedded in policy and professional codes of conduct. Since failings in healthcare were investigated and published in the Francis Report, a greater emphasis was placed upon educational providers to ensure caring was part of the curricula. This was to enable the graduation of caring practitioners.

Despite attempts to determine the notion of caring in the nursing and medical literature, it remains troublesome and nebulous. In therapeutic radiography there is a paucity of literature leaving the concept of caring mostly unexplored. This suggests a gap in knowledge. Without an understanding of the construct of caring in therapeutic radiography, it could be problematic for educators who must foster caring in students.

This study explored the perceptions and experiences of caring with academic therapeutic radiography educators and how these influenced their teaching practice. A descriptive, Husserlian phenomenological study was undertaken. This allowed bracketing, whereby the researcher's views of caring could be acknowledged and set aside. Semi-structured interviews were transcribed and the modified van Kaam approach utilised for data analysis.

Four themes were identified. 'Being Caring' related to the caring characteristics and moral virtue of therapeutic radiography educators. Experiences in the lives of participants were considered influential antecedents to 'Being Caring'. A further important antecedent influencing teaching practice was the previous clinical role.

A duality to caring emerged which included 'Caring For' and 'Caring About'. 'Caring For' was a task-oriented practical dimension of caring in both clinical and educational settings. 'Caring About' was perceived as emotive and feelings focussed. Prominent sub-themes were humanity, relationships and rapport, borne from 'knowing' patients and students enabling a 'connectedness' with them as individuals. 'Caring About' involved behaviours 'above and beyond' the essential perfunctory 'Caring For'.

The final theme of 'Caring in Pedagogy and Curriculum' involved implicit and explicit aspects. Explicit dimensions of teaching included compassion, empathy and person-centred holistic care. Experiential learning and related reflection were

considered opportunities for educators to model caring to students. However implicit role modelling was believed particularly influential in teaching practice. By ‘Caring About’, educators could nurture and enhance caring in students. This was related to the concept of a caring educator facilitating student-centred caring.

This research contributes to the knowledge base as the first UK study to explore caring with academic therapeutic radiography educators. Dimensions of ‘Caring For’ and ‘Caring About’ provide a framework through which teaching caring can be facilitated. It provides a new lens to caring in the specific academic setting which is important to teaching practice and the therapeutic radiography profession. Behaviours of the caring educator would enable academic therapeutic radiographers to reflect upon their own professional practice. Findings from this study can be used to better enable caring students entering the clinical setting as practitioners of the future.

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1.0. Introduction

This study aims explores academic educators' lived experiences and perceptions of caring in their teaching and clinical practice within the therapeutic radiography (TR) context. The following chapter provides an overview of the investigation. My personal motivation for conducting this study is included together with an outline of my professional setting. I will also introduce some key themes and concepts within the lexicon of caring. I shall describe the rationale for an investigation of caring, its timeliness and relevance within TR. The chapter concludes with a structural overview of the thesis.

1.1 Therapeutic Radiography – A Brief Overview and Emerging Tensions

1.1.1. Perplexing Tensions

In my role as a TR educator, I am responsible for cultivating the radiography workforce of the future through a curriculum to achieve professional and statutory requirements. Radiography education includes enabling students to develop essential technical and professional knowledge, but also the 'softer' skills held as core National Health Service (NHS) values. These values are described in the NHS Constitution (2015, p.5) and include the 'commitment to quality of care'.

As an educator, at the outset of this project in 2018, I began to critically review the TR curriculum to establish how we developed quality caring in our students. Caring was not a visible, discreet element within the curriculum, so I contemplated how that value was established. During clinical visiting, I questioned students on how caring, as a core value, was demonstrated within their practice. I became aware that, not only did definitions of caring contrast between individuals, but students' views on how caring might be enacted were also diverse. Pondering upon this inconsistency, I questioned if it would be significant when delivering the core value in practice. If indeed this was problematic, in what way could educators better develop caring attributes in student radiographers? These tensions remain at the time of writing this thesis.

Caring can be a difficult term to define, and no consensus has been reached upon its meaning (Morse *et al.,* 1990). When exploring the concept of caring, much is written from a nursing perspective which may arguably translate to any profession involving patients. There remains a paucity of literature directly related to caring in

TR, yet it is not a new subject. Ireland and Hansen (1978, p.240) stated that 'caring is the very essence of .... radiologic technology'. They suggest caring is essential to radiography but fail to define or give meaning to the concept. My concern is that if a notion is troublesome to define, educators might find it problematic to develop the concept in students. Indeed, this may, in part, explain why students demonstrated inconsistencies in their knowledge of caring and its enactment. My individual understanding of the notion of caring is likely framed by my professional experience (discussed later in the chapter), moral values and attributes as an individual which may all be of significance.

1.1.2. The Role of the Therapeutic Radiographer

To provide further context and to situate the problematic of this study, it is useful to explain, albeit briefly, the nature of the role of the therapeutic radiographer. The term 'Therapeutic Radiographer' is classified as a protected professional title by the Health and Care Professions Council (HCPC), whilst across the globe other titles may include radiation therapist, therapy radiographer or radiotherapist. The HCPC is an organisation that regulates, quality assures and accredits professional health and social care education programmes, set standards and registers professionals within the United Kingdom (UK) (HCPC, 2018).

The small, specialist allied health profession of TR is little known amongst both the public and other healthcare professionals (Meeking, 2018; Office for Students, 2018). There are approximately 3,550 full time equivalent therapeutic radiographers within the UK (College of Radiographers, 2022). Cancer incidence is rising globally, one in two people will be diagnosed during their lifetime (Ahmad, Ormiston-Smith and Sasieni, 2015). Of those individuals diagnosed with cancer, approximately 40% will be cured by radiotherapy (Baskar, Lee, Yeo and Yeoh, 2012), making this a small but essential profession. The prevalence of cancer in conjunction with the limited awareness of the TR profession, has prompted the Office for Students to develop the Strategic Interventions in Health Education Disciplines (SIHED) project. This seeks to raise awareness, increase demand for and understanding of higher education courses in small specialist allied health disciplines including TR (Office for Students, 2018). A key intervention from this project is the *'I see the difference'* campaign (Office for Students, 2022), which provides infographics on both the role of the therapeutic radiographer (TRa) and what is considered to make a 'good' TRa.

Caring features prominently in both aspects of the campaign. In defining the role of a TRa the phrase "…treats and '*cares'* for people with cancer…" is identified first (Office for Students, 2022). Explaining what makes a '*good'* radiographer, the first word used in the *'I see the difference'* materials is *'Caring'* (Office for Students, 2022). The use of caring and the qualities it may suggest to the public are powerful, thus situating the attribute as dominant in radiographers' role. The ascribed significance adds further to the perplexities, how might a profession espouse such importance to caring yet not identify what that means. In nursing, caring theory is prominent, driving practice, provision, decisions and all endeavours of the nurse (Dyess, Boykin and Rigg, 2010), whilst this appears to be less so in TR. It is timely to investigate and explore the notion of caring in the TR setting, to help bring clarity to practitioners, inform practice, person-centred-care, and support educators in providing curricula that helps students develop and deliver caring.

1.2. Therapeutic Radiography – Professional, Statutory and Education Context

In addition to the first characteristic of a 'good' TRa described by the *'I see the difference'* campaign, in the professional and statutory context *caring* is considered an essential attribute of practitioners. This is evidenced within both the regulating body HCPC Standards (HCPC, 2016) and the Radiographers' Professional Code of Conduct and Ethics (Society and College of Radiographers [SCoR], 2013a). However, neither provide a definition of caring specifically within the TR setting. The absence of a specific definition within the standards may well be intentional as there has been little exploration of caring within TR. Furthermore, caring can be considered a threshold concept and open to interpretation (Clouder, 2005), ergo troublesome to define. Threshold concepts are those that allow new ways of thinking (Clouder, 2005). Caring is such a concept as individuals, including students, would have their own intuitive, common-sense understanding of the notion but can reframe that conceptualisation through the lens of their professional practice. This opens a new view which may cause students to question, encounter doubt and consider their own fundamental understanding of caring through a professional context, described by Clouder (2005, p.506) as 'troublesome knowledge'. It may be particularly troublesome in TR as a full evidence-based understanding of caring is absent.

Few studies have explored caring in the TR setting. Bolderston, Lewis and Chai (2010) investigated radiation therapists' views of caring through a series of focus

groups. Three themes emerged – human connection, identity and technical care, where the concept of care was seen primarily as a supportive relationship with the patient. Participants disagreed about the technical aspects of the role and if that was also a part of caring (Bolderston, Lewis and Chai, 2010). This thesis will build upon the work by Bolderston, Lewis and Chai, by exploring educators' perceptions and adding to the current dearth of research, literature and knowledge.

Within the educational context a similar picture emerges to that from the professional and statutory perspective. The Educational and Career Framework for the Radiography Workforce (SCoR, 2013b) does not specify the intricacies of the pedagogy to develop the caring TRa. Furthermore, in TR, the evidence-based curriculum to foster the attribute of caring in students is possibly implicit or hidden (Gaufberg and Hodges, 2016) rather than an overt framework. Yet the Shape of Caring Review (Willis, 2015) places an expectation upon educational establishments to develop the caring workforce required by the NHS. Although the Shape of Caring Review focuses upon nursing education and professional practice, it translates well across other healthcare professions including TR. The report cites the 6 C's of Care, Compassion, Competence, Communication, Courage and Commitment (Willis, 2015, p.21) and demands all education establishments develop programmes to assure these attributes in students.

Possible debates and complexities around the nature, importance and meaning of caring in TR, and more broadly within the healthcare and education context will be explored in subsequent chapters of this thesis. Indeed, it is from such questions and uncertainties that the initial research topic has evolved. My own assumptions and views have undoubtedly framed the nature and scope of this enquiry, so it is appropriate to now situate myself reflexively and as a professional within the research study and the subject of caring.

1.3. Positioning Myself Within the Research

The focus of this research study has emerged from my own experiences, both personally and professionally, as a TRa and academic educator. My views, ideas and beliefs must be recognised throughout this research so that they may be examined, acknowledged, and reflexively considered (Reid *et al.,* 2018). The research theme, the framing of the research questions and my methodological

approach, emerge from my own history, experiences, and assumptions, some of which will now be explored in an autographical sense.

As a child of around twelve years old, I remember a Christmas present from my parents that sparked my awareness of TR. A book, aimed at children, entitled '*Hospital'* identified and explained all roles within the late 1970's UK healthcare setting. This was the first time I encountered the profession and the title TRa. I was interested in caring for people with cancer, my grandfather had died from the disease before my fifth birthday, but I remembered him fondly and resented his loss of life so early in mine. As a teenager I joined the Red Cross and although I was only part of the organisation for a couple of years, it further fuelled my focus on caring and wanting to help those in need.

My career aspirations did not waiver from radiography, except for a slight uncertainty when applying to schools[1] to begin training. My dilemma was in the choice of diagnostic or TR. At an interview for diagnostic, I was told I was much better suited to TR. This, and an offer at a school within a local hospital, solidified my decision to become a TRa. As a novice student and then qualified radiographer, I thrived on the contact with patients and relatives, my shy, quiet nature transformed into a competent, caring professional delivering patient-centred care.

My interest in the notion of *caring* arose from my clinical practice and then my later role as an academic educator. During my clinical career of over twenty years, I developed a strong interest in the caring aspects of my practice and that of my peers. As the landscape of healthcare policy focussed more upon targets, for example the introduction of maximum waiting times for cancer treatment (Department of Health[2] [DH], 2000), I realised that delivering patient-centred care became more challenging. I experienced tensions in my clinical leadership role around meeting targets for Trust performance and quality patient care in terms of timeliness. In my opinion, this was often at the expense of fundamental caring practice within every patient interaction. As a leader with an overarching view of service provision and the radiotherapy department staffing profile, I became perplexed with the levels of patient care I observed from some radiographers. Conversely, in my opinion, other individuals appeared to demonstrate caring for

[1] Prior to 1993 education was provided in schools of radiotherapy within hospitals rather than in universities
[2] This changed to the Department of Health & Social Care in 2018

patients at all stages. I was intrigued by the notion of caring, how it appeared in some of my peers yet not in others, but remained a strong, fundamental ethos of my practice.

As part of my Masters in Oncology Practice my focus on patient-centred care remained, becoming the topic of my dissertation. Here I was able to explore the support requirements of women with breast cancer who were receiving radiotherapy. This qualitative study highlighted some essential needs of participants through five main themes: *information, communication and support, dignity and individualised care, service accessibility* and *staff relationships* (Hendry, 2011). These themes influenced my clinical practice but also inform my current practice as an educator within an undergraduate TR programme.

In my current position as professional lead within a London Higher Education Institution, I am accountable for the programme and fulfilment of professional, statutory, and regulatory body requirements for educating student TRa. When in my previous role of course lead, I began to ponder further upon the nature of caring as an educator in addition to that in the clinical setting. How might the academic educators' experiences and perceptions of caring influence the students they teach and support. I contemplated my values as a TRa and educator, and how I learnt to care. Caring naturally became to focus of my Doctorate, through both the taught years and the topic of this thesis. As I drew upon my personal, clinical and professional knowledge and experiences, the research focus began to develop.

1.4. Developing the Research Focus

In exploring the word caring, I became aware of terms often used as a surrogate: compassion and empathy. These will be considered in detail within the literature review chapter. Empathetic and compassionate care are commonly used phrases in healthcare and education. The terms may be intertwined, have similarities and be part of our interpretation of 'caring' so for this reason each will now be defined in the healthcare context. Empathy originates from the term *Einfühlung* which is German for 'to feel one with' (Singer and Klimecki, 2014, p.1) and relates to an understanding or imagination of another person's feelings. The personalities involved resonate with each other when empathy exists (Post *et al.,* 2014). If empathy is considered 'feeling with...' compassion is 'feeling for…' involving warmth, concern, attention for the other, and including a strong motivation to help improve wellbeing (Singer and

Klimecki, 2014). Caring may include both these constructs; this study will consider the terms in the radiotherapy setting both of which will be further discussed in the forthcoming chapter.

Caring has been shown to be important and at the heart of healthcare, the NHS (DH, 2015; Willis, 2015; Francis, 2013) and professional TR practice (SCoR, 2013a; SCoR, 2013b; HCPC, 2016). As previously discussed, Ireland and Hansen consider 'caring is the very essence of .... radiologic technology' (1978, p.240), an essential part of practice. Few practitioners and patients would disagree with this ideal, yet within the professional TR context caring has not been fully explored, considered, and deconstructed to provide a detailed level of understanding. In contrast to this, within nursing numerous theories have been suggested to help develop and instil caring within clinical and educational practice (Fawcett, *et al.,* 2001). Although the complex nebulous nature of caring is acknowledged, frameworks and structures help students, nurses and educators to work towards skills, attributes and demonstrable caring factors or '*caritas processes'* (Watson, 2006, p.131). These are Watson's core conceptual aspects of human living and caring theory that serve as a guide or blueprint for professional practice. I considered if or how these '*caritas processes*' might translate to TR. It was bothersome to me, within nursing much was considered and written around caring, yet so little in my setting.

The perceived variation and possible lack of caring I witnessed could be explained by the absence of a similar guide or theory in TR. Students have reported to me the desire to be caring with patients, often the driver for entering the profession, but anecdotally, in practice this may differ to the views and expectations of some TRa. Not only might the absence of knowledge and theory around caring exist, but the problem may be compounded by the nature of caring itself. Caring is a personal construct influenced by personal experience, moral values and individual attributes. These issues are problematic to me as an educator, and potentially to the profession overall. Indeed, the 'troublesome knowledge' and 'threshold concept' of caring previously described by Clouder (2005) are challenging. There remains an absence of a suitable evidence base on which these questions, queries and the nebulous notion of caring may be answered, supported or refuted. Caring may indeed be revealed as a singular notion within TR or based on experiences and our own 'troublesome knowledge', may remain diverse and indefinable. The present problematic is that there is an absence of knowledge leaving concerns for me as a

radiographer and as an educator. Thus, it is appropriate to explore caring within TR to begin to unravel the multifaceted difficulties we may share as a profession and as educators. It should also be acknowledged that my concerns may well be unfounded, but as yet this remains unknown.

The aim of this research inquiry is to explore how academic TR educators construct caring through their lived experiences and individual perceptions. This study intends to provide an original contribution to the professional knowledge around caring in TR. In addition, it will illuminate the pedagogic practices of TR educators, and how they include or demonstrate caring to student radiographers within the academic setting.

1.4.1. The Nebulous Notion of Caring in the Literature

The notion of caring is acknowledged within the literature as difficult to define, particularly as it can be considered a personal, individualised construct (Brilowski and Wendler, 2005). Yet within the public domain and indeed the media, society appears to be aware when experiencing the absence of, or sub-optimal caring (Reader and Gillespie, 2013), which can be termed as *'noncaring'* (Reimen, 1986).

Returning to the TR setting and possible similarities with the nursing professions, although both include patient interactions radiotherapy has arguably a greater, more significant technology focus when delivering patients' treatment. Since 2000, there has been a radical increase in this technicality, so it is suggested the humanistic aspects including caring have become second place (Colyer, 2005; King's Fund, 2014, p.8). Thus, it is now opportune to explore the nature of caring, and how academic educators perceive the notion. In addition, this study may gather knowledge of the frameworks around teaching caring, be they implicit or explicit within the curriculum. Such original knowledge could better enable the development and enhancement of caring within student radiographers through the role of academic radiography educators and curriculum developers.

1.4.2. Some Preliminary Aspects from Policy

The NHS Constitution (DH, 2015, p5) has influenced practice in the UK over the past 7 years by describing the need for all healthcare practitioners to have a 'commitment to quality of care'. Every patient has the right to appropriate individualised care, compassion, dignity and respect, which is promoted within

professional codes such as the SCoR Code of Conduct and Ethics (2013b) as previously highlighted. All healthcare practitioners are required to meet the expectations of relevant professional codes. The onus lies upon educators, within both the academic and clinical settings working with students, to enable the development of such skills and attributes prior to registration. Furthermore, certain skills and attributes such as caring, remain an essential aspect of the self-regulated professional obligations TRa have as registered practitioners (HCPC, 2016).

Despite caring being at the forefront of policy and a key focus of professional practice (Dewar, 2013), recent high-profile reports have highlighted a greater need for 'care to be patient-centred, compassionate and well informed' (Willis, 2015, p.3). Although primarily focussed upon the nursing profession, the content of these reports is arguably of relevance to the multi-disciplinary healthcare teams responsible for all patient care. There are clear expectations upon Allied Health Professionals (AHPs) to demonstrate high levels of caring, as an underpinning principle of the NHS (DH, 2015). TRa are part of the wider healthcare team, being one of the fifteen AHPs registered in the UK, who '…make a significant contribution to the care of people affected by cancer' (HEE, 2019, p.5). Through appropriate knowledge, skills and behaviours, all AHPs should provide high quality care for people affected by cancer (HEE, 2019). These skills are highlighted within a range of competencies from Macmillan Cancer Support and include communication, building good relationships with patients, and the skills to '…provide safe, effective, high quality and accountable care for people affected by cancer.' (Macmillan Cancer Support, 2017, p.8). Although patient stories are shared, the concept of caring and the discrete elements that constitute caring during radiotherapy are not explained. So, it remains that despite the unequivocal need for caring in the healthcare setting, a universal understanding and definition of caring remains problematic and potentially unknown.

In their discursive literature review of caring, compassion and empathy in nursing, Richardson, Percy and Hughes (2015) established the debate surrounding the meaning of these humanistic values remains contentious. Producing a definition can be problematic due to the '...inter-relatedness and nebulous nature of concepts such as caring, compassion and empathy...' (Richardson, Percy and Hughes, 2015, p.2). Concepts such as caring may be troublesome to measure scientifically and establish universal agreement, however, they do propose that caring is frequently related to

patient-practitioner interactions and person-centeredness. This aligns with previously discussed HEE and NHS policy and suggests a role for the therapeutic relationship involving three components: partnership, intimacy, and reciprocity (Muetzel, 1988). These components will be discussed within the literature review chapters of the thesis.

Academic educators are expected to support students to meet the professional requirements of compassionate, caring practice with their patients. As this chapter has begun to highlight, many tensions and uncertainties surround the promotion of caring in the TR setting. These include the role of the academic educator and their experiences brought from the clinical professional setting, in addition to the influence these experiences and perceptions may have upon teaching practice. Thus, it would be important within this study to establish the lived experiences of educators and how these might influence their practice. The complexity of understanding and promoting caring to students might create tensions in academic education, to be negotiated by teachers with little, if any evidence-base upon which to inform their practice. This research will explore such tensions and uncertainties, adding to the evidence-base whilst providing an understanding of how these inform and shape teaching. Pedagogic practice around caring in TR may therefore be enhanced.

1.4.3. Study Aim

The overall aim of this study is to explore how academic TR educators construct caring through their lived experiences and individual perceptions. It is useful to acknowledge that an individual's view of caring would be multi-faceted, which will be explored in subsequent chapters. Within this study academic TR educators will be defined as qualified TRa who have specialised their practice within the university academic setting. Practice will be considered as the learning, teaching and support aspects of an academic educators' role in the university setting.

1.4.4. Research Question

What are academic educators' perceptions, lived experiences and conceptualisations of caring within the clinical and educational (university) settings?

1.4.5. Research Sub-questions

How do academic educators perceive the notion of caring in clinical and educational TR practice?

What are academic educators lived experiences of caring in the clinical and educational contexts?

How might academic educators' perceptions, experiences and conceptualisations of caring influence their practice in the education setting?

1.5. Thesis Structure

This thesis is structured in a conventional manner (Oliver, 2014) and includes the following main sections:

- Literature Review (chapter 2) - introduces the key concepts and main arguments regarding why this study is relevant and important.
- Methodology (chapter 3) - outlines the research approach used.
- Findings and Discussion (chapters 4 and 5) - present and find meaning from the data.
- Conclusions, Recommendations, and Implications for Practice (chapter 6) - provides an overall conclusion, summary of findings, the professional implications, recommendations and contribution to knowledge. Potential areas for further research will also be included. Reflections on my personal development with dissemination plans, will feature in Appendix 14.

1.6. Summary

This chapter has provided an outline of the research study and structure of the thesis. I have given an overview of the nature of TR in addition to my personal context that have informed and driven the subject under exploration, caring. Some initial consideration of the key phrases and terms related to caring have been shared, to set the scene for forthcoming chapters, beginning with a structured review of the literature.

2.0. Literature Review

2.1. Introduction

This chapter will discuss the term caring and consider its relevance to clinical and education practice. It will also identify why the concepts are relevant to this study exploring TR educators' experiences and perceptions of caring.

The chapter includes themes and concepts arising primarily from a structured search associated with caring and synonyms such as compassion and empathy. This also includes literature retrieved during the preliminary stages of the study, to inform decisions around the research questions in general. This iterative approach to literature exploration combined with a more purposeful approach will bring a range of useful publications to the debate whilst informing the overall nature of this study.

The literature review will add context and understanding to the complex nature of caring. There is a paucity of TR-specific literature regarding the concept of caring and how it may be fostered in the pre-registration education setting. Nonetheless, other areas of healthcare and related professional education may provide literature relevant to this study. Such literature will be discussed to support the exploration of caring when transferrable in whole, or part, to the TR setting. Related healthcare professional fields will be included, acknowledging that nursing and medicine appear to be more prominent. This may be because both are long-standing, traditional professions, whereas the Society of Radiographers was founded in 1920 (Price and Paterson, 2020). However, nursing and medicine may also be more dominant in the context of healthcare. Literature from these professions will be utilised with caution as the settings may include fundamental differences, though there could also be pertinent similarities.

The following areas of caring in healthcare, nursing and medicine, radiography, and TR are proposed as a lens through which the core literature might be explored. As previously mentioned, caring is a fundamental concept within healthcare, so an overview of the construct in the general healthcare setting would be useful to this study. The research questions posed centre upon the TR profession, so it follows one would seek to explore the notion of caring in radiography. Finally, the study will be situated within Higher Education, so caring through an educational lens will be

explored. Additionally, related concepts such as empathy and compassion, will also be considered. This structure intends to provide both a broad overview of caring, but also a focussed review in the TR and educational landscapes.

A brief historical perspective of caring will provide a foundation for a deeper exploration through the lenses already suggested.

2.1.1 Historical Perspectives of Caring

Caring can be considered a moral virtue that historically has been a core feature of healthcare and teaching practice (Nightingale, 1860; Aristotle, 2009). The seminal works of Nightingale and Aristotle, while in different settings, provide a valuable introduction to the virtue aspects of caring. Although Nightingale's work was within nursing, key philosophy can be related to radiotherapy. For Nightingale, the environment for interactions was important. Although the term 'patient-nurse relationship' was not used, the intimation was apparent. The nurturing, individualised patient-centred attributes of nurses were part of Nightingale's philosophy of nursing. Similarly, the Greek Philosopher Aristotle in his seminal works on Nicomachean Ethics, did not explicitly identify caring virtues within individuals, but his writings do propose attributes of a desire for the wellbeing of others beyond a mere goodwill (Aristotle, 2009). The ethics of caring are evident in his work and will feature later within this chapter.

Attributes of caring may exist in all individuals (Aristotle, 2009), formed and influenced by a variety of antecedents or pre-existing experiences, relationships, cultural and social aspects of life (Maben *et. al*., 2012). These will undoubtedly influence the perceptions of practitioners in the clinical and academic setting and may emerge from my study.

Policy aspects of caring have been considered within the Introduction. The chapter will now turn to the strategies used to search and filter literature, within the chosen lenses and related synonyms for caring.

2.2. Search Strategy - Themes and Concepts Related to Caring

An extensive literature search was conducted from September 2019 to September 2020 with generalised, broad searches related to the topic of caring untaken through Google Scholar. A search for caring was performed in December 2020. Regular searches were made after this to ensure any new, relevant publications were included. A total of 70 articles were included from the structured search, details can be found in Appendix 1.

Although this structured literature search forms the basis of the chapter, it has been accompanied by a general nonspecific search to ensure as much knowledge could be gathered around the construct of caring. From the literature searches, structured and unstructured, the following sections provide an exploration and critique of caring in healthcare, in diagnostic radiography, then in the cancer and TR domain. A final section will consider caring from an educational perspective.

2.3. Caring in Healthcare

The evidence base associated with caring is prolific from both the nursing and medical professions, perhaps due to the volume of practitioners in clinical and academic settings, but also due to their political and social standing in healthcare. Academic professionals are prevalent authors of publications relating to caring, possibly reflecting the universal troublesome need to identify and define the construct to best enable learning and teaching. Evidence is predominantly from the developed western world, although it is slowly emerging in South Africa and Asia. Authors are generally, although not exclusively, female. These personal and professional characteristics are important to consider when reviewing any assertions as they may influence the lens through which explorations of caring are made.

The construct of caring has not been clearly articulated in healthcare (Bridlowski and Wender, 2005), despite a strong focus within hospital mission and vision statements, professional codes, and statutory body requirements (Bolderston, Lewis and Chai, 2010). Attempting to understand the construct of caring can be problematic due to the vagueness and ambiguity surrounding its conceptualisation (Bridlowski and Wender, 2005).

A review of nursing literature by Paley (2001, p.189) acknowledged caring to be '...elusive, complex, ambiguous or vague...'. Paley (2001, p.189) reports that caring

is a nebulous concept diverse in nature which, '...nurses have constantly sought to retrieve... from its elusiveness...' to define. Paley argues that what is known about caring is mainly based upon 'knowledge of 'things said', a chain of association and resemblance which is constantly extended, constantly repeated' (Paley, 2001, p.196). Attempting to achieve the elusive knowledge and thus define caring, Paley (2001) proposes, may be unrelated to the concept itself. Rather the 'ways of knowing' caring are 'self-vitiating' (Paley, 2001, p.189). This means the endless list of attributes serves only to compound the complexity and elusiveness of caring. The lack of an empirical focus means nothing specific can be identified from the knowledge of 'things said' about caring. Furthermore, Paley (2001) suggests the absence of a true, measurable phenomenon means nothing can be contended when defining caring, and so scholars continue to add to the complex, endless list of attributes. It remains unclear if knowledge of caring could assist TR academic educators and students in understanding the value themselves. Nevertheless, caring exists and can be observed and experienced in context. The requirement remains for the professional value of caring to be developed, so exploring potential meaning in the unique academic setting may help to build professional knowledge.

Caring can be considered a basic human need (Maslow, 1970), a humanistic attribute that is essential in healthcare (Bolderston, Lewis and Chai, 2010). Policy situates caring at the heart of healthcare practice (DH, 2015; Dewar, 2013). Yet there is a perception that the technological aspects of healthcare may be in opposition to the humanistic, aspects of caring (Misch, 2002).

Within their seminal literature review of caring as a concept in nursing, Morse *et al.,* (1990, p.1) suggested 'knowledge development related to caring ...is limited by the lack of refinement of caring theory...' and the lack of definitions. Limited conceptualisations of caring may negatively influence the understanding of the concept (Morse *et al.,* 1990). This may be problematic in the TR setting as without knowledge of meaning, questions remain around how educators and students might perceive, teach, and learn the value of caring. My study could help address these difficulties, but a thorough exploration of the views suggested by Morse *et al*. could support knowledge of the concept of caring in TR.

Five epistemological perspectives were highlighted by Morse *et al.,* (1990): caring as a human trait, a moral imperative, an affect, an interpersonal interaction, and a

therapeutic intervention. These can be seen in Figure 1 and will now be explored in more detail.

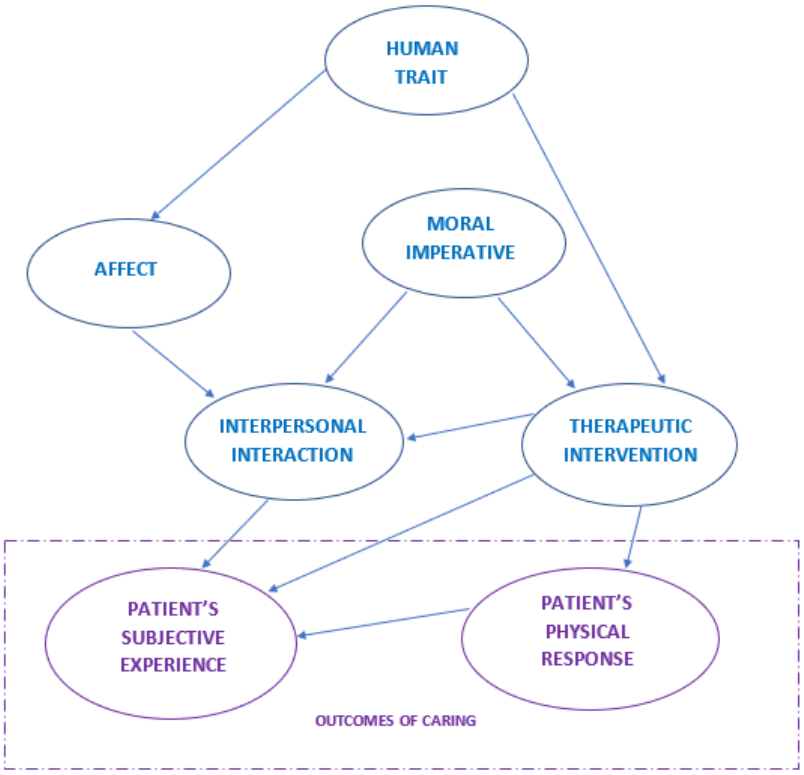

Figure 1 The Inter-Relationship of Five Perspectives of Caring (Adapted from Morse *et al.,* 1990, p3) Arrows denote proposed relationship of perspectives.

Through their literature review, Morse *et al*. (1990) proposed caring was an innate trait whereby all humans have a capacity for caring, although it was not uniform amongst individuals. Subsequently, Roach (2002, p.38) stated caring was the '…human mode of being…' and reflected this through six dimensions of professional caring. These focus primarily on nursing so will not be further debated. However, the attributes (compassion, competence, confidence, conscience, and commitment) are worthy of mention, hence I have summarised in Figure 2.

Attribute	Overview/Explanation

Compassion	'Awareness of one's relationship to all living creatures.' (Roach, 2002, p50) Participation in another's experience, being sensitively aware of their pain and providing a quality presence to share experiences. Compassion is a humanising attribute.
Competence	'The state of having the knowledge, judgement, skills, energy, experience and motivation required to respond adequately to the demands of one's professional responsibilities.' (Roach, 2002, p54). The combination of competence and compassion are essential, otherwise competence without compassion is '..brutal and inhumane..'. Compassionate competence is more than kindness but can be the victim of professional power and an individual's need to progress. Compassionate competence is a high level of '…emotional maturity.'
Confidence	'The quality that fosters trusting relationships.' (Roach, 2002, p56), without dependency, is truthful, respectful, and empowering.
Conscience	'The morally sensitive self, attuned to values' (Roach, 2002, p56). It is the sacred core of the person, their personality and integrity and relates to an authentic moral consciousness.
Commitment	'A complex, affective response...' (Roach, 2002, p62) bringing together obligation, desire, and a choice to act in line with them. Commitment extends beyond behavioural responses and becomes part of the identity of a professional caring practitioner. A commitment to care needs prioritising and an acknowledgement of limitations.
Comportment	'Bearing, demeanour, dress and language...' (Roach, 2002, p65) convey the professional caring comportment of the practitioner.

Figure 2. Roach's Caring - Human Mode of Being (Adapted from Roach, 2002)

A dimension proposed by Morse *et al.* (1990) was Moral Imperative. This was considered a fundamental value not manifested as behaviours, more a commitment to integrity and patient dignity. They proposed all actions would be underpinned by caring yet acknowledged this may prove difficult for practitioners due to tensions within practice around a possible lack of autonomy. Considering caring as an Affect, Morse *et al.* explained how caring is more than an emotional involvement with the patient and empathy for their experiences, involving selflessness, dedication, and motivation. They further explain this involvement is in response to an intimacy, attachment and attention arising from the patient-practitioner relationship which may suffer from technology demands, time pressures and a professional socialisation to 'not get involved'. The interaction aspects of caring proposed by Morse *et al.* include the Interpersonal Relationship which they consider may be the essence of caring. It is an expression of feelings and behaviours showing concern and offering support. The final dimension is the Therapeutic Interaction which includes specific actions such as attentive listening, advocacy and being there. These dimensions are intertwined and interrelated, providing physiological and psychological outcomes for patients. However, the setting is primarily nursing which

may influence findings, but it remains a useful overview and framework in which to situate further sections of this literature review.

Morse *et al.* (1990) also explain how caring is an emotion with humanistic motivation, present in all humans but maybe more so in caring professionals or possibly manifested differently in professionals. They also suggest how the interaction aspects of caring could enable learning and role modelling whilst the moral imperative dimension would suggest caring is constant regardless of the individual patient. This remains at odds with the individualised approach that is professed by person-centred caring. These aspects of caring proposed by Morse *et al.* will be explored in the following sections, beginning with centredness and how that could relate to caring.

2.3.1. How Might Person-Centred Care Relate to Caring?

Previous medical models of care[3] and a paternalistic view of health have been latterly replaced with a person or patient-centred approach. Policy and research now advocate patient-centred healthcare but despite its widespread use, the concepts involved receive little if any, consensus to meaning.

Caring and patient-centred care have been used as synonyms in many studies and articles. So, exploration of the concepts of person-centred care would be useful to this study. Eklund *et al.,* (2019) explain in their systematic review of person-centred care, a patient-centred approach requires a holistic understanding of the individual patient and their world. This includes knowing them as a unique human being before attempting to provide a diagnosis, investigation, or treatment as part of the healthcare process. The concept of 'centredness', of knowing the person behind the illness has an ethical perspective and sees the individual as active in their care and decision making (Hughes, Bamford and May, 2008). As such, person-centred care should include inherent humanistic values.

In their literature review, Eklund *et al.,* (2019) seek to determine if concepts of person-centred and patient-centred care are similar or different. Their thorough systematic review employed a clear, reproducible strategy to retrieve 21 articles

[3] Historically, models of care were medical, biomedical and then as evidence emerged, the biopsychosocial model was favoured as it enabled improved outcomes for patients and moved away from a paternalistic approach.

across a variety of professional settings and countries, including the UK. The authors do acknowledge, as with any interpretivist methodology using a thematic analysis, that several interpretations are possible. However, they engaged in a reflexive approach to raise awareness of preconceptions and made use of multiple researchers to minimise undue subjectivity. Nine themes were revealed as common to both person and patient-centred care. These included: empathy, respect, engagement, relationship, communication, shared decision-making, holistic focus, individualised focus, and co-ordinated care and are shown in Figure 3. These themes relate to those discussed by Morse *et al.,* (1990) and are useful concepts to be explored as constituents of caring, to be considered in due course. However, the aim of Eklund *et al*.'s paper was to determine differences and similarities between the concepts of patient- and person-centredness. They suggest that although the route to both concepts may differ, the meaning of person-centred, and patient-centred care are indeed similar. This may be contentious, and the meaning perhaps different. In person-centred care the goal is for a 'meaningful life' (Eklund *et al.,* 2019, p.8) whilst in patient-centred care it is for a 'functional life' (p.8), which I propose is an extension of the biomedical model. This possible tension may best be explored through an example such as empathy.

In patient-centred care, Eklund *et al.* suggest empathy means to '...infer the patients' specific feelings...' (2019, p.8) where their emotional state is recognised, and support is provided, delivering a functional outcome. Conversely, empathy within person-centred care looks '...beyond the person's specific feelings in the present moment to the life he or she is living.' (2019, p.8). This means not only understanding an individual's fears, joys and sadness at the present time, but also to see from the person's perspective their life's extension and structure. Unravelling these terms is important to my study on caring. If humanistic values, and individualised knowledge of a person are essential to caring, then moving from a 'patient' to a 'person' focus may best enable caring in the TR setting.

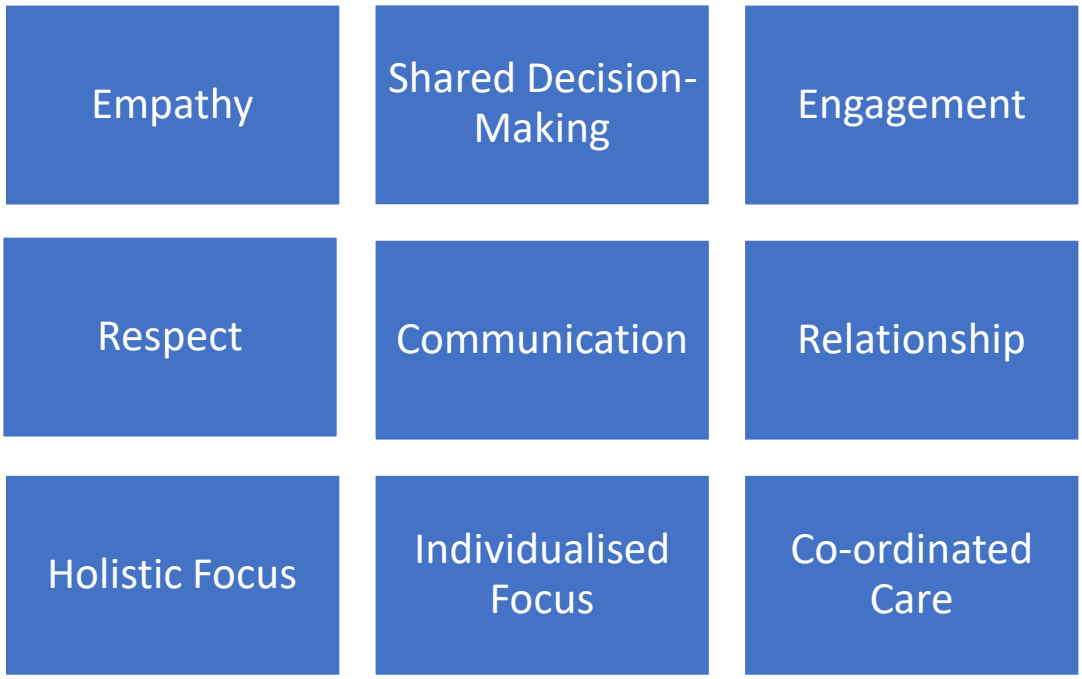

Figure 3 Nine Themes Common to Person-Centred and Patient-Centred Care (Adapted from Eklund *et al*., 2019, p7)

Similarly, Eklund *et al.,* (2019) explore the concept of communication and its diverse meaning. In the patient-centred care articles retrieved, communication is described as an unbiassed exchange of information enabling common ground for understanding and co-operation. Contrary to this, in person-centred care communication is emphasised to be the multifaceted approach with dialogue and narrative, to truly clarify what is important to the individual involved. This also features in the framework for person-centred care proposed by McCormack and McCance (2006) and relates to Values-Based Practice (Strudwick *et al.,* 2018). Here the importance or values of the individual direct the focus of any intervention and every interaction. In person-centred care, communication enables a picture of what is valued by the individual in their own life. Eklund *et al.,* (2019, p.9) describe communication as much more that decision-making, it is an '...integral part of the whole caring encounter.' This suggests caring and communication are intrinsically linked.

Although not exclusively within TR, the general aspects of person-centred care provide a conceptually interesting lens through which to consider this study of caring. Oncology departments and NHS Trusts frequently use person-centred care in vision and values statements. As such the phrase may be important to educators

from a pedagogic, employability and conceptual aspect and as such is essential to consider as part of this study on caring.

Other researchers have explored patient-centredness as it forms a guiding principle in healthcare, being considered ethical and good (Pluut, 2016; McGrath, Henderson and Holewa*,* 2006; Duggan *et al.,* 2006). Patient-centred caring can be deemed a fluffy, fuzzy concept (Bensing, 2000) as a globally agreed model or definition has not been established. Pluut conducted a discourse analysis based on 34 articles from a range of scientific and healthcare journals, to unravel the defining principles of patient-centredness. She revealed three main discourses, caring for patients, empowering patients and being responsive. Each will be considered, as they may bring useful evidence to the meaning of caring as a concept.

The 'caring for patients' discourse reported by Pluut (2016, p.504) relates to the need for 'holistic caring' for the patient as a whole person. This is similar in concept to that of the holistic focus determined by Eklund *et al.,* (2019). Pluut suggests the suffering and vulnerability of disease can be reduced and alleviated through the process of caring. Caring is constructed through patient-centeredness and the biopsychosocial model of health, so that caring is for the whole person not merely the parts. Seeing patients as individuals is part of that holistic caring process together with an understanding of the values held by that individual (Pluut, 2016). Values again comes to the fore when researchers unravel the meaning of these intertwined constructs, relating to the themes reported by Eklund *et al.* and Strudwick *et al.* Knowing the context, personal development, and life history, is part of knowing the individual and caring for them holistically (Pluut, 2016). Through this understanding, vulnerabilities can be alleviated but should not be assumed by the healthcare practitioners. Pluut (2016, p.505) further explains her findings that to 'emphasise the importance of therapeutic engagement between healthcare practitioners and patient' is indicative of caring discourse. Again, linking to work by Morse and Eklund, that relational aspects of caring are essential. However, this humanistic approach to caring, although patient-centred, aims to reduce vulnerability and suffering, which may suggest patients are passive recipients of caring, being subservient to the biomedical model of health. The humanistic discourse may be appropriate but not as a reaction to distress, more as a human-to-human relational approach.

The second discourse in Pluut's analysis critiques the need for patient-centredness to include patient empowerment. This aspect includes information-giving to facilitate choice and autonomy, concepts resonating with findings from Eklund *et al.* Empowerment as an aspect of patient-centredness is morally sound and essential for informed shared decision-making (Pluut, 2016). As healthcare practitioners, it is proposed that individuals must have a responsibility to be advisor, facilitator, and an expert resource of information for choice. This suggests caring should empower and enable individuals as actively involved rather than passive receivers of caring.

In her final discourse, Pluut (2016, p.505) describes 'being responsive' as an element of patient-centred care. Healthcare practitioners need to be responsive to the individual, their needs, and values such that their required levels of humanistic caring and empowerment can be met. Communication may be preferred by some patients to be paternalistic whilst others wish for greater involvement in care decisions. Thus, it is essential to recognise the needs of the individual, adapt and be responsive to them as healthcare professionals. For this to be successful, it suggests a relational process, sharing perspectives between patient and practitioner. Although these discourses can serve as principles for patient-centred care, this variation may indicate that one singular model may not meet everyone's needs.

Constructing patient-centredness as a process of caring involves a moral concept that cannot and should not be determined by a generic model (Pluut, 2016). Openness is required to explore what individuals' desire from caring, empowerment and responsiveness. There may not be a panacea in terms of caring. Although Pluut determines patient-centeredness to be a relationally constructed concept, she provides similar ideas to those by Eklund *et al.* around holism, empowerment, and communication. What may be interesting to note is that empathy and compassion did not feature in Pluut's analysis, which may indicate an over-reliance, conscious or not, of the biomedical model.

In contrast, Feo and Kitson (2016, p.3) define caring as '...attending to a person's physical and emotional needs, in addition to feelings of concern or empathy...' This links with a holistic view previously described but also acknowledges the importance of empathy, emotional concern and attachment. They explore a patient-centred approach to 'fundamental care', concerning basic care needs such as eating,

drinking and hygiene needs which they distinguish from the broader concept of caring. Nonetheless, they propose the essential elements of care encompass '...physical, psychological and relational aspects...' with an emphasis on '...holistic care and subjective experiences...' (Feo and Kitson, 2016, pp.4-5). Again, supporting the notion that caring is multifaceted, interpersonal, linked to the individual and their emotions.

Other authors have considered how patient-centredness relates to caring in healthcare. Holmström and Röing (2010) used a concept analysis approach to compare patient-centred care and patient empowerment. They concluded that the concepts complement each other, and that patient empowerment can be achieved by patient-centredness. In their exploration they define five distinct dimensions to patient-centred care worthy of consideration. One, the caregiver attends to the biological, psychological, and social aspects of the patient's health which aligns with findings from Eklund *et al.* However, Holmström and Röing only explore patient-centred care whilst Eklund *et al.* also considered person-centred care. The caregiver understands the personal meaning of illness to the patient, suggesting a personalised individual approach. Power and responsibility are shared, where the practitioner is sensitive to the information needs and decision-making of the patient, and that a shared relationship exists. Finally, the practitioner brings personal qualities, attributes and a subjectivity to the interactions which may be influential. These concepts align with those expressed by Pluut but similarly empathy and compassion are absent from the reported dimensions. There is an expectation of respect and awareness of each other in the relationship described by Holmström and Röing (2010). Empathy and compassion are not mentioned, which seems at odds with the relational aspects of patient-centred care. I question how practitioners can understand patients' values and beliefs and be an advocate for them if they are not demonstrating empathy and compassion. Possibly through an understanding and respect for the patient empathy is implied, however some deconstruction of the term would better enable consideration of that idea. Empathy and compassion are important aspects within the concept of caring, often being used as synonyms for the construct, so it would be appropriate to now explore each within the healthcare literature.

2.3.2. How Might Empathy Relate to Caring?

Empathy is a term often used within healthcare practice and policy, and for many professionals and practitioners it is an integral part of caring (Moudatsou *et al.,* 2020). The Code of Professional Conduct expects all radiographers to practice aligned to the '…values of respect, empowerment, empathy, trustworthiness, integrity and justice.' (SCoR, 2013b, p.1). It also describes an accountability '…at all times for quality compassionate care.' (2013b, p.2). The importance of empathy and compassion is established and as such will not be purposefully debated, but the meaning of these concepts would be useful to explore within the context of caring. The terms are often linked, related, and frequently used interchangeably (Moudatsou *et al.,* 2020), yet in contrast to caring, there is a greater consensus within the literature of both empathy and compassion.

In a recent review Moudatsou *et al.* (2020) explored the meaning and role of empathy within healthcare literature. They considered the concept relevant to all healthcare professionals and so their findings may usefully translate into the TR setting. Empathy was defined as '...the ability to understand and share other people's feelings' (Moudatsou *et al.,* 2020, p.2), facilitating the therapeutic relationship between patient and practitioner. This definition is shared by Buckman, Tulsky, and Rodin (2011, p.569) who define empathy as '...the ability to understand another's experience, to communicate and confirm that understanding with the other person and to then act in a helpful manner.' Both definitions suggest the healthcare practitioner attempts sharing the feelings and encounters of the patient to develop understanding and appreciation of their experiences. This enables a therapeutic relationship which was also suggested as part of person-centred care previously discussed. Definitions of empathy convey it to be a multidimensional concept with affective, cognitive, and behavioural aspects (Moudatsou *et al.,* 2020). Considering each of these dimensions in turn, the affective aspect of empathy relates to the emotions or feelings concepts and experiences, bringing a consensus of these sensations to the patient-practitioner interaction. This dimension links well with caring concepts as Moudatsou *et al*. (2020, p.2) consider caring to be '...the assistance and support as by-products of an emotional interaction'. It relates to an acceptance or congruence, an agreement between the patient and the practitioner, as an emotional response (Halpern, 2003).

The cognitive dimension relates to a sensitivity and understanding of the others perspective. This sensitivity requires a level of knowledge of that individual acquired

from both verbal and non-verbal means or cues. It may be this dimension of empathy that is familiar to many being described as ‘walking in their shoes’. The cognitive dimension may relate to caring and a developing shared relationship, with communication of emotions, experiences, and feelings.

The final behavioural dimension concerns the enactment of the therapeutic relationship, and of altruism and empathy in practice. Altruism relates to the behaviours of an individual in the best interest of the patient, not self-interest (Sajjad *et al.,* 2021). Altruism connects to the underpinning principles of professionalism and ethical practice, being explored later in this chapter. Returning to empathy and the therapeutic relationship, outcomes, satisfaction, and experience are increased when patients receive quality, empathetic caring (Howick *et al.,* 2018; Buckman, Tulsky, and Rodin, 2011). The therapeutic relationship and the empathy involved can be considered fundamental to caring as a combination of cognitive, emotional, and practical skills (Moudatsou *et al.,* 2020; Deligianni *et al.,* 2017). These essential, core components of caring are crucial to explore in this study of the lived experiences and perceptions of educators in TR. Not only from the aspect of revealing what caring means in this setting but also to better enable methods of teaching student radiographers learning about caring.

Although it may appear from the literature that empathy and caring are intrinsically linked, this may not be so. The emotional engagement, sharing of feelings and appreciation of the other that is empathy, could lead to mistaken assumptions and a false sense of security (Weiner and Auster, 2007). In their discussion paper, which lacks a clear methodology, method and literature retrieval process, Weiner and Auster claim that empathy in its original sense and meaning, may pose a ‘risk’ to patients. Their discussions should be treated with caution as they are based on opinion and experience alone and so may be subjective at best. Nevertheless, they bring an alternative view to empathy that is scarce within the published literature and so worthy of circumspect consideration. They propose the original use of empathy, ‘feeling into’ something or someone when considering art and the humanities, may be a danger when translated into the healthcare setting (Weiner and Auster, 2007). The ungrounded assumptions made under the guise of empathy could lead to error and compromised patient care in their view. They also suggest demonstrating empathy in patient interactions may actually preclude valuable questioning, particularly if the anticipated response of the patient may evoke

emotions the practitioner would prefer not to deal with. Their paper retells personal experiences when patient interactions were not successful (in their opinion). However, their decisions that failed encounters were due to empathic engagement is presumptive and subjective. The views of Weiner and Auster (2007) appear to be mainly personal rather than grounded in research and so should be considered with caution. However, Buckman, Tulsky, and Rodin, (2011) do acknowledge that there can be an avoidance of empathetic communication by physicians and oncologists, but this is slightly different to the ideas suggested by Weiner and Auster (2007). Buckman, Tulsky, and Rodin, (2011) report when patients expressed deep emotions such as 'I have nothing to look forward to …' their feelings and the opportunity for an empathetic encounter were not only overlooked, but oncologists chose to discuss less emotive aspects of the patient's medical care. This may mean not all individual practitioners have the capacity to be empathetic, may feel ill-prepared or out of their depth. The educational aspects of caring and empathy will be considered later in this chapter, but these may be areas that could better facilitate empathy for our patients (and students).

The multidimensional approach to empathy espoused by Moudatsou *et al.* (2020) better reflects the affective, cognitive, and behavioural aspect of the concept. It improves patient outcomes, although acknowledging empathy can be difficult to enact in practice. Self-esteem, work engagement, stress, emotions, and fatigue can be influencing factors against empathy in practice (Moudatsou *et al.,* 2020, p.5). Weiner and Auster do not entirely dismiss empathy, but interestingly they suggest it does not necessarily involve caring. These views will now be explored.

Empathy, unlike caring, is considered detached by Weiner and Auster (2007). They imply a practitioner may empathise, '*I feel your pain'*, but argue this empathetic response does not mean there is a motivation to help address that pain by the practitioner. Neither does this response suggest it is any more to help the patient, rather just a reaction due to discomfort experienced by the practitioner. In contrast to empathy, they suggest caring is '...a sustained emotional investment in an individual's wellbeing, characterised by the desire to take actions that will benefit that person.' (Weiner and Auster, 2007, p.126). The literature demonstrates that caring and empathy are intertwined, and one cannot have care without empathy. Nevertheless, an investigation exploring how TR educators conceptualise their integration is necessary and will be considered within this study.

Empathy is an integral part of healthcare and an aspect of caring directed by professional codes and policy. Empathy is linked to an understanding of feelings which enables a therapeutic relationship to develop between patient and practitioner. As a suggested component of caring, empathy itself is multifaceted with affective, cognitive, and behavioural aspects that facilitate an emotional interaction. It is this emotional interaction that intrinsically links empathy and compassion for many authors and practitioners. Thus, it is now appropriate to consider compassion and any relationship it may have with caring.

2.3.3. How Might Compassion and Caring Be Related?

Compassion may be the key to caring relationships (Haslam, 2015). In his debate article entitled 'More than Kindness', Haslam links compassion, caring and empathy with person-centred and quality care. Compassion involves certain attributes or characteristics such as '...empathy, sensitivity, kindness and warmth...' (Haslam, 2015, p.2) which he suggests are lacking in poor quality, impersonal 'task-based' care. He also describes how people wish for dignity, respect, and compassion, all of which are attributes that 'cost nothing'. Haslam (2015, p2) defines compassion as the '...humane quality of understanding suffering in others and wanting to do something about it.'. This shares commonality with previously discussed concepts of empathy and caring. All include cognitive understanding, sharing emotions and feelings, combined with an action or a response. Similarly, Fotaki, in her short editorial questioning links between compassion and good quality care, favours the definition of compassion proposed by Gilbert and Choden (2015, p.199) as the '…sensitivity to suffering in self and others with a commitment to try to alleviate and prevent it', the emotional response and subsequent actions are again evident in this definition. As Haslam (2015) also explains, compassion is closely linked to the 'therapeutic relationship' between patient and practitioner which concurs with suggestions from Fotaki. Both link compassion to the ethical aspects of caring, not only at individual levels but also at an organisational level. Ethics of caring will be explored later in this chapter as a potential influence upon compassion, empathy and thus caring.

Returning to Haslam's debate article, he suggests strong links between empathy and compassion result in quality caring. The empathetic response arises from knowing the patient as a 'real human' having built a relationship with them as an

individual. Haslam acknowledges how the pace of healthcare, the shifts and 'turnover' or throughput of patients can result in an implied lack of responsibility, less continuity, and thus non-existent personal relationships that he refers to as 'dehumanising' healthcare (Haslam, 2015, p.2). Arguably, from empathy comes compassion and Haslam (2015, p.2) describes how 'compassion often flows spontaneously from empathy – the ability to imagine another's experience'. To Haslam the answer to a lack of empathy, compassion and caring is to find out what matters to the patient, what is important, and what are their values. He further explains that 'humanising the individual will be the first step to empathy – the very opposite of the task-based care that risks getting in the way of empathy and compassion.' (Haslam, 2015, p.3). Relentless demands to meet targets, he suggests, may be the reason professionals become drained to respond with humanity, which should be retained, encouraged, and nurtured by compassionate leaders and teams.

Empathy and compassion appear to be closely intertwined, maybe the terms are indistinguishable and as integral components of person-centred care, to separate them could be fruitless. This study of radiographer educators may reveal the concepts to be separable and so better enable teaching of individual caring dimensions, but it might not be the case. The problem may be where would empathy end and compassion begin, in addition to a consideration of whether such concepts are indeed available to all practitioners.

The ability to exercise empathy and compassion in healthcare may often be considered a preference or virtue of the individual practitioner, not solely due to personal decisions to be empathetic. A broader, overarching consideration of the healthcare service and systems may be of influence. Kerasidou *et al.* (2021), in their discussion paper, propose empathetic compassionate healthcare is not solely reliant upon individuals' and their practice. The lack of time with patients, emphasis upon targets and high workload leads to an absence of '...empathy and compassion in the therapeutic encounter.' (Kerasidou *et al.,* 2021, p.2). Focussing upon individual deficits in empathy, compassion and caring, whilst building resilience and mindfulness of staff, may obscure the root cause which could be a lack of an empathetic, compassionate culture of concern within the healthcare system. Indeed, rewarding and promoting the task and target focus of health reinforces that belief, concentrating on the illness rather than holistic, empathetic relationships

which should be prioritised. Kerasidou *et al.,* also propose that if the virtues of empathy and compassion are not endorsed or supported by the healthcare environment, it becomes less likely for individuals to develop these qualities. The importance of culture and environment suggests a profound move towards holistic caring lying more, or equally with healthcare, education institutions and systems than individual practitioners alone. If virtues are acquired through habituation, the target-driven setting may stifle their development (Kerasidou *et al.,* 2021, p.2). In addition, the notion that empathy, compassion and caring rely solely with individuals remains questionable and that '…moral agents other than individuals; ….systems and institutions.' (Kerasidou *et al.,* 2021, p.3) have an essential role to play in delivering empathetic compassionate caring.

The institutional responsibility for caring, which encompasses empathy and compassion may be important within this study. In framing the research questions and methodology, exploring the lived experiences of 'good' and 'lacking' examples of caring in this study of TR educators could help explore these issues. Although the study may focus upon the individual practitioner, the wider institutional culture and ethics could be influential to their caring experiences and perceptions. The culture may be supporting or indeed contradicting the notion of caring.

Caring is a complex concept to define and deconstruct as previously discussed. General healthcare literature, policy and guidance use the terms caring, empathy and compassion interchangeably which arguably compounds the complexity of the concept. In this chapter literature has, so far, suggested that person-centredness and a holistic approach enables therapeutic relationships to develop between patient and practitioner. Through the ideas of emotional attachment empathy and compassion arise and can be enacted which may be interpreted as caring. At present these remain conceptualisations in the TR educational setting. This study will illuminate the aspects of caring yet to be determined by exploring lived experiences and perceptions of clinical radiographers, now professional educators. The study intends to clarify and explore relationships that might exist between person-centredness, empathy and compassion all suggested components of caring.

A further aspect of person-centred practice yet to be considered is that of dignity. With tasks and targets a focus for individuals and organisations, it brings into

question if there remains any opportunity to consider and explore the small details or 'little things' (Williams, Kinnear and Victor, 2016, p.787). These constitute another dimension of person-centred caring, that of dignity. The following section will now explore perspectives of authentic, dignified caring.

2.3.4. How Might Dignity Be Related to Caring?

As caring can be problematic and challenging to define, being considered complex and elusive (Pearcey, 2010), the same may be proposed for dignity. In a UK study by Williams, Kinnear and Victor (2016), the themes from participant interviews suggest dignity is an integral part of caring and delivering care. Participants comprised various professionals including Allied Health Professionals in both health and social care settings. They all worked with older people, which may be of influence considering study outcomes. However, cancer is predominantly a disease of older people so similarities may exist within the oncology and TR setting. Their study explores what constitutes good, dignified care and how it might be enacted. The findings link dignified care to 'good care as individualised, patient focussed care…humanistically provided through the presence of a caring relationship.' (Williams, Kinnear and Victor, 2016, p.783). This appears to align with previous discussions in this chapter, around person-centred care, the humanistic, individualised approach, and development of a therapeutic relationship. The exact influence of dignity may be unclear, as with empathy and compassion, these constituents of caring might be difficult to isolate and reveal as they could be fluid, nebulous and interconnected. However, two main themes emerged from the study of forty-eight participants' stories related to dignified care. That 'the little things' matter to patients and that staff must 'make poor care visible' to challenge and improve care (Williams, Kinnear and Victor, 2016, p.785).

Participants retold experiences of how the 'little things' could be thought of as the '...extra care and consideration shown to the patient...' (Williams, Kinnear and Victor, 2016, p.785) such as bringing chocolate to a dying patient because staff knew it was her favourite. The 'attention to detail' (p.785) was demonstrated by informing the patient they were leaving the room for a few minutes and checking if the patient was warm enough. Dignity and caring also meant introducing oneself and asking if the professional could enter the patient's room. In a similar way to the previous exploration of empathy and compassion in this chapter, a 'personal

element' and basic good manners were evidence of dignified caring whilst just '...a task being done...' (p.785) compromised dignified care. The 'little things' bring humanity to caring and the small, almost insignificant actions in busy departments can be the most meaningful to patients (Williams, Kinnear and Victor, 2016). The 'little things' could be summarised as those of great importance to patients which were demonstrated by 'personalised patient-centred care, empathy and attention to both patients' needs and their environment.' (Williams, Kinnear and Victor, 2016, p.786). Interestingly, national, or Trust-wide initiatives to improve dignified care, such as red dignity pegs[4] were not mentioned at all, suggesting a more personalised, individual approach has most meaning.

Williams, Kinnear and Victor (2016) suggested that rather than a purposeful, deliberate lack of caring, dignified care had become 'unnoticed' such that certain caring actions were now '…so engrained, task orientated and habitual...' (p.786) that they were virtually overlooked by staff. These included actions such as talking over the patient or carrying out care without explanation. Staff well established in that setting, over a long period of time, had '…simply stopped noticing' (p.786) poor or lacking dignified caring. Their second theme concerned making poor caring visible. A way to help minimise poor caring was best provided by peers rather than a management approach. Individual staff raising awareness of engrained and habitual behaviours at the 'grass roots' in a respectful and non-judgemental way would help improve dignified care. This might be via recorded film, conversations, and reflection. The study concludes with the outcome that the 'little things' are important, allowing staff to not only 'care for' but 'care about' patients. The 'little things' enable an intrinsic interlinking of these caring dimensions. The findings from their study may well translate into the clinical TR setting, but also potentially into the educational environment too. Williams, Kinnear and Victor, (2016, p.788) recommend not only drawing upon conceptualisation of caring and dignity, but also suggest sharing 'concrete aspects' of how to focus on the little things in practice could enable human, rather than task-focussed dignified caring. Within my study exploring TR educator perceptions, it will be essential to include questions around what this might mean in both the clinical and educational setting.

[4] Red dignity pegs were designed to be used on bed surround curtains when the bed was 'engaged'. The idea to improve patient dignity and privacy, began in 2012 and the pegs remain in use to date.

Treating people with dignity, in a human and person-centred way, allows choice. This returns us to the concepts of autonomy and ethics and how they may link to the notion of caring. The habitual tasks Williams, Kinnear and Victor, (2016) described as eroding dignified caring, may be more challenging in high technology healthcare environments (Lindberg *et al.,* 2018) and adversely impact advocacy, autonomy and ethics of caring, to which we now turn.

2.3.5. How Do Patient Advocacy, Autonomy and Ethics Relate to Caring?

Advocacy may link to the concepts of empathy and support but also involves an action which aligns more with compassion as previously discussed (Vitale *et al*., 2019). A recent concept analysis of patient advocacy by Abbasinia *et al.* in 2020 defined attributes of patient advocacy in nursing as safeguarding, apprising (information giving), valuing (enabling decision-making, individualisation and humanity), mediating and championing social justice. Although in the nursing domain, aspects of advocacy within this analysis may be useful to this study of caring in TR as parallels may be drawn between professional settings. Many attributes identified within advocacy are closely linked to those considered to be aspects of caring and so provide an interesting lens to consider within this study.

Effective patient advocacy can help to preserve values and autonomy of patients (Abbasinia *et al*., 2020) which links to empathy, centredness and individualisation in addition to other aspects of caring explored within this chapter. Patient advocacy is empowering for individual patients but also enhances practitioners' sense of satisfaction, motivation and self-concept (Abbasinia *et al.,* 2020). However within advocacy, tensions may be created depending upon the organisational culture which was explored by Kerasidou *et al.* (2021) and discussed earlier in this chapter. In the medical setting, Gerber, Mahoney and Gold (2017) developed a unit of teaching specifically to enable patient-physician communication and patient advocacy. Through patient videos, in-person lived experiences followed up with small group discussion. Students reported effectively knowing the patient perspective and developing advocacy skills from the module. Elements of advocacy included patient autonomy, empowerment and enabling of decision-making which are closely inter-twined and will now be explored.

Autonomy translates from the Greek to be 'self-rule' and as healthcare has moved from a biomedical to a more person-centred focus, autonomy has gained

importance (Lindberg *et al.,* 2018). Patient autonomy, alongside shared decision-making of treatment options, has been accepted to an extent. However, even in high technology areas of healthcare, of which TR is one, the move from passive recipient of care, to being a care partner has been a paradigm shift for patients and healthcare practitioners. Individual values and wishes being respected and enacted link with person-centred care and are arguably suggestive of 'self-rule' or autonomy. But as Lindberg *et al.* (2018) explain, autonomy also presumes a level of education, experience, discipline, and capacity, which for patients in a high technology setting may be paradoxical due to their vulnerability. Although the authors focus mainly upon the intensive care unit setting, there may be elements that transfer to TR as a high-technology environment with vulnerable people suffering with cancer. The purpose of the paper by Lindberg *et al.* (2018, p.4130) was to promote a conceptual development of patient autonomy, drawing upon three previous studies exploring autonomy from '…a patient perspective within a caring context'. The methodological approach was inductive, to fully explore the concept drawing upon previous research, empirical data, descriptive phenomenology, and concept analysis. This approach was rigorous and systematic so adding credence to their findings that will now be considered in greater depth.

Patient experiences, thoughts of autonomy and how healthcare practitioners can meet their needs were described through three main themes and provided a partnership of caring. These were 'being involved', 'being recognised by others', and 'avoid too much responsibility'. Patients wanted to be noticed, asked, listened to, shown respect, and given information (Lindberg *et al.,* 2018, p.4132). The authors further describe autonomy in terms of adapting, befriending, involving partnerships and relationships. These underpinning ideas also have featured in the exploration of empathy, compassion, dignity, and person-centred care. Each of these relational aspects as sub-concepts of caring, may help untangle what is known in healthcare, and consider what may be revealed in TR.

To enable dignified, person-centred caring, of which autonomy may be considered a part (Lindberg *et al.,* 2018), it could be argued that a culture of caring is required. Indeed, autonomy is one of the principles of ethical practice espoused within nursing, medicine, and radiography, so linking a culture of caring with health and care ethics. The ethical foundations and principles of healthcare is to do no harm, to actively do good with a person-centred holistic approach (Koskinen *et al.,* 2020;

Fry and Johnson, 2008; SCoR, 2013). Nyholm *et al.* (2018) suggest a sustainable model of healthcare can only exist if ethical values such as dignity and respect exist. Good, compassionate leadership and an engaged, educated workforce can create and sustain a culture of caring, of which ethics is a central part. In their hermeneutic study involving reflective dialogue, Nyholm *et al.* propose a model for ethical care and reveal five central values. These are: dignity, responsibility, respect, invitation, and vows. Some concepts or values have already been considered within this chapter, but each will now be explored through the model proposed by Nyholm *et al.* (2018).

In common with study findings from Williams, Kinnear and Victor, Nyholm *et al.* (2018, p.267) consider 'being there' for the patient essential for dignity avoiding feelings of '...powerlessness or despair', possibly supporting autonomy. Responsibility relates to previously discussed empathy and compassion whereby practitioners are '*seeing* the patient' (p.268) and are 'affected by the patient's suffering' (p.268). Although an individual responsibility is clear, there is also a collective responsibility and an 'ethical care culture', a common mission to do the best for patients.

Respect entails noticing patient values, taking their wishes into account, and treating them with 'tactfulness and consideration' (Nyholm *et al.,* 2018, p.268). Invitation relates to a 'welcoming atmosphere', openness, interest, availability, and engagement with the patient (p.268). Finally, vows were included in the model proposed by Nyholm *et al.* (2018). These may be unsaid vows of professionalism, and 'showing concern for the patient as a fellow human being' (p.268). Inclusion and participation in these values would enable an organisational caring culture. The fundamental ethos relies upon these ethical principles and so provides ethical patient care. These values must not only be at an individual level, but within the organisation too, supporting work by Kerasidou previously discussed.

The principles of dignity, responsibility, respect, invitation, and vows described by Nyholm *et al.* (2018) reflect autonomy and ethical practice and may transfer into the education setting. Exploring participants' views of caring in experiences, perceptions and practice may help reveal these principles espoused by Nyholm *et al.* Conversely, they may not be indicated within the education setting but remain important principles to explore. My methodological design and overarching study

approach are influenced by such principles, forming an integral part of my education and research practice. Principles underpinning dignified caring, and the related duty of care will be explored through questioning participants. Not only in terms of caring in the clinical setting but also how aspects may influence their current practice as educators. This will enable the essence of what caring may mean to TR educators to be fully explored, adding to the knowledge base, and providing a conceptualisation to enable effective learning and teaching of its constituent parts.

This chapter sub-section has begun to explore the notion of caring in the literature. Considered a nebulous construct, aspects of caring such as person-centredness, empathy, compassion and dignity have been explored. Caring may well remain an elusive concept, and that might be appropriate to an extent as it is constructed by the individual. However, useful principles, dimensions and possible synonyms have been explored in this review. The role of centredness has been established, be that from a person or patient focus. Underpinning virtues, values, and attributes such as empathy, compassion and dignity are suggested dimensions of caring. Autonomy and care ethics, from an individual and organisational perspective have also been shown to influence caring. The relational aspects of caring seem to be agreed within the literature. These and other dimensions of caring will be further deliberated as a focussed approach into the literature relating to caring in the nursing, medicine, diagnostic and TR settings.

2.4. Caring Concepts in Nursing and Medicine

Caring has been well established as a central aspect of the nursing profession and its practice (Scotto, 2003). Jean Watson's seminal work in 1979 almost initiated the interest in caring when she described nursing as the science of caring, identified through 'Carative Factors'. These may be considered as attributes, values, processes, and behaviours enabling caring. Watson deliberately choses the term 'Carative' to distinguish from the medical term 'curative'. Exploration of Watson's Theory is beyond the scope of this review. However, Figure 4 provides a short summary of the Carative Factors embedded within the nursing professions.

Caring is considered the 'essence of nursing' (Scotto, 2003, p.290) yet despite early work by Morse *et al.* (1990) and many other authors, a definition remains problematic and its nature obscure. Previous sections in this chapter have indicated specific terms related to caring, such as empathy and compassion, have an

affective component but also an action component. Scotto (2003, p.290) suggests, '…caring indicates nurses should feel something and do something'. This idea may well translate to any healthcare setting and is worthy of exploration in this study of caring through the lens of TR educators. Scotto shares the concerns that initiated this study, if caring cannot clearly be defined how might educators teach the concept, and related actions, to students. As previously established, despite the term caring being written into policy and professional codes a definition remains 'complex and elusive' (Paley, 2001). Through this study, it is anticipated that some clarity will be brought to caring in the TR setting, supporting knowledge in the clinical and educational domains of the profession.

The core of Scotto's discussion paper is to provide an alternative view of caring, suggesting it should be defined as 'offering of self' (Scotto, 2003, p.290). This means the individual caring attains the goal as a human being drawing upon 'intellectual, psychological, spiritual, and physical aspects (2003, p.290). In nursing, the goal can be self-agency of patients to enable their 'ability to do and decide for themselves' (2003, p.290). In TR this may transfer to a similar self-agency during treatment for cancer and in education with the possibility of self-agency for TR students. Through the proposed study of caring in the TR setting, such views held by Scotto may be supported or possibly contradicted. In her paper, it remains unclear how Scotto established her definition, the methodological approach is not stated so the view of caring may be personally created through her experiences. As caring may have personally constructed elements, borne from individualised practice and person-centredness, this may not be problematic if subjectivity and the possible absence of a suitable research methodology are acknowledged. The aspects of caring explained by Scotto may be valuable to this study and so will now be considered individually.

Carative Factor	Overview/Explanation
1. "The formation of a humanistic-altruistic system of values."	Humanistic values include kindness, empathy, and concern. Result of personal and professional beliefs and experiences. Altruistic behaviours and values, creating humanistic feelings and relationships.
2. "The instillation of faith-hope."	Patient beliefs are encouraged, honoured, and nurtured. Autonomy and empowerment.
3. "The cultivation of sensitivity to self and others."	To allow sensitivity of the self and others, to feel our feelings. Development of feelings and sensitivity in human relationship. Includes awareness of emotional states and compassionate life experiences. Links to emotional intelligence
4. "Development of a helping-trusting, human caring relation"	Connection and relationship that creates a unique bond and promotes dignity.
5. "The promotion and acceptance of the expression of positive and negative feelings."	Listen to and acknowledge other's feelings and emotions even if non-rational. Enables authentic caring.
6. "The systematic use of a creative problem-solving caring process"	Creative imagination as well as logic, technology, and professional knowledge. Can 'read a room' – intuitive almost.
7. "The promotion of transpersonal teaching-learning."	Explicitly, learning is more than information received. It involves a caring relationship as context for teaching and learning.
8. "The provision of the supportive, protective, and (or) corrective mental, physical, societal, and spiritual environment."	The evolved caring consciousness, presence, intentionality, of the professional are critical ingredients creating an environment that is high quality, with clean comfortable surroundings. As part of the environment the professional needs the presence, voice, touch, gestures, and heart to care.
9. "The assistance with the gratification of human needs."	Touching the patient involves more than physical touch but spiritual too. This is a privilege experienced by the professional. It is important for caring.
10. "The allowance for existential-phenomenological spiritual forces"	Phenomena and aspects of human experience That may not conform to conventional views and rational thinking. There may be spiritual meanings, cultural beliefs and areas that remain unknown but are part of one's subjective life

Figure 4 Summary of Watson's Carative Factors (Adapted from Watson, 2006. p131-132)

First turning to the Intellectual Aspect, meeting health needs requires ‘an acquired, specialised body of knowledge’ (Scotto, 2003, p.290) supported by clinical judgement, and linked to continuous professional development. The psychological need includes the ‘feelings, emotions and memories’ making up the human experience and encounter. Scotto raises the importance of nurses being aware of their own human experiences and how they have influenced them as individuals and professionals. The previous explorations of caring in this chapter have not yet raised the idea of self-awareness in this way. Scotto believes that a level of self-awareness is required to facilitate communication and allow for empathy, both aspects of caring established earlier in this chapter. The role of antecedents may provide important information to this study of caring in TR. Understanding participants lives, to a certain extent, and how caring manifests itself could influence views, experiences, and perceptions of caring. For me as an individual, my own experiences and antecedents have been profoundly important to my professional and personal life, and indeed this study.

Moving onto the Spiritual Aspect, Scotto relates this to making meaning of ‘why?’. In their own meaning, nurses can relate personal experiences to those of the patients they encounter. This aspect remains quite vague and abstract to me, whether all individuals ‘struggle with the search for meaning’ and how this might influence caring. Possibly it is in the understanding that many different answers may result from this one question and that nurses can facilitate and support the searching with their patients.

Finally, the physical aspect of caring Scotto describes as taking care of ‘their own bodies’ as much as being ‘skilful in nursing interventions’ (p.290). Bringing all aspects to an encounter with a patient, intellectual, psychological, spiritual, and physical, nurses show caring. These four human aspects create a framework through which nursing students can be taught caring and self-assess their practice. Transferring Scotto’s aspects to the TR setting potentially makes sense. Strong professional knowledge and critical reasoning skills exist alongside psychomotor skills which can enable good TR practice in meeting the patients’ needs which combined with an awareness of their own humanity, makes a caring professional. Scotto (2003, p.290) suggests definitions of caring as ‘an indescribable set of feeling and actions’ are not helpful to patients or professionals, nor do they facilitate teaching. This may be true but her preference for the four aspects of caring she

describes, could be inadequate at explaining the emotive concept of caring, and potentially contradict previous discussions in this chapter. These value emotions, relationships, empathy, and compassion.

In contrast to Scotto's deliberations, a discussion paper by Gelhaus in 2013 explains caring as not only an activity, but an attitude which is of moral value. This means, in delivering empathetic compassionate caring, the doctor has 'morally emotive' attitudes and 'tacit values' (Gelhaus, 2013, p.125). Attitudes may be considered part of our personality. Although Gelhaus writes from a physician viewpoint, she considers these attitudes and values to transcend professional boundaries as 'the whole health***care*** system is about care' (2013, p.125), with direct patient contact. This would translate to TR where patient contact is essential. Values and attributes are worthy of elaboration, and so I shall now attempt some clarity and definition to the terms and how they might apply in TR. Such terms include virtue, attitude, behaviours, and morals. The use of attributes such as honesty, compassion, respect, and trustworthiness (Branch, 2000b) may appear to be subjective caring behaviours, but could better enable education of students regarding these topics and thus caring.

Virtue can be considered a trait of character (core of an individual) that enables a goal of practice in a way that achieves excellence (Gelhaus, 2013, p126). This means that there is an emphasis on the agent, their habits, skills, and ideas as a person. Whilst caring behaviours (the way in which we act or conduct ourselves) are measurable using the Caring-Nurse-Patient Interaction Scale (CNPI Scale) based on Watson's carative factors which may enable a more tangible indication of caring, from the patients' viewpoint (Cossette *et al.,* 2007). Although not providing a philosophical exploration of caring, the four domains of the Scale relate to areas previously discussed: clinical, relational, humanistic, and comforting care or 'latent factors'. Other scales exist but often do not include clinical care which relates to the actions around patient diagnosis and treatment. The relational domain is like connectedness or human presence. Whilst comforting care has not been discussed in this chapter, it concerns support and attentiveness which have been mentioned. The humanistic domain reflects sensitivity and respect which may link to previous discussions around dignity. Interestingly there is no mention of empathy, kindness, or compassion, even within the comforting domain. Further behaviours checklists exist, for example Quirk *et al.,* (2008) created a list from a 'think aloud' focus group

including lay people which was then tested through scenarios. Although the study considered physician behaviours it was suitably thorough and based on patients' experiences and views, so is worthy of consideration in the TR field.

Thirteen caring behaviours emerged from the study by Quirk *et al.* (2008, p.263) represented by the acronym, **CARE** - **C**ommunicate effectively, **A**rrange to meet healthcare needs, **R**espectful and **E**mpathetic. The behaviours represented by **C**ommunicate effectively encompass elements previously discussed in this chapter relating to listening, using intuition, information giving and consistency in verbal and non-verbal behaviours. This was the theme with the largest content in their study. **A**rranging to meet healthcare needs includes acting with patient autonomy in mind and helping the patient to move forward with a flexible action plan. It also included going out of the way, working around, and bending rules to best take care of the patient's problem. The **R**espectful theme included the importance of 'knowing' the patient as an individual, 'connecting' with them whilst focussing on the problem. It also involves taking responsibility, especially if things go wrong or there are delays. The final them **E**mpathise involved carefully crafted empathetic statements that were appropriately measured in concern and timing.

An important idea emerging from the study by Quirk *et al.* (2008, p.364) is arguably that at a behavioural level, 'caring is in the eye of the beholder', although some agreement exists around the concepts. Also significant is that caring involves 'eliciting and understanding each patient's perspective' (p.364). The orientation towards the patient as part of caring can be intuitive, anticipatory, and reflective to meet the other's needs. They conclude their paper suggesting that rather than a set of behaviours or attitudes, caring involves a set of abilities that may be of most importance at an intuitive or unconscious level. However, there is no indication of how these abilities may be taught or learnt. It may be useful to explore more deeply, the concept of 'caring attitudes', what they mean, what they might be and how they could influence caring in TR.

Attitude, moral sensitivity, and motivation are aspects of caring explored by Branch, an American physician and prolific writer on the topic of caring. In his article on the ethics of caring, Branch (2000b) differentiates between moral sensitivity and the motivation of empathy and compassion. He considers empathy and compassion to be 'receptive' attitudes, the attitude of responsibility and putting these ethical

attributes into action, as caring. This means one might have the attitude and cognition to be empathetic and compassionate but only with an accompanying responsibility for ethics of caring are any actions resulting. These are the actions experienced by patients and potentially I would suggest, students in the education setting. This conceptualisation of caring is shared by that of Gelhaus, where caring is a benevolent attitude (good will) that accompanies a related activity. Caring has been suggested to be a relational notion, as previously discussed in this chapter, giving a link between people, implying a moral aspect which involves worry, concern and promoting a desire to nurture and help. So, caring can be considered to have two aspects, one of attitude which can be considered as caring about, another of activity that may relate to caring for. Attitude involves being attentive and well meaning, enabling the individual to grow whilst the activity involves attending to needs, to help, to console and to nurture.

Before moving to the specific settings of diagnostic and TR, it would be useful to summarise discussions from this section on specific literature from the nursing and medicine professions. Caring has been explored through terms such as centredness, empathy, dignity, and compassion in the earlier sections of this chapter. Some clarity has been made in distinguishing between compassion and caring through means of an action aspect to the nature of caring. Although both concepts require an engagement with feelings and emotions, caring moves beyond that to have an associated 'call to action'. The ability or desire to be caring may be borne from personal character, attributes, virtues, and behaviours which can be influenced by morals, ethics, and antecedents such as one's upbringing. The notion of caring for and about have been considered. Through duty and professional practice, *caring for* the patient may be undertaken on a practical level, yet 'giving of the self' is required to enable *caring about*, this suggests caring attributes, virtues, character, and behaviours. The nature of caring is revealing itself as the chapter progresses, so it would now be appropriate to explore what is written specifically in the domain of radiography, in the sister professional of diagnostic radiography before finally turning to the focus of this study, the setting of TR.

2.5. Caring in Diagnostic and Therapeutic Radiography

Considering the specific literature relating to the diagnostic and TR professions, there are multiple publications in the diagnostic setting which may be related to the

larger volume of patients, higher numbers of staff, or the more transient nature of the patient encounter. Conversely, TR is thought to have more opportunity to build relationships with patients as they are encountered multiple times. However as patient numbers and TR technology has increased, caring may become more challenging. This concern was reported by the researcher's students and acted as a catalyst for this study. It must be acknowledged at this stage much remains the opinion of the researcher. There is a gap in knowledge as so little empirical evidence exists within TR. Recent research has predominantly concentrated upon technical aspects of treatment and TR imaging. With caring, a subject very close to my individual practice, my preconceived notions could overly influence the study and so the important of reflexivity is paramount. For these reasons, purposeful searches of the Radiography Journal and the Journal of Radiotherapy in Practice were undertaken to inform this chapter and the overall research study.

Diagnostic and TR both have a high technology environment. The size of the diagnostic profession far exceeds that of TR. Numerous universities in the UK provide undergraduate education for diagnostic radiography. In addition, diagnostic imaging of at least one modality is offered in almost every healthcare setting. For TR few universities offer an education programme, but some academic settings do include diagnostic and therapeutic teaching teams providing shared teaching and learning opportunities. Thus, many studies in the diagnostic setting may be helpful to this research situated in TR.

2.5.1. How are Compassion, Connection and Communication Reported in Diagnostic Radiography?

Having previously explored compassion in the general healthcare setting it would be useful to consider what is known in diagnostic radiography. It is of interest to note that the articles retrieved for this study relating to compassion, were by three main authors in academic settings. This may indicate their research area but could also provide a rather subjective view which is important to consider when reviewing the content.

In their concept analysis Taylor *et al.,* (2017) intended to define compassion reviewing over 200 articles. They conclude that compassion is a complex term which is subjective, is displayed by healthcare professionals and perceived by patients. Although the publication does not relate to radiography alone, the authors

are radiographers and introduce the importance of compassion through a radiography lens. The authors propose compassion is defined by five attributes, which in a concept analysis specifically means 'characteristics of the concept identified repeatedly in the literature.' (Taylor *et al.,* 2017, p.351). This meaning of attributes is slightly different to that discussed in the previous section, and the measurement of the concept occurrence is noted through empirical referents.

The five attributes identified were recognition, connection, altruistic desire, humanistic response, and action. Each term will be considered briefly to add to the context specific understanding of the term compassion. Similarities with subjects including caring, previously discussed in this chapter, do emerge which could be significant to my study. Areas of alignment include verbal and non-verbal displays of compassion and professional practice. Taylor *et al.* (2017, p.355) describe recognition as an attribute of compassion, related to the cognitive awareness of another's 'adverse circumstances, physical, psychological or emotional wellbeing'. This concept aligns with the cognitive understanding Haslan (2015) espouses in respect to compassion and empathy. Other attributes, also previously considered and arguably self-explanatory, included a personal 'connection' with another based upon thoughts, an 'altruistic desire' to help and a 'humanistic response' or understanding of being human. These result in an 'action', a responsive behaviour by the practitioner, an act. For these reasons I would suggest Taylor *et al.,* have moved beyond a discussion and exploration of compassion into that of caring where an action is almost essential as explained by Gelhaus (2013).

The consequences of compassion for patients were positive and included a 'feeling of being cared for...' (Taylor *et al.,* 2017, p.357). The closeness of compassion and caring are evidenced in this study, yet as previously highlighted caring has an action, whilst compassion does not necessarily include 'activity' in the same way. I wonder if unravelling compassion from caring serves a purpose and is 'caring about' patients and students even feasible if compassion is not present. It might be why the term compassionate caring is utilised. My current study may help further reveal the complexities and relationship of these intertwined terms.

The relationship discussed in Taylor *et al.*'s concept analysis is also considered by Bleiker *et al.* (2018) in their qualitative study involving 34 interviews with people undergoing diagnostic imaging. Patients wanted to feel cared for during their

examination even if they did not openly disclose their emotions of anxiety and vulnerability. This is suggestive of the intuitive behaviours of practitioners, also sensing the person's needs and emotions which was proposed by Quirk *et al.,* (2008), albeit in a different setting. Patients experienced being 'cared for' through empathy, kindness, awareness and listening by the radiographer. Communication was also a key feature of compassionate caring. Bleiker *et al.,* (2018, p.S31) claim to reach 'saturation' which is interesting terminology as their study explores individuals' experiences. Individually constructed ideas of compassion and caring are just that, individual and although common themes emerge the individualistic aspects of the concepts should not be overlooked. Might the authors be viewing this through a positivist lens, suggesting they are overly reliant upon the biomedical model of health rather than the person-centredness of caring and compassion.

The same lead author previously explored compassionate care in radiography through the literature (Bleiker *et al.,* 2016). They define compassion as involving '...awareness and feelings of discomfort around another's suffering together with a desire to act in order to relieve it...related to terms such as kindness, altruism and nurturance' (Bleiker *et al.,* 2016, p.258). They use the terms compassion and compassionate care interchangeably which may support the action-oriented aspect of care in addition to the emotional aspects related to compassion. They also acknowledge that although well documented in policy and codes of conduct, the terms compassion and caring are not explained causing tensions for those in education tasked with teaching the constructs. Bleiker *et al.* (2016) are the first to raise the notions of emotional intelligence in relation to empathy and compassion in radiography. Emotional Intelligence (EI) relates to the ability to recognise and monitor feelings and emotions of the self and of others, to inform thinking and actions (Mackay *et al.,* 2012). Mackay *et al.* (2012) explored the EI traits of radiographers and determined that higher EI better enabled empathy and compassion in addition to enhanced practitioner wellbeing. This links to resilience and coping mechanisms such as humour (Strudwick, 2011) that lie beyond the scope of this study.

The themes of connection and communication have repeatedly arisen in the literature within the radiography settings and beyond. Taylor, Bleiker and Hodgson (2021) specifically review communication and propose four elements to compassionate communication: verbal, non-verbal, active listening and finally

engagement and rapport. The themes proposed by the authors have also appeared in previous sections of this chapter. They are worthy of discussion within the specific radiography context due to the similarities with the TR setting in which this current study is situated.

Taylor, Bleiker and Hodgson (2021) reported that for verbal compassionate communication, language and tone were important. Language can be dehumanising especially if 'telling' patients what to do rather than 'asking'. This also relates to autonomy and empowerment. Although tone itself may not entirely convey compassion, a comforting rather than frustrated tone does. But non-verbal communication was considered more important by the authors. The impact of non-verbal cues remained with individuals and were considered compassionate if radiographers smiled and made eye contact. Patients interviewed in studies within both therapeutic and diagnostic radiography experienced a lack of compassionate communication when staff were time pressured but felt it through the 'little things' such as displaying attentiveness and kind gestures. Although worthy and demonstrating compassion, I begin to question if such actions are actually a demonstration of caring. Within my current study it will be useful to see how educators perceive caring in the clinical and educational settings.

Being heard through active listening enables patients to experience compassionate communication or arguably feeling cared about. Whilst picking up on cues from the patient to indicate their true feelings and experience, being able to interpret feelings and cues involves an understanding of the individual, almost 'sensing' a need to talk. These 'skills in reading the patient' (Taylor, Bleiker and Hodgson, 2021, p.S46) were considered part of being an experienced practitioner, having rapport and engaging with patients through formal and informal dialogue. A rapport, 'chatting' at appropriate times was considered compassionate communication. These findings specifically within the clinical TR setting, align with the previous work by Morse *et al.* (1990) in the nursing setting and more recently Quirk *et al.* (2008) across healthcare professions. The same concepts may be revealed within the academic setting as part of this study, exploring educators' experiences and perceptions.

Taylor, Bleiker and Hodgson acknowledge their findings reflect elements of caring with compassion. So, a further two studies, one in TR and the other in diagnostic, combined within this article have still not fully defined and clarified the caring –

compassion problem. They do suggest that compassionate communication can be a casualty of the pressures and workload experienced by clinical staff, that without a culture adverse to rushing patients, compassionate communication may not be realised.

Another emerging yet related area of study in diagnostic radiography is that of patient-centred care. Hyde and Hardy, both academic staff in UK, have published a series of articles on this topic. They argue that to achieve patient-centred care in radiography, practitioners need to understand the phrase and what it means to those experiencing it. Only then can a culture of patient-centred care be created. They used a combination of surveys and focus groups involving service users, students, and practitioners in addition to educators to explore the topic. This may be an important study to explore as it includes the clinical and educational viewpoints, in a similar way to my current study in TR.

Of particular interest is that perceptions of patient-centred care differed between managers and clinical staff, as well as those experiencing and delivering imaging. Hyde and Hardy (2020) report the target and efficiency focus of radiography may create a timely process and service, but potentially to the detriment of patient-centred care. Service users also valued human interaction and caring radiographers as part of quality care. In their follow-up article, student and academic staff perceptions of patient-centred care included '…basic care needs' (2021, p.807) or expectations of dignity, respect and privacy, personalised to the individual. A tension between patient-centred care and efficiency was reported, similarly to that in their first paper. Holism and caring gestures were recommended as part of patient-centred care.

Although themes of humanism, holistic individualised care and carefully considered compassionate communication have emerged, these remain from a focus on compassion. However, Naidoo, Lawrence and Stein (2018) explore caring in the diagnostic radiography setting where students were interviewed to ascertain their views. The authors acknowledge that despite attempts to define caring since last century and the times of Florence Nightingale, a consensus remains elusive. Caring is 'an act or display of kindness, compassion and empathy towards another individual.' (Naidoo, Lawrence and Stein, 2018, p.163) which may vary with our culture, upbringing and moral obligations (Bolderston, Lewis and Chai, 2010). This

distinct definition combines concepts previously discussed and demonstrates the action aspect of caring but may still not convey the whole concept.

Naidoo Lawrence and Stein (2018) report three main themes from their study which is conducted in South Africa. Although not in the UK, the authors explain a similar tension experienced around a reported lack of caring and empathy in radiography. From their study Naidoo Lawrence and Stein (2018, p.164) explain caring to include '..being compassionate, sensitive, showing concern, empathy and having some form of human acknowledgement towards…patients'. They also explain how caring involves altruism, putting the patients' needs before one's own, and 'little gestures of caring' (Naidoo Lawrence and Stein, 2018, p.165). Participants also felt 'workload pressures, time constraints and poor role models' hindered the development of a caring identity (Naidoo Lawrence and Stein, 2018, p.165). Students often saw the human element of caring reduced in radiographers, so that good clinical role models were absent. Participants explained they felt rushed, had limited time with patients and were often removed from the clinical area to perform administration tasks because they lacked speed.

The concerns raised by Naidoo Lawrence and Stein around the lack of humanity in radiography are not new. In 2001 Murphy explored the influence of increasing technology in the radiography clinical setting and the potential risk of depersonalisation it could bring. After CT and MRI scans, participants were briefly interviewed by Murphy to explore their experiences. These modalities were selected because they involved a separation of the patient and radiographer, not dissimilar to TR where staff deliver treatment from outside the room. Many patients in the study conveyed anxiety and fear related to the technology or machinery used to scan them. Although Murphy reports previous social interactions were significant in the patients' experiences, often negatively, there appears to have been no lengthy explanation and information giving to the patients prior to their scans which may have reduced fear and anxiety. Patients reported receiving leaflets but no verbal explanation of the process until they attended. I would suggest this does not demonstrate caring, and that uncertainty and fear experienced would arguably be due to a lack of personalised interaction.

In a follow up article, Murphy questions whether radiography has reached a point where '…technology has surpassed our humanity' (Murphy, 2006, p.171) and

discusses the dehumanising effect and objectification of patients during high technology procedures. These areas of high technology include both diagnostic and therapeutic settings. Objectification is at odds with person-centredness, being fuelled by the biomedical model of healthcare focused upon the disease rather than the individual. Murphy suggests radiographers have the role of 'bridging the divide' (Murphy, 2006, p.172) between humanity and technology. Efficiency may be at the expense of this humanity as departments become an '...assembly line' (Murphy, 2006, p.172) which could be similar in TR, as suggested by students frustrated by their experiences. It is now appropriate to turn to TR, the professional setting of the researcher and this current study.

2.5.2 Therapeutic Radiography

Considering published literature, most is written by academic radiographers. Topics related to person-centred care, communication and information-giving are most common.

In a focus group study by Hendry (2011), patients receiving radiotherapy for breast cancer reported that a friendly face, active listening, and good communication by staff enabled relationships to be built. The patient-radiographer relationship was a form of support to patients. Participants felt this was more than just professionalism as the rapport and relationship were highly influential of the emotional and psychological support experienced. This has been a consistent theme throughout this chapter. Similarly, dignity and individualised care were also reported as important to the women receiving radiotherapy. These are key aspects of caring although again, this article does not explicitly identify this, rather it refers to the 'information, support, and communication needs' (2011, p.104) of women. I would argue these are and can facilitate caring. More recently Probst *et al*. (2021) employed a participatory co-design methodology to explore women's experiences during breast radiotherapy. Feelings of disempowerment and a loss of dignity were experienced by women in the study, suggesting these aspects of person-centredness remain troublesome within TR practice.

A qualitative study was conducted in 2013 by Egestad in Norway who interviewed people with head and neck cancer receiving radiotherapy. Patients in Egestad's study retold how they felt less anxious when radiographers were friendly, kind and showed appropriate humour. Smiling staff and being treated as an individual were

important findings. In addition, respecting patients' dignity, covering them, and 'understanding' were important to patients. Although Egestad does not refer to these findings as caring, they do indicate aspects of the concept identified by other authors and discussed earlier in this chapter. In agreement with Hendry's findings, meeting information needs meant patients 'felt safe' (Egestad, 2013, p.251) despite the acknowledged lack of time with radiographers. Good communication and information-giving reduced anxiety, uncertainty, and vulnerability in patients. Lack of conversation meant loneliness and rejection to some patients, but empathy, compassion and a 'relationship' enabled an improved experience for patients. Again, Egestad does not combine these actions and feelings into the term 'caring' but focusses on the relationship between the patient and radiographer. Relationship has been shown as essential to caring in previously discussed studies.

Similarly in an earlier study, Martin and Hodgson (2006), discuss communication during the first day interviews patients have with radiographers. They promote the importance of active listening, empathy, communication, and information-giving to the extent that they suggest elements of counselling skills are needed by radiographers. These skills include reflective listening and communicated empathy, where the patient needs to know the radiographer is empathetic to build their relationship. Intertwined with this experience is compassion and 'catharsis', the first time this term has been used in the TR setting. Catharsis relates to the releasing of strong emotions, which logically exist with a cancer diagnosis and how patients may arrive at their first treatment with a plethora of emotions. Martin and Hodgson suggest the first day interview if skilfully performed, can enable a trusting relationship and be empowering and cathartic for the patient. This links to previous concepts of autonomy, an aspect of centredness and caring. The humanistic approach is suggested by the authors but interestingly from a relationship, but not specifically a caring aspect. It may be that when published in 2006, as person-centred care was evolving, the idea of caring and its constituent parts had yet to emerge in the TR setting. The timing of these studies discussed, and the tensions remaining around the construct of caring confirms the importance of this current study. There remains the need to better understand the elements of caring in the TR clinical and educational settings, particularly as the small number of studies conducted relate more to clinical rather than educational practice.

One study that did explore caring in TR is that by Bolderston, Lewis and Chai in 2010, previously mentioned within the introduction chapter. This is an important article to consider in this current study as it involves radiation therapists' perceptions of caring in their profession (in Canada) and uses a qualitative phenomenological approach. To the best of my knowledge and searching, this remains the only study of its kind and although in Canada, there are similarities that can be made with the UK setting. Those participating were clinical therapists, so the topic of caring remains an unexplored area for academic radiographers in the UK. Bolderston, Lewis and Chai (2010, p.199) discuss the 'potential technology-humanism dualism' which has previously been considered. They suggest that technology and its role in healthcare can be at the expense of the affective, humanistic caring aspects of practice despite the omnipresent caring in vision and mission statements, which is also reflected in UK Trusts.

Three overarching themes emerged from the study; human connection, identity, and technical care each underpinned with several sub-themes. Exploring these in some depth is important to the current study of caring in TR, mainly because so little has been published in the area. Human connection was the most prevalent theme within which concepts of dignity, respect, compassion, empathy, and kindness emerged. Alongside this was the importance of seeing the patient as an individual where '…caring for the patient (is) based on a fundamental empathetic human connection...' (Bolderston, Lewis and Chai, 2010, p.201). Seeing the person as an individual and being 'fully present' or engaged with them is paramount so that a connection or reciprocal relationship can develop as part of the 'human connection'. This aligns with other views of caring previously discussed, although it is interesting to note that Bolderston, Lewis and Chai refer to 'caring for' the patient yet do not consider the concepts of 'caring for' and 'caring about'. Their connection theme, I would suggest relates to 'caring about' rather than 'caring for' but as an arguably seminal publication on caring, the early conceptualisation may not have enabled this further consideration to take place. Thus, the current study of caring in the UK education setting is important, in part to determine if these terms are different.

The second theme emerging from the study was that of identity. Surrounding the ideas of caring at a human level, this theme relates to caring as part of professional responsibility or identity as reported by participants. This has two elements, that of

the therapist (radiographer) and that of the individual. The unique role of the therapist was identified by participants, whereby they 'chose' cancer as their profession. This uniqueness is important due to the vulnerability of people with a life-threatening disease and the multiple encounters during fractionated TR. The uniqueness enables a rapport to develop unlike other professions where people may specialise in cancer, TR professionals consciously decide to work with people with cancer. Bolderston, Lewis and Chai suggest this creates a special sensitivity to the fundamental issues of a cancer diagnosis. The resultant patient-radiographer relationship can be more open and informal that that with doctors, and radiographers can act as advocates for the patient during their treatment. This uniqueness may be the reason some traditional views and models of caring may not immediately translate to the TR setting. It arguably adds to the need for this study, not only to establish views and perceptions of clinical radiographers who are now educators, but also to enable 'teaching' of caring in TR.

Within the identity theme, the individual is also important and Bolderston, Lewis and Chai separate this from the 'therapist' or professional sub-theme. Each therapist brings their own uniqueness in addition to that of the setting, and the focus on cancer. Personality and life experiences were identified as influential aspects concerning caring. Perceptions of a personality more suited to the role emerged, and alongside that a discussion around the potential teaching of caring if it was not '…an inherent element of the radiation therapists' personality.' (Bolderston, Lewis and Chai, 2010, p.203). Caring is a product of experiences, relationships, and values of the radiographer but also patients have individualised concepts of caring and how it is expressed. This creates a troublesome issue for TR educators. If the concept of caring cannot be defined, how might it be taught. Again, a clear rationale for this study that seeks to explore caring in the unique TR setting, but in contrast to Bolderston, Lewis and Chai's study, through a clinical-academic lens rather than clinical alone.

The final theme was that of technical care. Participants agreed that skills such as caring would often be undervalued whilst more easily measured indicators such as number of patients treated were more important. There were mixed views around the technical and patient care aspects of the radiographer role. Some felt they were interconnected whilst others saw them as separate roles. This also included 'doing your best work' (Bolderston, Lewis and Chai, 2010, p.204) For some participants,

but not all, this meant technical accuracy and following protocols, but I would argue competency and safety are already implicit in the professional role. As Bolderston, Lewis and Chai explain, some participants struggled to relate the technical aspects of TR to caring, which may bring the notion of caring for and about to the fore again.

Within the profession specific domains of radiography and TR, caring has an emerging evidence base. There is much in agreement with aspects of caring from within the general healthcare literature. Communication, connection, compassion, and empathy being considered as essential elements of caring. Yet within TR specifically little has been explored. What is known relates caring firmly to a humanistic connection with the patient, to provide individualised interactions in which empathy, compassion, kindness, dignity, and respect are firmly bound. This is from a clinical practitioner viewpoint. What remains to be discovered by my current study is whether such perceptions and experiences are shared by academic radiographers in UK and how the term caring is perceived and experienced in both the clinical and educational settings. In the final forthcoming section, caring will now be considered in the educational domain.

2.6. Caring in Education Practice

Caring in the education setting is of relevance to my personal practice as a TR educator. Students' development of the attribute of caring can be influenced by a variety of pedagogical practices, including the actions and role modelling of academic educators (Hendry, 2019). Thus, the professional practice of academic TRa and their perceptions of caring in the education context will be considered. This may illuminate caring relationships and interactions between students and academics rather than the specifics of caring for patients in the clinical setting.

Across the medical, nursing and radiography professions there are a series of themes relating to caring and education. Many publications have been written by academic colleagues suggesting caring and its related pedagogy is troublesome and there remains a need to unravel the concept. Also, academic staff, myself included, acknowledge the important role we play educating students to be caring competent practitioners. Caring through the educational lens relates not only to the concept, the curriculum and pedagogy but also in our relationships and interactions with students. Unravelling and deconstructing caring in the clinical setting is essential for meeting the needs of professional and statutory bodies and the NHS

Constitution, but as educators we cannot directly influence caring with patients directly. We may, however, impact the concept of caring vicariously through our students as developing practitioners, our teaching practice and as role models (Hendry, 2019).

A conceptual exploration of caring has preceded this section. Some studies discussed included student participants so no further exploration of the meaning of caring to students will be considered here. However, this section will now explore how caring might feature in the academic curriculum, the involvement of service users or patients and the responsibility of educators acting as role models and as 'caring teachers'. Before considering these individually, we return to caring as a 'threshold concept' (Clouder, 2005, p.506) that transforms healthcare students during their time in higher education.

The transformation of students from novice to practitioner is not a new concept in higher education (Mezirow, 2003). Hendry (2013, p.251) suggests educators act as transformative 'leaders to student followers', where learning through experiences, life and understanding can be facilitated by transformative teaching. Clouder (2005) considers caring to be a threshold concept, meaning this core notion, when understood can transform perceptions of the concept. She considers the troublesome knowledge of caring when in practice, added to the common sense understanding of caring, is almost counter-intuitive. This results in a transformation of students and their understanding of caring. Professional learning, Clouder reports, may not fully enable the emotional or affective aspects of healthcare to be considered. All students enter their healthcare programme with a common-sense and experienced view of caring as a human being. In the healthcare setting, and particularly that of oncology, the 'troublesome knowledge' experienced in viewing caring through a professional lens suggests it to be a 'threshold concept'. There may be doubts and uncertainties experienced by students, and Clouder considers healthcare education may not adequately address these. The troublesome aspects of learning about caring, their own capacity and subjectivity, can be challenging to students. They may feel a lack of authenticity and may mimic behaviours, which could be concerning as in healthcare and TR specifically a perceived reduction in caring in favour of technicality and targets exists. Clouder goes on to explain how the responsibility of caring can be a burden, and potentially overwhelming to students. Indeed, if students witness detachment from staff in practice, they may

believe they ‘care too much’, creating anxiety and uneasiness in them (Clouder, 2005, p.510). This resonates with some experiences students have relayed to me, staff telling them not to spend so much time with patients (building a relationship) and not to get over-involved. Students may become de-sentimentalised to patient suffering. This might be the stage of crossing the caring threshold, to conceptualise caring as a professional. However as previously discussed, attachment and involvement are aspects of caring so moving to a professional or detached, de-emotionalised state could be counterproductive to person-centred caring. Clouder continues to suggest that healthcare education fails to include the emotional and affective aspects of practice in preference for rationality. This ‘emotional capital’ could be developed during education programmes in a purposeful way, through the curriculum, as a ‘...framework for learning, assessment support and guidance.’ (Clouder, 2005, p.514). Clouder believes caring discourses should be more explicit in curricula than currently where a more implicit view of caring is favoured. These ideas will be important when exploring the views of TR educators in this study.

A study of EI in TR students by Carmichael, Bridge and Harriman (2016) demonstrated an increase in key aspects of EI (self-awareness, self-management, social awareness, and relationship management) during a three-year undergraduate programme. EI has been associated with key skills of healthcare practitioners such as empathy, compassion, reflection, and resilience (Carmichael, Bridge and Harriman, 2016; Ioannidou and Konstantikaki, 2008) which are also linked to caring. Carmichael, Bridge and Harriman’s longitudinal study of 26 students identified an increase in EI over time, particularly for social awareness and relationship skills. The development of EI was predominantly through clinical placement. These findings may initially be contradictory to those by Clouder, although direct comparisons cannot be made. Both articles suggest caring, and its various aspects, remain yet to be fully understood. My current study into perceptions of TR educators may help further illuminate caring and its role in curricula. We shall now consider how caring might influence curricula and pedagogy.

2.6.1. Educational Strategies

Learning activities including simulation, role modelling and the importance of service users and patient advocacy in the teaching and learning of caring have been

considered by various authors. Similarly, the concept of a caring curriculum has been explored in healthcare education. Some studies lie heavily within the medical and nursing domains but there is a strong emerging evidence base in radiography.

Simulation is an increasingly important area of learning for students in TR, in part due to demands to increase the workforce despite the finite number of clinical placement opportunities for students (Ketterer *et al*., 2020). Simulation has been used within the nursing and medicine curricula, supporting the development of caring within students (Symons, McGuigan and Akl, 2009; Lillekroken, 2020). Simulation refers to the imitation or representation of an activity (Lillekroken, 2020) which in healthcare can include role play, technology and an immersive environment (Society for Simulation in Healthcare, 2023).

Social interaction is facilitated within the simulated learning environment, which is an important aspect of student learning (Vygotsky, 1978). The combination of social speech and higher order thinking converging with practical activity enables student leaning and development. Social interaction with a knowledgeable educator in a safe environment was shown to better enable student learning and development in a qualitative exploratory study by Lillekroken (2020). Lillekroken (2020) explored nurse educators' perceptions of teaching care in a simulated environment. Not only did her study suggest educators help students develop professional skills, but also practical task delivery improved. In addition, transferrable skills such as communication and critical thinking increased, as did student confidence and knowledge (Lillekroken, 2020). In effect, educators are role modelling in an environment similar to the clinical setting, but where it is safe for students to make mistakes and openly reflect. Similar findings were revealed by Ketterer *et al.* (2020) in their radiotherapy study using VERT (Virtual Environment for Radiotherapy Training).

With a specific focus upon enacting and developing person-centred caring for patients, Saunders, Green and Cross (2017) conducted an exploratory study utilising the flipped classroom and simulated learning. As this chapter has previously discussed, person-centred caring has elements of centredness and individualisation alongside practicing effective communication and relationships (Currie *et al.,* 2015; Kitson *et al.,* 2013). The opportunity exists within the simulated environment or session to develop such skills. Within the flipped classroom,

students are exposed to materials prior to a practical session (River *et al*., 2016). Often e-learning resources are used prior to the session so students enter with some theoretical understanding, ready to enact person-centred caring in the simulation environment. In this way, the classroom may act as a 'clinical learning environment' (Saunders, Green and Cross, 2017).

Findings from the study by Saunders, Green and Cross (2017) revealed that students enjoyed the flipped classroom simulation model, and their experiences of learning were enhanced. Interactions better enabled knowledge and understanding of person-centred caring with educators as role models. Considering the use of VERT within all HEI for TR, this may be an important aspect of teaching practices to develop caring in TR students. Although Saunders, Green and Cross (2017) acknowledged modelling of high quality of caring may vary within the clinical environment due to staffing and resource issues, students' knowledge and skills transferred well. Additionally, placement-related anxiety was diminished by their flipped simulation approach which so enabled students to feel more prepared.

Within TR the environment of the treatment units can be time-pressured and anxiety-inducing for students which may jeopardise learning, competence and progression. The flipped classroom and use of VERT could be optimal for understanding and knowledge of caring in TR. Indeed Saunders, Green and Cross (2017) found small groups in simulation would also enable relationship building between students and staff.

Case studies, scenarios, or care situations as Gramling and Nugent (1998, p.48) explain can be a lens '…through which students experience and learn about caring' from academic and clinical staff. The authors developed two patient care situations as short videos, or vignettes, both enacted by nursing students with the same interval of time available. One was hurried, rushed, abrupt and a goal-oriented nursing encounter, the other caring and patient-focussed. The endpoint was reached in both scenarios within the given time, disproving the frequent 'too time-pressured to demonstrate caring' (Gramling and Nugent, 1998, p.50) rhetoric from some staff. In a similar way, short videos together with case studies were used within the nursing curriculum (Richardson, Percy and Hughes, 2015; Percy and Richardson, 2018, p.201), based upon Muetzel's Model of Therapeutic Relationships. This acted as a framework for a module in year 2 concerned with

therapeutics of nursing (Percy and Richardson, 2018, p.201) shown in Figure 5. Muetzel believed that the patient and practitioner in partnership was key to a 'therapeutic relationship' and so enabling caring, compassion, and empathy. Previous discussions in this chapter have highlighted the importance of the relationship with the patient.

The Model used has 'partnership, reciprocity and intimacy' overlapping to provide a therapeutic encounter Percy and Richardson, (2018, p.202). Although the framework is situated within nursing, its components appear to align with previous concepts explored in this chapter. I would argue they translate to any patient-practitioner interaction. The authors use this framework to deliver a module around caring, compassion, and empathy (Richardson, Percy and Hughes, 2015; Percy and Richardson, 2018, p.201) which may be a useful tool in any healthcare programme.

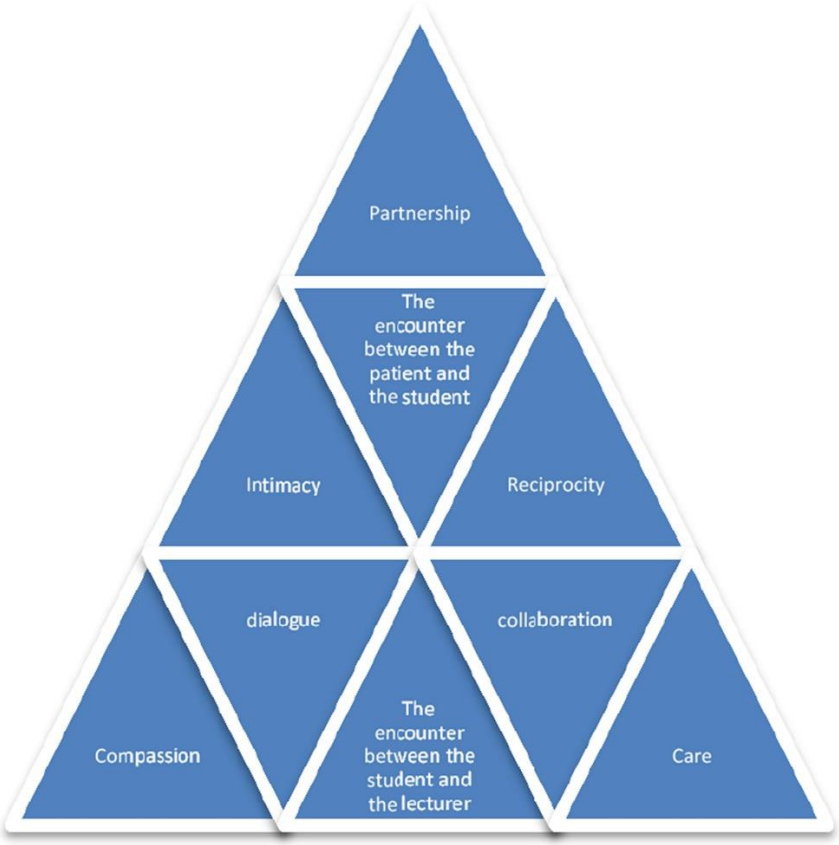

Figure 5. The Relationship Between Care, Compassion, Muetzel's Model and the Case Study Approach (Adapted from Percy and Richardson, 2018, p.202)

In the diagnostic radiography setting, Naidoo, Lawrence, and Stein (2020) used a qualitative, theory generating research design to develop a model to facilitate teaching caring to radiography students. The model is generated from concepts of caring perceived by first-year students. Although the model will be used by diagnostic educators as facilitators, it is interesting that students effectively 'designed' the model. As previously discussed, the potential for caring to be a threshold concept could raise concerns over where the students within the study lie in terms of their transformative journey. Also, as Carmichael, Bridge and Harriman (2016) identified, EI increases as students progress through their programme to year 3. Nevertheless, the model may help illuminate aspects of teaching caring in the sister profession of radiography. The model focuses on creating a 'culture of caring' (Naidoo, Lawrence and Stein, 2020, p.5) to facilitate teaching. It can be found in Figure 6. I would suggest the model is quite general, providing more of an overview or ethos with little if any practical aspects of delivering the phases of the model. So, it might be questionable exactly how much this model might influence and help facilitate the teaching of caring.

The three phases in the structure begin with developing a respectful, trusting relationship between student and educator but provides no indication of meaning or how it might be enabled. The optimism of the student should be 'captured', together with shared values, ideas and beliefs. Again, there is a lack of clarity over meaning in terms of pedagogy, so the model remains limited. The second 'working phase' includes teaching communication skills and 'interacting with patients in a humanistic manner' (2020, p.5). Naidoo, Lawrence and Stein (2020) also suggest a patient-centred empathetic compassionate approach but again do not clarify how this might be taught. A final assessment phase evaluates skills learnt in the 'culture of caring'. Although the model appears limited, it may the first steps in considering a framework through which caring in diagnostic radiography may be taught. This could be significant as models and theories of caring have generally been within the nursing domain. This current study in TR may add to the knowledge base in the specific TR setting.

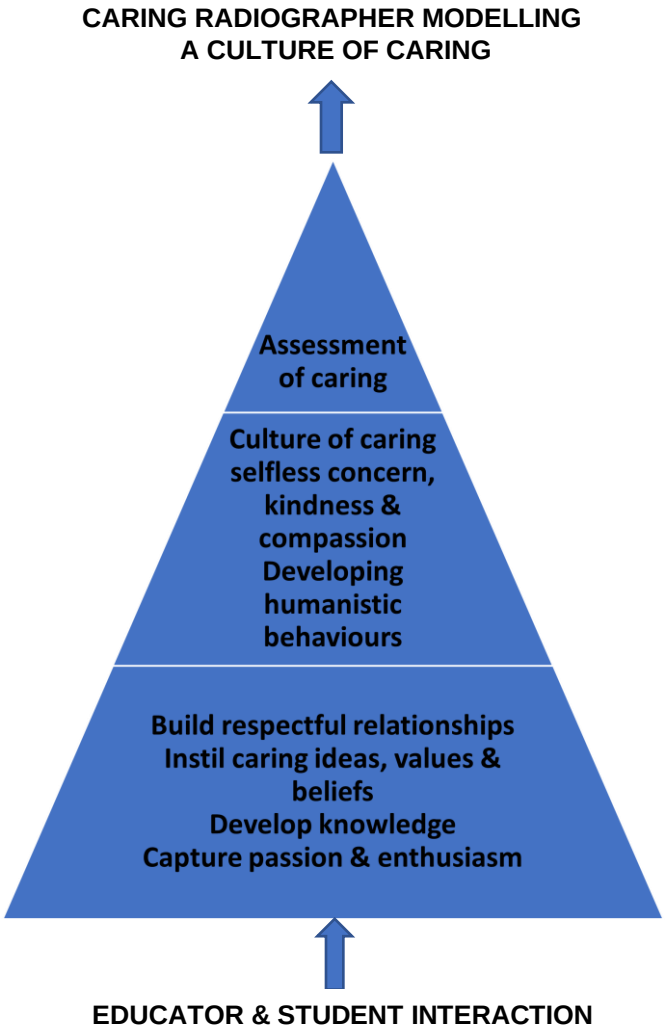

Figure 6 A Model to Facilitate the Teaching of Caring to First Year Diagnostic Radiography Students (Based upon Naidoo, Lawrence and Stein, 2020, p.5)

As Naidoo, Lawrence and Stein (2020) give a generalised framework, Hendry (2019) provided more structured, practical methods of teaching compassionate care in radiography. Hendry suggests three themes to guide pedagogy for compassionate care, based upon the work by Christiansen *et al.,* (2015). There is some reflection of these earlier findings in synergy with Naidoo, Lawrence and Stein's work. 'Practicing compassionately' relates to the emotional connected relationships with patients, delivering person-centred individualised care and 'doing the small things' (Hendry, 2019, p.271). Hendry suggests patients as educators, role modelling from academic staff and facilitated reflection may enable compassionate caring. Values feature in the theme 'Individual and relationship

factors', which she suggests can be fostered through patient stories, sharing experiences and a values-based curriculum.

Modelling caring behaviours is also discussed by Adam and Taylor (2014). They found role modelling by academic staff was key to students understanding of compassionate care, particularly through facilitated reflection. Peer discussions also enabled empathy to be enhanced as students learnt through facilitated discussion of experiences involving patients. The careful, purposeful role and facilitation by educators was reflected in the final leadership theme emerging from Hendry's discussion paper (Hendry, 2019). Compassionate leadership by educators links to the previously discussed paper by the same author from 2013, where role modelling, overt or covert, may be essential to caring. If students experience caring from staff, and witness compassion and empathy in action within the education setting, it might help foster and develop similar attributes in the students themselves.

As much as staff may be influential, service users or patients in the academic setting can enhance the curriculum and caring (Hill *et al.,* 2014). Hatem *et al.* (2008) use the CARE model as a curriculum framework for teaching caring to medical students. As previously discussed, 'CARE' relates to C-communicate effectively, A- arrange to meet healthcare needs, R- respectful and E-empathetic. Case scenarios were used to facilitate experiences and learning across breaking bad news, palliative care and explaining a medical error has occurred. Rather than a skills-based approach, Hatem *et al*. (2008) used patient actors in videos, followed by reflective facilitated discussions exploring caring and uncaring behaviours. Scenarios enabled students to contextualise aspects of the learning experience to the patient view. Reflection in action was key to each encounter enabling adaptation to specific person-centred needs, thus individualising the interaction.

Within the TR curriculum Hodgson *et al*. (2017) involved service users and carers in their curriculum review. They believed patients and carers could be more involved in learning and teaching in addition to the workshops currently employed. Topics included were communication, experiences of cancer and role play. Collaboration with service users and carers resulted in rewriting the programme learning outcomes to give a greater emphasis upon the skills required to facilitate caring. This is important for my study as the findings and subsequent changes by Hodgson

et al., (2017) began to unravel the complexities of caring and how it might be taught. Learning outcomes moved from 'demonstrate and maintain communication...' to include detail such as '…awareness of cultures, ethical user and carer centred practice in which advocacy and strategies to challenge oppression are key.' (Hodgson *et al.,* 2017, p.97). Also included was the outcome to 'Practice with empathy and understanding appreciating the patient experience in the wider context of your professional development.' (Hodgson *et al.,* 2017, p.97). These outcomes bring caring and some of its components to the forefront of students' learning and teaching expectations.

Also, within the radiography curriculum, Bleiker, Knapp and Frampton (2011) suggest a blended approach to teaching patient care. In line with other pedagogic practices, they utilised video clips of patient-practitioner interactions with reflective discussions to support learning. They evaluated student experiences of the blended learning model and concluded there was enhanced understanding of patients' feelings brought through observation and reflection of patient experiences. Students felt enabled to visualise situations not yet encountered, thus better equipping them to provide caring to patients.

Having explored possible educational strategies it is appropriate to now consider what the concept of a 'caring teacher' may mean and how that might influence students' learning.

2.6.2 The Caring Teacher

The concept of caring is well explored within the practice of teaching school age children, with considerably fewer publications relating specifically to HEI. However Walker and Gleaves (2016) constructed a theoretical framework of the caring HE teacher, suggesting two main pedagogic elements to caring teaching. Firstly, the importance of actively developing relationships and secondly, including trust and individualisation within these relationships (Walker and Gleaves, 2016). Caring teachers demonstrate the concepts within their practice by timely interactions with students, knowing and having insight into the students as individuals, acting authentically and consistently. A result of such caring behaviours and actions Thayer-Bacon and Bacon (1996, p.255) suggest teachers who care about their students stimulate growth, effect change and are remembered, more likely being successful in teaching their students.

The study by Walker and Gleaves (2016) used a Grounded Theory approach to explore HEI teachers perceptions of being a caring teacher. It must be noted that of none of their six participants were in healthcare. However those not required to teach caring to students as developing professionals, would still hope to enact emotive caring moral practice towards their students (Hargreaves, 1998; Carr, 2006). Findings from the study by Walker and Gleaves (2016, p.10) revealed four main themes, 'a relationship at the centre', 'being compelled to care', 'caring as resistance', and 'caring as less than'.

The most powerful theme was that of relationships based upon trust, bonds with students and teaching as a social activity. It also featured elements of individualisation. Through being 'compelled to care' teachers described being aware of the emotional impact of learning and its importance within the student experience. The need to include humanity and emotions within teaching were aspects of the theme, 'compelled to care'. The third theme of 'caring as resistance' raises an interesting debate around education, its moral purpose and potential conflict with the economic and consumerisation of HE. Caring teachers within mitigation panels would demonstrate a moral resistance to operationalisation of policies that centred on business rather than learning. A deep relationship with students enabled a buffer or defence to support learning. This theme links with values-based practice and the moral virtue of educators discussed previously.

The final theme from Walker and Gleaves' (2016) study was 'caring as less than'. Here participants explained how being caring and developing meaningful relationships with students is often considered 'less than', being time consuming and wasteful if students are performing academically. For some there was a tension between being caring and being considered an academic. Considering these findings involved participants from non-healthcare programmes, there may be some nuance with a programme focussed upon caring professionals which may be revealed by my study of caring in TR.

Caring teachers are linked to caring pedagogy and successful student outcomes (Walker and Gleaves, 2016) whilst Goralnik *et al*. (2012) also include relationships and emotions to learning as the ethic of care for teachers. They suggest emotion impacts students' memory, focus and attention (Goralnik *et al*., 2012, p415) and in a similar way to simulation, utilises social interaction. Emotions and learning are

described as particularly important when learning involves moral and ethical practice and knowledge such as caring. The significance of social interactions and relationships is an important theme throughout their discussion paper.

Strategies to foster the ethic of caring are offered by Noddings (2002) and include co-operative, social learning which again links to simulation. However as Freire (1970) explained, it is essential for strategies to become fully embedded within classrooms through modelling, practice, dialogue and a non-hierarchical setting. Relationships are again espoused as essential to learning, caring and emotional pedagogy (Andersson, Ohman and Garrison, 2018; Moen *et al.*, 2020).

Building relationships with students through caring teaching practice requires a shift from impersonal, highly regulated, vertical relationships of educator and student to a more personal, equal, and horizontal relationship (Brown and Evans, 2004). Any interaction between student and educator would be situational and unique, fostered by relational practices (Gordon, Benner and Noddings, 1996). Thus a caring teacher uses relational aspects of mutuality, recognition, empowerment, humanity and equality (Gordon, Benner and Noddings, 1996). Noddings' (1997) philosophy of caring meetings with students suggests the cultivation of social justice and social capital in education, a topic worthy of exploration but beyond the scope of this chapter.

In summary, caring in the education setting is as complex to deliver as it appears conceptually. A multifaceted construct could involve a variety of pedagogical approaches to support student learning. These include simulation, reflections, role modelling and integration of patients or service users within the curriculum. The ideas of caring pedagogy and a caring teacher have been considered in other disciplines and may be revealed as important within this study of caring. Across healthcare, many academic authors have suggested useful approaches to teaching. Patients and carers, whether in person or in video, maybe essential to this process. However, we return to the issue that without an understanding of the meaning of caring, specifically in TR, we cannot fully develop suitable pedagogic approaches. These will be more attainable when this study has established what caring in the TR education setting means.

2.7. Potential Contribution to Knowledge

This chapter has established the paucity of literature regarding caring in TR. One study of note is that by Bolderston, Lewis and Chai, (2010) which explored the concept of caring with clinical radiation therapists in Canada. My study will provide unique knowledge around academic radiographer educators' views and perceptions of caring in the clinical and educational settings. It will establish how caring, and its perception might impact educators' teaching practice. These aspects have not yet been considered in the UK. Thus, outcomes from this current study will add to knowledge of caring, but also provide specific meaning in the UK TR and education domains.

2.8. Reflexive Thoughts

The whole prelude to this research study, within the taught aspects of my doctorate, assignments and papers focussed upon caring. My interpretation of the concept, as an individual, practitioner and researcher continued as part of the constructivist approach to this study. Although the significance of caring to me could never be removed from the nature of this study, it was important to be reflexive. I needed to look back upon the processes, writing and conduct of the study to be aware of *the self*, and to attempt to minimise the impact of my views in overshadowing the literature and the findings. When retrieving the literature to review within this chapter, I was mindful of the danger that I may consciously or subconsciously select literature of a particular type and content to meet my perceptions of caring. So, I decided to conduct a structured search and methodically include and exclude articles from those retrieved. The purpose was two-fold. Firstly, it enabled me to have a broad and wide search of the literature to minimise omission of a potentially important article relating to a concept with little exploration in my setting. Secondly, it helped reduce my views overbearing the retrieval process. I did strive to maintain an open mind and purposefully looked for publications suggesting caring was not so important in clinical and educational practice. Very few were found.

Once my study was underway, I planned to write this chapter early in the process. I had used literature to write the study proposal and protocol, informing the research questions. Having conducted my structured search process, I began to interview participants and then upon reflection, decided to write much of the literature review after completing data analysis. Again, my rationale was to reduce overshadowing participants' views with my own strong perceptions of caring. It was also to avoid

my knowledge from the related literature overly influencing the data analysis process. This could help ensure that revealing the essence of caring from this study was as genuine as possible.

2.9. Chapter Summary

Caring has been considered a long-established virtue or moral attribute within individuals, extending back to the early writings of Aristotle, although the word caring was not purposefully used. Caring within the nursing domain has been supported by seminal writings from Watson, presented within a framework or theory which may support nurses, students, and nursing educators in comprehending the term and its enactment. In the general healthcare setting, caring is recognised as fundamental to practice and features within codes of conduct and the NHS Constitution. Caring appears within literature concerning the radiography professions and a knowledge base is developing, particularly for diagnostic radiography. There remains a paucity of literature with TR.

As a concept, caring is revealed by the literature to be a multidimensional construct that can include a relational aspect and an activity aspect. Figure 7 provides a diagrammatic summary of caring, from the literature reviewed. Caring involves consideration, empathy, compassion, and dignity. When relationships are built between the patient or student, and practitioner, caring can be cathartic and reciprocal. Although the individual may demonstrate caring behaviours such as making time, active listening and individualisation, there can be tensions within the workplace culture. At times, the focus upon processes and targets, especially within a high technology environment, can detract from caring.

Aspects of caring from the medical and nursing literature appear to align with the limited literature relating to the clinical TR setting. Yet the academic and educational influences of caring remain under-explored. Teaching caring may be facilitated through role modelling, reflective and experiential learning from staff and patients. At this point, inferences only may be made as very few studies have been reported from within the TR domain. This study can debate if such inferences are valid, whilst providing unique findings in the previously unresearched TR academic education landscape.

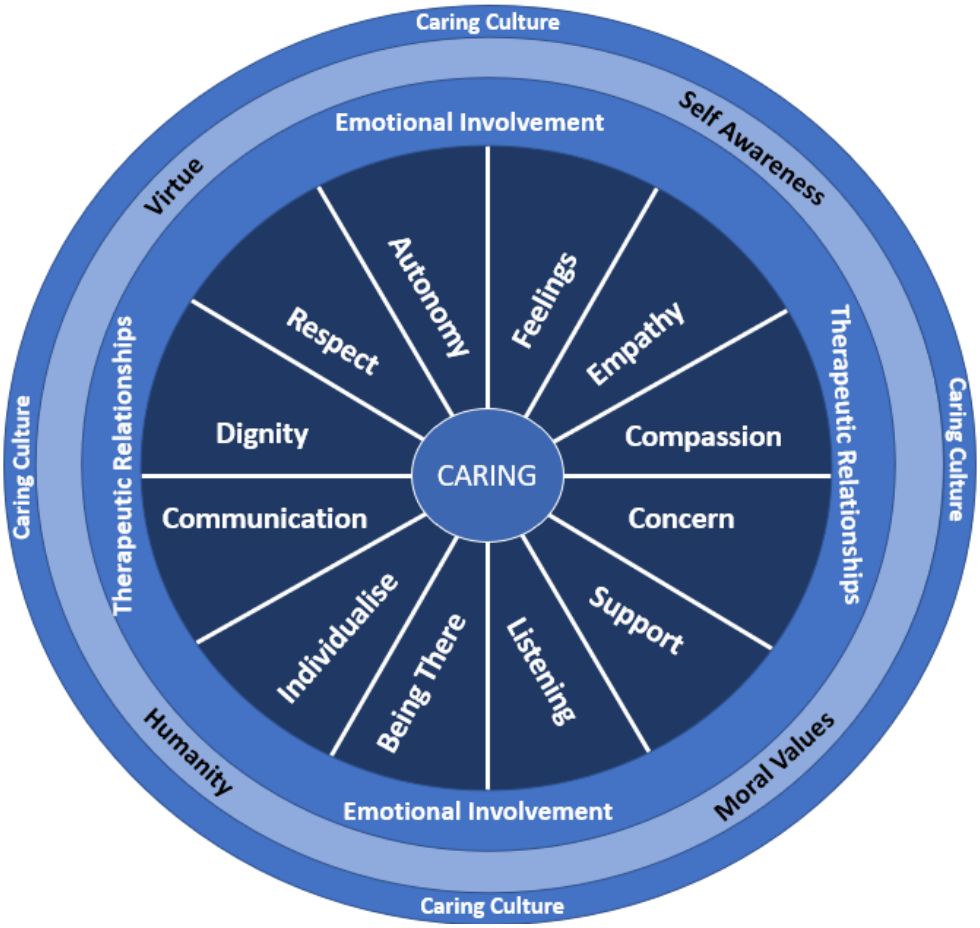

Figure 7 A Diagrammatic Representation of Caring Based upon the Literature Reviewed

3.0 Methodology

3.1 Introduction

Previous chapters explored the background, context, and significance of this study, in addition to the literature around caring as a concept. This chapter considers the methodological approach to the study, including my own ontological and epistemological stance. The practicalities of semi-structured interviews, and data analysis will also be deliberated, in addition to the appropriate ethical considerations related to conducting a research study.

Before considering the methodological choices and practicalities of data collection, it would be useful to review the questions this study explored. The main research question was to establish what are academic educators' perceptions, lived experiences and conceptualisations of caring within the clinical and educational (university) settings TR practice.

The sub-questions explored:

- How do academic educators perceive the notion of caring in clinical and educational TR practice?
- What are academic educators lived experiences of caring in the clinical and educational contexts?
- How might academic educators' perceptions, experiences and conceptualisations of caring influence their practice in the education setting?

3.2 Rationale for Research Approach

This research study was approached from my role as a TR academic educator. My sphere of influence now within academia, this research forms part of an educational doctorate, and as such may be classified as educational research. In his exploration of the philosophy of education research, Pring (2015, p.10) identifies many criticisms of educational research to be carefully considered when undertaking a study. He suggests failure to address a practical question, disconnect with professional practice, fragmented studies failing to build a broad, overall perspective of an issue and finally, poor quality are all issues facing the educational researcher. These concerns have been acknowledged within the research design.

The realities of teaching caring are closely linked with educational practice. This study aimed to determine how academic educators construct caring whilst also exploring the pedagogic approach to the value of caring. I argue that this study will address a practical question intrinsically linked to professional, educational, and clinical practice. Considering the quality of the research, trustworthiness and authenticity featured within the study, facilitated in part by a reflexive approach and completion of a reflexive journal. The study provided quality through credibility, transferability, dependability, and confirmability (Lincoln, 1995, p.277), which will be discussed in greater depth later within this chapter.

The intention of this research was to explore how academic educators construct caring, in addition to considering the influence of their perceptions and experiences upon their professional teaching practice. My underlying philosophical perspectives as the researcher were of influence when selecting the research methods (Newby, 2010) although the problem under investigation arguably defined these methods (Malterud, 2001). Denzin and Lincoln (2013) suggest qualitative researchers' philosophical assumptions highly impact the nature of their research. This is in concordance with Creswell (2007) who further explains the influence of the researchers' oncological, epistemological, axiological, and methodological perspectives upon the choice of research methods. Thus, it would be appropriate to consider my own philosophical position in relation to the chosen research study; that of the interpretivist paradigm.

Firstly, I will clarify some of these terms for completeness and then explore their influence on my study. Laverty (2003, p.12) describes ontology as 'the form and nature of reality and what can be known about it' and 'epistemology is described as the nature of the relationship between the knower and what can be known'. My ontological positioning is that there are multiple realities depending upon the experiences of the individual. Single phenomenon may have multiple interpretations rather than an absolute truth determined through measurement. Knowledge and understanding are constructed through lived experiences and interactions with others. This influenced my research as I wished to explore the realities of caring and how it is observed by individuals, accepting that there may be multiple perceptions influenced by participants' experiences and interactions. Thus, my approach was interpretivist. When exploring the construct of caring which is meaningful to me, it would feel wholly appropriate to be fully engaged with the

research process and the participants when gathering data. Conversely, this deep engagement may overshadow participants' views with my own; reflexivity was thus essential and will be discussed later (Attia and Edge, 2017).

Epistemology refers to the creation of knowledge (Creswell, 2007). The epistemological approach within this study was that reality is constructed by individuals though a series of events, and activities. Actors experience the phenomenon of caring in a variety of different ways, rather than the existence of a universal meaning or truth (Creswell, 2007). The interpretivist approach enabled not only a description of these phenomena as experienced by participants, but also a deep understanding of them in the social context (Pham, 2018). In relation to this study, my beliefs and understanding of the importance of caring in practice and how I feel it may impact pedagogy must be acknowledged as subjective and influential preconceptions (Malterud, 2001). This creates further need for a reflexive approach.

The axiological perspectives I brought to the study related to the role of values within the research (Creswell, 2007). My values highly influenced the choice and nature of the study. My own values around caring practice must be acknowledged as influential in framing the nature of this research. Caring is a highly dominant aspect of my own personal and professional practice which is fundamental to the chosen thesis subject.

Having established my theoretical viewpoint underpinning this proposed research, it would be appropriate to explore the methodological perspectives that guided the study.

3.3. Alternative Methodologies

A variety of possible methodologies related to the research questions and the interpretivist standpoint, were considered. These included ethnography, discourse analysis and action research. However, the two methodological frameworks that resonated most with the questions proposed were Phenomenology and Grounded Theory. Phenomenology studies the lived experiences of individuals and how meaning and knowing are socially constructed notions (van Manan, 2001). This approach sits well with the research questions proposed. With Grounded Theory the focus is the generation of theory, 'grounded in' or developed from a systematic analysis of data, often in a group setting (Bolderston, 2012). This may be suitable

to theorise the notion of caring, but this study intends to explore the individuals' lived experiences rather than from the aspect of a group and the social process of caring (Bolderston, 2012; Starks and Trinidad, 2007). This is important as the individual socially constructed phenomenon of caring is the focus of the proposed research study. Phenomenology thus offered a more suitable framework for the study, and I will now elaborate on why it is justified.

3.3.1. Phenomenology

Phenomenology is a complex, philosophical approach that concerns themes arising from the consciousness, the lived experiences of individuals (Giorgi, Giorgi and Morley, 2007). Two main approaches to phenomenology can be utilised, descriptive phenomenology based upon the original work of Husserl (1960) and interpretive phenomenology developed by Heidegger (1962). Either approach could have been suitable to address the research questions, but the Husserlian methodology was utilised in this study, primarily as it 'brackets' or attempts to reduce the researcher's influence on the data (Mapp, 2008). The Heidegger approach uses Hermeneutics or interpretation, bringing the researcher's own understanding and experiences of the phenomenon under scrutiny to the research process. The intention was to avoid my own influence and experiences in the research as much as possible, therefore the Husserlian, or descriptive approach was necessary. This methodology advocates firstly describing, and then analysing the same phenomena as they appear to different participants (Mero-Jaffe, 2011). The aim being to determine meaning; to understand the essence of the phenomena under inquiry through descriptive categories of the real world as perceived within the stories of the participants (Giorgi, Giorgi and Morley, 2007). A brief exploration of the historical perspectives of the two main approaches to phenomenology and how this study was situated within the chosen style, will be useful.

3.3.1.1. Husserlian and Heidegger Approaches – a Brief History

Descriptive or transcendental phenomenology was developed by Edmund Husserl around the turn of the 20th century. Husserl's philosophy challenged the established positivist stance, seeking the true meaning by delving deeply into individuals' reality. There was a focus on exploring the 'things' themselves, the objects of knowledge, the essence. The observer transcends the phenomena rising above it and so the investigation of meaning develops a global view. Thus, the term

transcendental phenomenology was used. The descriptive or transcendental approach allows the researcher to uncover descriptions of the essences and phenomena under investigation. Human experience could in effect, be objectivised.

In contrast Heidegger a student of Husserl, developed a model based upon descriptive phenomenology, often considered a follow on. The Heidegger approach (1962) may be referred to as hermeneutic or interpretive phenomenology. Heidegger's view was that the observer could not remove themselves from the identification of the essences, and that they existed with the phenomena. This position would need to be considered when investigating a phenomenon, as the researcher cannot remain neutral or detached from the essences. Heidegger also had language and the interpretation of an individual's 'meaning-making' (how they attribute meaning to a phenomenon) central to hermeneutic phenomenology (Dowling, 2007).

After the initial work by Husserl and Heidegger, other researchers and philosophers refined the approaches described above. Gadamer concentrated on how language reveals 'being' in the philosophy of Gadamerian Hermeneutics (Dowling, 2007). Van Manen (2007) furthered hermeneutic phenomenology through the language of an interview with cultural and historical context which reveals itself to the participant and the researcher during the process.

Descriptive and hermeneutic phenomenology are not in competition one appearing better than the other, more the choice of descriptive or hermeneutic phenomenology lies with the judgement of the researcher to determine which approach is most applicable to their study.

Husserl's descriptive phenomenology differs epistemologically from other types of phenomenology in terms of the nature of how the understanding of a phenomenon is processed. Husserl believed that one could set aside personal assumptions to describe a particular phenomenon and derive understanding of that phenomenon. In descriptive phenomenology, he described the human lived experiences as 'life world'. Life world (Husserl, 1970 cited in Laverty, 2003, p.4) can be considered as '…What we experience pre-reflectively, without resorting to categorisation or conceptualisation, and quite often includes what is taken for granted or those things that are common sense.' This means the description is pure and is the lived experience before being reflected upon. With respect to this study, caring is much

used within healthcare and education, and generally within society. To enable this study to truly reach the heart of what caring means in TR, it was essential to describe the lived experiences before they were reflected upon in depth. It was also essential to remove my own lived experiences and assumptions of my view and perceptions of caring. In descriptive phenomenology two key terms or processes are employed to shape the approach, intentionality, and reduction, both of which will now be explored.

3.3.1.2. Intentionality and Reduction

Intentionality for Husserl was a process where the mind or consciousness is intentionally directed towards the phenomenon studied, through which a description of the object of the study, caring, can be made (Laverty 2003). Through intentionality, structures of thought or consciousness (Moustakas, 1994) follow making the experience distinct from others, and so giving rise to the *essence* under scrutiny. McLean (2015) explained *essence* through the metaphor of an onion. In peeling away each layer of an onion, the centre or core is reached, the essence. Thus, uncovering each subsequent layer of the lived experience enables us to reach the core or the essence of caring. Every intentional act is comprised of '*noema'* and '*noesis'*; Noema can be considered as the phenomenon itself and how it is perceived, whilst noesis is the meaning that is assigned to that phenomenon (Moustakas, 1994).

Phenomenological reduction means that any of the researcher's assumptions and beliefs are held in abeyance so that the pure phenomenon can be identified and isolated from what is already known (Abalos *et al.,* 2016). This was particularly important within this study as caring is well known to individuals, admittedly hard to define, but any adult human would offer a view or opinion of the concept. In the professional setting, assumptions could be compounded and maybe lack authenticity as much is written in policy about the expectation of professionals being 'caring'. The need to attempt to set aside the researcher's prior knowledge was important, this process is 'bracketing' (Moustakas, 1994). Bracketing is an aspect of reduction in phenomenology, it does not seek to eliminate all prior knowledge, more to enable that knowledge to be separated from the essential lived experiences of those within the study. For this study on caring, I have much prior knowledge as an individual, a clinical radiographer and as an educator. Thus, it was essential to

attempt to bracket my own knowledge and experiences throughout the study. As Husserl said, enabling me as the researcher to go 'back to the 'things themselves' (Husserl, 2001, p.xxiii).

To better enable the important aspect of bracketing within descriptive phenomenology, and prior to beginning the data analysis, I recorded my own description of the phenomenon of caring through my own experiences within the reflexive journal (Appendix 2 and subsequent sections within this chapter). This written exploration of experiences and presuppositions was essential to allow perceptions to be acknowledged, and to situate myself emotionally and socially regarding the perceptions of caring I hold. These experiences and opinions could then be set aside as much as possible, allowing the essences to be illuminated from the participants' viewpoint.

Husserl describes two main types of reduction. The first is transcendental or phenomenological reduction, the second being *eidetic* reduction. Transcendental reduction requires bracketing to put aside any bias or assumptions about a phenomenon. This can also be referred to as phenomenological *epoché*, which means to refrain from judgement (Moustakas, 1994). A result of bracketing or detachment means the true phenomenon can be visualised which is important in this study around caring. My own views, experiences and assumptions could potentially overwhelm the descriptions from the study and its participants. This was crucial as there appears to be no other study exploring the phenomenon of caring in TR practice and education.

The first supplementary research question in this study sought to define how academic educators perceive the notion of caring in clinical TR practice. There was a danger that without *epoché* my own views could dominate the findings due to my fierce personal feelings, values, and experiences as a clinical and educational practitioner. It would be preferable to reveal the notion of caring from the perceptions and lived experiences of the study participants. With a Heidegger approach the observer could not remove themselves from the identification of the essences, as they exist with the phenomena. Thus, the Husserlian phenomenological approach was better suited to my study.

Bracketing sets Husserl's phenomenological epistemology aside from other approaches and is accompanied by other benefits, hence the alternative name,

transformative phenomenology. The approach can positively impact the researcher and the study participants through heightened self-awareness, reflection, and change (Perry, 2013). The transformative nature of my study on caring has already been identified and will be discussed in later chapters. After completion of the interview, some participants acknowledged (when responding to an email of thanks by the researcher), that their lives had been positively impacted by the research process. This is suggestive of the transformative nature of the phenomenological approach.

The purpose of phenomenology is 'to illuminate the specific, to identify phenomena through how they are perceived by the actors in a situation' (Lester, 1999, p.1). Academic educators as actors within the undergraduate TR curriculum will have individual perceptions around the construct of caring. Phenomenology would seek to describe the lived experience of caring for educators allowing meaning to be made of the concept (Starks and Trinidad, 2007). A phenomenological framework would enable these experiences and interactions of participants to be explored within the context of their own specific reality of caring (Starks and Trinidad, 2007; Sokolowski, 2000). This could be because each participant has their own life experiences and interactions as an individual that may be influential in framing the meaning of caring. Highlighting similarities through a phenomenological approach could be used to develop a pedagogic framework whilst illuminating differences could recognise areas teaching might address. Phenomenology aims to develop 'a complete, accurate, clear and articulate description and understanding of a particular human experience ...' (Brown, n.d.). It explores the 'essential perceived reality with common features' (Starks and Trinidad, 2007, p.1373) which means the subjective truth, known only through the perceptions of the individual actors can be explored.

In summary, considering the research questions posed, a phenomenological approach was decided most suitable for this study. Phenomenology considers the 'values of the individual's experience and their whole being' (Reiners, 2012, p.1). This aligned more with my values and approach to practice, my own ontological and epistemological stance but also favoured the individual and subjective realities of caring.

3.4. Data Collection

In phenomenology, stories may be elicited from participants using carefully crafted questions as part of face-to-face interviews (King, Horrocks and Brooks, 2019). Open ended questions such as *"Can you tell me an example of when you…?"* or, *"What was it like when…?"* enable the researcher to seek values and context when exploring participants' experiences. Phenomenological research does not demand justification or defence of participant's opinions or behaviours (Bolderston, 2012). Exploring personal, lived experiences and perceptions can be best elicited through storytelling and conversation. However observation is a well-documented method within qualitative ethnographical research (Cypress, 2019) where the researcher observes first-hand the actions and behaviours of individuals in the setting under study. This may have been helpful in this study to see caring behaviours but would not enable the essence and meaning and perceptions of caring as a concept to be revealed. To garner individual views of the potentially emotive experiences of caring, one-to-one interviews rather than focus groups were more suitable. In retelling early experiences of caring, participants could divulge much less personal detail in a group setting, thus the option of interviews was considered preferable. However focus groups may have enabled sharing of stories and provided a combined view of what caring means to the participants. Of course any anonymity is 'lost' as participants are in a shared space discussing experiences. Focus groups would be more challenging for participants in terms of time and travel required (Sim and Waterfield, 2019). Additionally, due to the pandemic it would have been more difficult to convene an online focus group and achieve the same interaction of a live in-person focus group.

3.4.1. Choice of Method – Interviews

Interviews allow for greater flexibility in data collection and a better understanding of emotions, experiences, and events as required for this study concerning participants' perceptions of caring (Bolderston, 2012; Newby, 2014, p.340). The format of interviews may be considered to lie within a continuum; from unstructured, semi-structured and finally structured (Brinkmann, 2013), each providing potential advantages and disadvantages related to this study of caring. Structured interviews were considered unsuitable due to the absence of any free-flowing dialogue or

conversation between participant and researcher (Cypress, 2018). Additionally, the lack of prompts with this interview format, to elicit greater understanding and clarity of participants' lived experiences, could potentially reduce the richness of data.

Unstructured interviews offered a different approach, beginning with a broad open question related to the study focus. Pre-formatted follow-up questions would not be scheduled, with a reliance on the researcher guiding the interview with themes, allowing a flexible, non-directive storytelling (Doody and Noonan, 2013). The researcher engages fully in active listening to participants' lived experiences which can be useful when little is known about a topic, as in this study of caring in TR. However unstructured interviews may hold some challenges. For example, there may be more researcher bias, which could be crucial within this study of caring (Doody and Noonan, 2013). The importance of caring to me as a practitioner and researcher could be more likely to influence unstructured interviews. Despite attempts to bracket my views, these may more naturally come to the fore through less appropriate questioning linked to my personal views. Data may also be harder to analyse with unstructured interviews as participants can retell issues of less relevance to the study. An ideal within the interview continuum may be the semi-structured format, allowing some structure and prompts whilst retaining free-flowing storytelling by participants. Thus, a semi-structured approach enhanced the credibility of the data (King, Horrocks and Brooks, 2019).

Benefits of the semi-structured format were that areas may arise within the interviews that required a greater depth of exploration. It also allowed for probes to better elicit meaning and clarity when participants told their stories and outlined their experiences. The structured interview format would be too restrictive when exploring personal experiences, views, and meanings. As the interviewer, clarifying understanding of the individual's viewpoints is an important consideration, enabling exploration of areas that were unforeseen when formulating the research questions.

Having decided upon a semi-structured format, the next decision was to conduct either telephone or face-to-face interviews. A person-to-person interview was preferable to this study when compared to telephone interviews. The interpersonal relationship of interviewer-interviewee is an essential aspect of the interview (Stacey and Vincent, 2011; King, Horrocks and Brooks, 2019). Non-verbal communication can be considered when face-to-face (recorded as a set of

interviewer notes) and a rapport can be better established (Newby, 2014). Conversely, telephone interviews may offer less spontaneous discussion and indeed create issues when intending to record discussions (Newby, 2014, p.342). Although spontaneous discussion is to be encouraged in the interview setting, there is a concern over participants responding in an inauthentic manner to the emotive subject of caring. This means the possibility of responding with the 'acceptable answers and views of caring', influenced by social and professional convention rather than their own experiences and perceptions. In addition, my passion for the topic could overly direct responses, creating social desirability (Stacey and Vincent, 2011), bias and inauthentic responses. A reflexive approach helped minimise such bias. Despite a preference for in person face-to-face interviews, this became impossible due to the Covid-19 pandemic.

3.4.2. Population and Sampling

The questions arising from my deliberations and practice related to the small population of TR educators within England. Practice within Ireland, Scotland and Wales varies. Degree programmes for example, are four years long in Scotland, in addition to the NHS structure being different to that in England. So, for these reasons the study was limited to England which included my educational setting.

As previously explained, TR is a small profession, and few Higher Education Institutions (HEI) deliver an undergraduate degree programme. At the time of this study ten universities provided education to student TRa. Within a small professional sphere, the overall population of educators is naturally also rather small, fewer than fifty within England. For practical reasons, the study planned to involve face-to-face interviews with participants at HEIs within a one-day travel window. Geographically this was Southeast England in which six of the ten HEI were positioned. This would allow for a suitable sample of participants to be drawn from a variety of institutions. However, as the Covid-19 pandemic caused national restrictions, this geographical limitation due to travel practicalities became obsolete. Moreover, face-to-face interviews were no longer possible as Universities moved to a wholly online presence.

Programme leaders within this small sphere of TR are known to each other through many aspects of our practice, but to access names and contact emails, the SCoR used a platform known as GlassCubes to provide a community of practice

(Appendix 3). Initially this was utilised to make contact through an invitation email (Appendix 4) to the network of TR educators within the Southeast of England. The invitation email was distributed in January 2020 with the interview dates set for March 2020. Two interviews were completed face-to-face before restrictions came into force. Four other interviews scheduled for March 2020 took place via Skype and telephone. Data collection was then interrupted due to the pandemic.

In September 2020 as some restrictions were eased, a further invite was made. However, the platform 'GlassCubes' was no longer supported by the SCoR, thus contact was made directly to programme leaders through their email address on the various HEI websites. As the interviews would now be completed online or via Skype, the constraint of travel was negated. The final three interviews took place in November 2020. Participation was open to all TR educators within the HEIs, and programme leaders were asked to disseminate the invitation to their team.

A carefully crafted information sheet was provided to potential participants, explaining the nature of the study (Appendix 5). It was designed with good research practice in mind; standards of good ethical practice were adhered to (BERA, 2011) using the information sheet to convey full details of the study to participants. Well-being and anonymity of participants were maintained. Consent forms (Appendix 6) were designed and utilised for this study. Voluntary informed consent was gained from each participant, identifying possible withdrawal, the potential use of anonymised quotes, confidentiality and respect (Brooks, 2014; BERA, 2011). For the face-to-face interviews, the consent form was signed by participants. For remote interviews, the participants were emailed the consent form beforehand and verbal consent taken before commencing the interview.

Those responding to the invitation to participate may have chosen to do so due to their own particular interest in the subject of the study, caring. Thus, there may be a potential bias in those self-selecting to be interviewed. This has been considered within the design and the formulation of the interview questions. These do not presume any stance regarding caring, are open and relate to lived experiences and perceptions of everyone.

3.4.3. Participants

A total of nine interviews were conducted. The first two interviews were conducted face-to-face, the remainder by Skype and Microsoft Teams. The interview format and protocol remained unchanged. It must be acknowledged that there may have been an impact of the pandemic on the participants' views and experiences around caring. Nationally and indeed across the globe, public and practitioners alike experienced emotions, previously unconsidered, due to the pandemic which may have reframed some views. In my Weblog discussing this topic, I suggested:

> *'The real test of our culture, our society and us as individuals comes during adversity and I believe COVID-19 has reminded us of that. Caring interactions and compassion for all sentient beings has to be a priority.'* (Hendry, 2020)

The inclusion criteria for participation in this study were uncomplicated, the only criterium was that the participant was a TRa in an academic setting for an undergraduate programme within England. Participants would also need to be able to participate in a virtual interview when Covid-19 restrictions came into force. The length of time in the profession and the participants' time in role as an educator were not targeted specifically, neither was gender purposefully considered in participants. The aim was for a broad range of participants and characteristics to be achieved. Within a very small profession, purposefully sampling participants in terms of characteristics could lead to possible identification of subjects. Therefore, to adhere to standards of good ethical practice (BERA, 2011), which includes maintaining the anonymity of participants throughout the research, only time as a TRa and as an educator was recorded.

3.4.4. Pilot Interview

To check the feasibility of the study, a pilot interview was undertaken (Kim, 2010). A pilot acts as a small-scale test to help ensure the chosen study methods would work in practice. Moreover, Kim (2010) suggests the principal benefit of conducting a pilot study is to test the research protocol whilst providing the researcher with the opportunity to revise and adjust the data collection method when conducting the main study. The opportunity to test the acceptability of the interview questions, the interview format and my style and rapport can all be gleaned from a pilot interview. By inviting the presence of a research supervisor to observe the pilot, I was able to gain, not only feedback from the participant but also that of an experienced research supervisor. My role as interviewer could be examined during the process of the pilot.

This would benefit the credibility of the study and from the reflexive approach, enable me to self-evaluate my ability and readiness, in addition to my competence as an interviewer, and thus a qualitative researcher.

As the study was small with a small population and sample, it was decided to invite another member of Faculty, not from TR to be interviewed as the pilot. The first colleague approached agreed to participate in the pilot interview. The participant was a fellow educational doctorate student on the same programme, but in the related field of nursing. This was felt to be particularly useful due to knowledge, understanding and similarities between professions and the proposed study. The pilot was undertaken in January 2020 face-to-face, with one research supervisor present in an observatory capacity.

Feedback from both the participant and my supervisor agreed upon my engaging style, good use of prompts and positive ques to indicate active listening. The interviewee reported '*feeling at ease'* and *'it felt more of a chat'* acknowledging that she was readily put at ease – *'you made it easy for me to talk'*. This was encouraging as I felt a degree of nervousness, and an almost desperate feeling of non-maleficence. Reflecting on the pilot interview later in my journal, I realised it was a positive experience and I could acknowledge participants' views when they resonated with mine but still value them if they differed.

In practical terms, some minor rephrasing of questions resulted from the pilot interview. Rather than asking for very focussed positive and negative aspects of a caring experience, I made questions much more open within the main study. Using phrases such as '*what made you feel that was a really caring experience?*' for example. This is discussed in more detail within the interview protocol section.

An area that is important to check and confirm through the pilot, was that of timing, so that participants could be fully aware of timing and other requirements when voluntarily consenting to take part. I did have concerns about the number of questions I had within the protocol. I intended for the interview to last no more than an hour, for the benefit of the participant but also for the length of time I might be actively and attentively listening to their experiences. This was a further element of good practice. It became apparent that the participant was much more specific in their responses during the pilot. This could be due to their understanding of the interview process and the nature of the study, conducting a study using similar

methods in their own doctorate. Their interview concluded within 40 minutes, but subsequent interviews in the main study were longer, and some probes were needed to elicit clarity and understanding.

3.4.5. Interview Protocol / Guide

Interview protocols or guides are frequently used in qualitative research studies to provide transparency, meet ethical requirements, and enhance data collection dependability and consistency (King and Horrocks, 2010). The Interview Protocol for this study can be found in Appendix 7.

To support the semi-structured interview format, the protocol was prepared in advance based upon the research questions and overall aim of the study. To foster a more consistent approach, the researcher adhered to the same format for each interview. This would not remove the opportunity to ask prompts or probes, to clarify or to explore other aspects raised by the participant within the interview. The protocol did provide a structure and format to better enable all areas of the study, and each research sub-question, to be consistently included.

The interview format began with a brief introduction to the researcher and the nature of the study. Reference was made to the Participant Information Sheet (Appendix 5) and clarification sought from the participant around consent together with the opportunity to ask any questions. The anticipated timeframe for the interview (around 60 minutes) was reiterated together with the requirement to record the interview. With face-to-face interviews, the Consent Form (Appendix 6) was signed, for online interviews consent was confirmed verbally.

The interview was divided into five sections, although the move between them was fluid, it enabled both interviewer and participants to gather thoughts and be aware of timeframes. Questions were open and exploratory in preference to closed questions. They elicited experiences and perceptions of the participants. The first section related to general ice-breaker questions around length of qualification, time in role and when the participant moved from full clinical practice to education. An overview of the interview questions is provided in Figure 8.

The next section asked about personal experiences of caring as an individual. The third section related to clinical and the fourth educational practice. A final conceptual exploration was made. Within each section participants were asked to relate an

experience of caring to them, what made that experience caring or indeed when caring was absent or non-caring was experienced. Within the confines of time and relevance, participants were encouraged to speak freely. Pauses were not immediately filled by the researcher to enable thoughts and conversation to flow.

Voice recordings were made on two electronic devices to ensure no data was missed or lost should one fail during the process. Participants were made aware of the recording methods. Video recording was not undertaken.

Recordings were uploaded to the professional transcriber's portal at which point pseudonyms were assigned. Recordings would be deleted upon successful completion of the study, explained further within the next section.

The community of TR is small and five of the nine interviewed were known to me at a professional level. Although some unrelated discussion occurred before and after the main interview experience, the use of an Interview Protocol enabled consistency to be maintained and the process remain as unbiased as possible. Reflexively I acknowledged the potential for professional relationships to overshadow the discussions and ensured I checked and rechecked my questioning and behaviours during the data collection process. This helped maintain study credibility.

General
Tell me about your current role...

How long have you been in this role?

So how long have you been a Therapeutic Radiographer?

Experiences - Personal
Can you tell me about any of your experiences of caring in your personal life?

Can you recall what was memorable about these experiences?

How did these experiences make you feel?

Experiences – Clinical *Thinking now about your time as a clinical radiographer....*
Can you tell me about any of your experiences of caring in your clinical role?

When do you feel you have cared as a clinical radiographer?

Can you recall what was memorable about these experiences?

How did these experiences make you feel?

Can you tell me about an experience you had when you felt caring was absent or reduced?

What was it that made this a really caring experience?

What was it that made you feel it was not so caring an experience?

Experiences - Educational *Thinking now about your time as an educator...*
Can you tell me about any of your experiences of caring in your current role?

When do you feel you have cared as an educator?

Can you recall what was memorable about these experiences?

How did these experiences make you feel?

Can you tell me about an experience you had when you felt caring was absent or reduced?

What was it that made this a really caring experience?

What was it that made you feel it was not so caring an experience?

Experiences – Conceptual *Thinking now about caring as a concept overall....*
How do you think we can be or demonstrate caring?

What would demonstrate 'not caring' in your view and experience?

How do you feel caring can be developed?

Figure 8 Overview of Interview Questions

3.5. Ethical Considerations

Approval for the study was obtained, prior to commencing data collection, from the Local Faculty Research Ethics Committee. The application can be found in Appendix 8 and the confirmation of ethical clearance in Appendix 9.

For those interviews conducted face-to-face, the environment was carefully considered. A secure, quiet but comfortable room, with audio recording was utilised to enable a full transcription of the interview to be made (BERA, 2011; Kruger and Casey, 2008; Atkins and Wallace, 2012). My own safety as a lone researcher visiting participants' HEI was also ensured. For this reason, interviews in participants' offices were avoided and central rooms booked on campus. I identified my location to my supervisors and annotated my shared diary appropriately helping to better ensure my safety during the interview process. For interviews conducted 'online' this was via Skype or Microsoft Teams. The appropriateness of the participants' surrounding was checked before beginning the interview. For my own setting this was quiet, confidential, and secure, alone in my own home.

As part of good research practice, all studies must be conducted in such a way as to minimise and mitigate for possible participant distress (Stutchbury and Fox, 2009), particularly when the study explores lived experiences. Moreover, practice

should not only be ethical but also involve a sense of professional, moral duty or deontology which concerns 'doing your duty', regardless of the consequences' (Stutchbury and Fox, 2009, p.490). This study fully considered the ethical and moral practices of good educational research (BERA, 2011; Brooks, 2014). For participants within this study, caring experiences relating to professional, clinical, or individual emotions were discussed. These lived experiences could create tensions or possible distress for participants. So, after each interview participants were provided with the contact details of their local counselling/support service. Although unlikely, it was important to mitigate for potential problems. Each participant did in fact become emotional, but this related more to their personal experiences, and to a lesser extent those relating to clinical and educational roles. My focus at this time was on their well-being and when aware of their distress, I offered to break or end the interview. Each participant was keen to continue.

Storage of data derived from the study was also subject to appropriate ethical consideration (Brooks, 2014; BERA, 2011). The audio recordings of interviews could enable participant identification. Only the researcher (and professional transcriber) accessed any gathered data before anonymising recordings. My supervisors had access to the data once anonymised. Recordings were stored digitally on a password secured and encrypted computer accessed only by the researcher. In line with the institutional research data policy, study data will be kept for ten years (Kingston University, 2016).

The study was compliant with the General Data Protection Regulation (GDPR) (Information Commissioner's Office, 2018), principles of which include the appropriate use and processing of participants' personal data. This was a requirement of ethical approval together with completion of a Data Management Form (Appendix 10) that was completed online at https://dmponline.dcc.ac.uk/ to meet Institutional requirements for ethics and data protection.

3.6. Data Analysis

3.6.1. General Principles of Qualitative Data Analysis

Qualitative data analysis is not a straightforward, linear process as it is recursive, repeating the various stages of exploring, analysing, and interpreting the data, whilst also being reflexive, attempting to avoid overly influencing the data (Cohen,

Manion and Morrison, 2018). However, it must be acknowledged that in analysing qualitative data such as interviews, the researcher will have influence over the interpretation of these data, the themes generated and the drawing of conclusions. Thus, a reflexive approach is important to situate myself socially and emotionally in relation to participants experiences, not only at the data collection stage, but also during analysis (Mauthner and Doucet, 2008). The role of bracketing has been discussed and reflexivity will be covered in a subsequent section of this chapter.

To view phenomenological data with an open mind, it is suggested to complete data collection before reviewing all interviews (Moustakas, 1994). This was also important for the research questions posed with this study, as they sought to explore participants' lived experiences which are unique and individual. If the questions posed within the interview process were refined considering previously analysed data, the uniqueness of that data, experiences and perceptions may be lost. This distinctiveness was essential when seeking the 'essence' of caring in this study.

For all qualitative data analysis, some general principles or processes are involved (Cohen, Manion and Morrison, 2018). These include preparing and organising the data, describing, and presenting the data, analysing, and interpreting the data, drawing conclusions and presenting the findings (Newby, 2010; Creswell, 2012; Cohen, Manion and Morrison, 2018).

3.6.2. Possible Methods of Data Analysis

For phenomenological research, data analysis methods have been proposed by, for example, Colaizzi, Giorgi and van Kaam (Moustakas, 1994). They share many similarities but also nuanced differences that might better suit one type of study over another. Any thematic analysis process could arguably bring themes and codes from the data but using a process or method of analysis particularly suited to and frequently employed within a descriptive phenomenology study could provide an improved level of analysis and synthesis, to illuminate the essence of caring.

When fully immersed within the data, and attempting to set aside personal presuppositions, the researcher begins to interpret the data deriving themes, patterns, understanding and explanations within the context of the research questions (Cohen, Manion and Morrison, 2018). This process is inductive and as van Manen explains, participants' lived experiences can be interpreted by the

researcher through '...insightful invention, discovery or disclosure...' (van Manen, 2001, p.78). This gives a greater understanding of the 'structures of experience' (van Manen, 2001, p.79) rather than the simplistic view of just developing themes or categories. Within this study, a picture of caring in TR was revealed from the *disclosure* of participants' experiences, building upon their individual experiences to garner an understanding of the very essence of caring, not merely from assigning a theme.

Methods of analysis proposed by Colaizzi and van Kaam were best suited to a descriptive phenomenological study (Priest, 2002; Moustakas, 1994) as they both provided a description of the meaning of experiences. That proposed by Colaizzi was deemed less favourable as it suggested descriptions (during the analysis process) of transcripts were returned to participants for potential revision. In this study of caring, transcripts were not returned to participants for confirmation to maintain the authenticity of the lived experiences in the moments of the interview. This was particularly important as a phenomenological approach sought to explore the essence of caring as experienced directly by the participants. As Mero-Jaffe (2011) explains, reviewing transcripts may empower participants, but also allows the opportunity for reflection and amendment of text which may unintentionally change meaning from the original statements as transcribed verbatim. As caring is a frequently used term, a threshold concept (Clouder, 2005) with both professional and personal context, experiences within the moment were crucial to reveal the *essence* of caring itself.

3.6.3. Data Analysis Process – Modified van Kaam Method

3.6.3.1. Data Preparation

After recording the semi-structured interviews, data were transcribed by a professional transcriber. Individual transcripts were reviewed in full before beginning to explore emerging themes. This is known as familiarisation and is displayed in Figure 8. Transcripts were not returned to participants for confirmation as previously explained.

Denaturalised, in preference to naturalised, data transcription was utilised within the study. Denaturalised data accurately describes the dialogue but avoids detailed description of involuntary sounds or accent during the interview (Mero-Jaffe, 2011).

It provides flowing, uninterrupted data giving the essence of the interview, of the lived experiences, without the potential for misinterpretation of pauses, sighs or other sounds, thus may be considered more 'unblemished' (Mero-Jaffe, 2011, p.232). Voice patterns, body language and intonation can still be included in data transcription as these add meaning and relevance to denaturalised data.

Application was made for a small grant from Kingston University Graduate Research School (£400) to support transcription costs (Appendix 11). This was awarded to the researcher and enabled swift and accurate transcription by a professional.

3.6.3.2. Stages within the van Kaam Process

Moustakas amended and added to the process proposed by van Kaam for optimal analysis of data from phenomenological studies (Moustakas, 1994, p.120). This adaptation was considered preferable in this study for two main reasons, firstly the original van Kaam method includes early categorisation of data which is possibly at odds with the main aim of descriptive phenomenology. To illuminate the essence of the concept or phenomena avoiding preconceptions, early categorisation could undermine this notion. Secondly, the van Kaam method does not suggest emergent themes and concepts are determined from the combined analysis of all transcriptions. This was an aim of this study and indeed the first research question intended to determine how academic educators perceive the notion of caring in clinical TR practice. Thus, a composite deduction was preferrable. For these reasons, the method proposed by Moustakas as an adapted van Kaam process was selected (Moustakas, 1994, p.120). This will now be considered in more detail.

According to the modified van Kaam method (Moustakas, 1994, p.120), each interview should be transcribed verbatim, in complete form, for each participant. At this point pseudonyms were assigned so only the researcher and transcriber were aware of the participants' true first names, protecting and maintaining participant anonymity and confidentiality.

The following list of steps are based upon the modified van Kaam method (Moustakas, 1994, p.120; Priest, 2002, p.58) and were applied to each transcript in turn. When reviewing the transcripts, the research sub-questions were considered, with constant rechecking of the texts and the research intentions through a reflexive

lens. Figure 9 provides a diagrammatic overview of the steps involved in the modified van Kaam approach. Appendix 12 provides an example extract.

3.6.3.3. Horizonalisation

Horizonalisation refers to review of transcripts to identify any discreet statements that indicate the phenomenon being investigated, lifting them out of the transcript and recording them separately (Eddles-Hirsch, 2015). These statements are referred to as horizons (Moustakas, 1994). In this study, every relevant expression related to caring was listed, all given equal value, and preliminary grouping of expressions was performed. These horizons were discovered by selecting each statement of experience or perception related to caring and the overarching research question. Each sub-question was reviewed as the transcript was examined for each individual participant.

3.6.3.4. Reduction and Elimination

Having established a series of horizons related to caring, the next stage in analysis was to reduce the data by testing each expression related to caring to ensure that it could be sufficiently understood, abstracted, and labelled (Moustakas, 1994). If so, the experiences were known as 'Horizons of Experience', if not the expression was removed (Moustakas, 1994). Similarly, vague expressions were removed if they did not provide a sufficient moment of the experience that could be understood. These were later reviewed to ensure no data was overlooked or included when unrelated to the concept of caring and the focus of the inquiry.

3.6.3.5. Invariant Constituents of Experience and Imaginative Variation

After phenomenological reduction, the remaining expressions are referred to as Invariant Constituents (Moustakas, 1994), being 'never changing' or '*invariant'*. The next essential part of data analysis was *Imaginative Variation,* which required the researcher to see the phenomenon from a variety of perspectives, so that the essence of the participants' experiences may be understood (Eddles-Hirsch, 2015). Moustakas defines this task as seeking '[…] possible meanings through the utilisation of imagination, varying the frames of reference, employing polarities and

reversals...' (Moustakas, 1994, p.97). This means the researcher searched for possible meaning of experiences by examining the Invariant Constituents, using imagination, approaching the phenomenon from differing perspectives, roles, positions, and functions. In arriving at the description of an experience, through imaginative variation, the 'how' and the 'what' of the experience will be illuminated, to uncover the essence of caring in TR, address the research questions and reveal meaning. However, this step also offered the potential for the researcher's views to overwhelm the data and emerging essences. It necessitated a mindful and reflexive approach, being conscious of one's own views to avoid dominating the meanings with personal beliefs on caring. The reflexive journal was extremely useful and important during this process, revisiting the full description made before commencing analysis, so that views were acknowledged, and attempts made to 'bracket' them.

3.6.3.6. Clustering into Themes

The invariant constituents were *Clustered* and labelled as *Core Themes.* Clustering into themes related to grouping statements together into similar meaning units (Eddles-Hirsch, 2015). Themes were then checked by the researcher, against the original transcript, to determine if they appeared explicitly within the narrative. If not, they were deleted. The remaining expressions were known as *Validated Invariant Constituents.* Previously eliminated horizons were further considered and examined against the original transcription to confirm inclusion or elimination.

3.6.3.7. Individual Textural Description

The next stage was to organise and construct an individual textural description or story of each participants' individual experience of the phenomenon of caring (Moustakas, 1994). Examples or verbatims were extracted and used as quotes from the transcribed interviews to provide a vivid account directly from the transcriptions of the interviews (Becho, Sullivan and Bhattacharya, 2017).

3.6.3.8. Individual Structural Description

Using the *Individual Textural Descriptions* and *Imaginative Variation* (exploring various perspectives to help reveal the essences or phenomenon of caring itself), a description was made for each participants' experience. This revealed the

meanings and essences for each participant through a powerful account exploring how the experience of caring made the participants feel (Moustakas, 1994, p.135).

3.6.3.9. Composite Structural Description

In the final stage of the data analysis process a composite description of the meanings and essences of the experiences representing the group was developed (Moustakas, 1994, p.121). The *Individual Structural Descriptions* were combined for all participants revealing perspectives through collective description and comparison of different encounters. This stage enabled synthesis of meaning and illumination of the essences for the whole group jointly.

Process	Explanation
Epoché	Bracketing to minimise researcher impact upon data
Familiarisation	Read each transcription to become 'immersed'.
Horizontalization	List and group each expression related to the experience of caring, considering each sub-research question in turn
Reduction & Elimination	Reduce the data by testing each expression to be a moment related to caring that can be sufficiently understood, abstracted and labelled. If so, it is a *Horizon of Experience*. If not, it is eliminated along with any repetitive and vague expressions.
Invariant Constituents of Experience	The remaining data or Horizons of Experience are known as *Invariant Constituents*
Clustering into Themes	The invariant constituents are *Clustered* and labelled as *Core Themes.* The themes are checked against the original transcript to determine if it appears explicitly within the narrative. If not, it is deleted. The remaining expressions are known as *Validated Invariant Constituents*.
Individual Textural Description	The Validated Invariant Constituents and Themes for each participant are organised to create a description or story of the individual's experience. Verbatims are included.
Individual Structural Description	Using the *Individual Textural Descriptions* and *Imaginative Variation* (exploring various perspectives to help reveal the essences or phenomenon of caring itself), a description is made for each participants' experience. This reveals the meanings and essences for each participant.
Composite Structural Description	The *Individual Structural Descriptions* are combined for all participants. This reveal' perspectives through collective description and comparison of different experiences. This stage enables synthesis of meaning and the essences of the whole group.

Figure 9 Overview of the Modified van Kaam Approach

3.7. Rigour, Trustworthiness and Reflexivity

Qualitative research has been considered too subjective and lacking in the traditionally positivist research values of validity and reliability (Cypress, 2017). However, concepts such as rigour, trustworthiness, and credibility in relation to quality of research, other than quantitative, have emerged. Rigour relates to being precise, exact, or careful, demonstrating quality through accuracy and being thorough (Cypress, 2017). Yet any qualitative inquiry features an arguably subjective individual finding, free from the restraints of quantitative research, enabling the researcher and participant to travel a journey of exploration and discovery. Despite this, qualitative research must demonstrate levels of rigour to enable a study to be considered 'trustworthy' (Lincoln and Guba,1985).

Trustworthiness refers to authenticity, quality and truthfulness of study findings and relates to research design, methods and processes (Lincoln and Guba,1985). Similarly, reliability or dependability in qualitative research (Newby, 2014) is a test applicable to all research paradigms and infers a transparent demonstration of the study detail so that, if repeated, findings and conclusions would be similar (Yin, 2009; Bassey, 2000). Although the exact results of this study would not be directly reproduced as caring is an individual, socially constructed concept, certain steps within the research process enhanced reliability. These steps were particularly relevant within data collection and analysis and will be further considered here.

The role of the researcher in qualitative studies has already been identified and is particularly important within a descriptive phenomenological study, in part due to the 'epoché' described by Husserl. The researcher brings their own personal lens to the topic, any bias is explored and then conscious attempts to bracket are made so that 'everything is perceived freshly, as if for the first time' (Moustakas, 1994, p.34). Bracketing does not seek to completely remove the researcher from the study, as subjectivity is an inherent aspect of phenomenology (Mapp, 2008). Finlay (2008, p.2) explains that 'the bracketing process is often misunderstood and misrepresented as being an effort to be objective and unbiased'. The researcher should aim to be as open as possible to new ideas and how they are experienced by participants (Finlay, 2008), but also acknowledge my own perspectives. These views provide my 'understandings, beliefs, biases, assumptions, presuppositions, and theories' (van Manen, 1997, p.47) and are made explicit to both research participants and to myself. My epoché, made explicit elsewhere in this chapter and

in Appendix 2, was essential to confirm prior to beginning data analysis (Moustakas, 1994).

Reflexivity is the process by which the researcher acknowledges their subjective, yet essential, role in knowledge-production (Hennink, Hutter and Bailey, 2011; Finlay, 2002). As previously established when considering the research questions and theoretical standpoint, my own personality and experiences shaped the research process and potentially, data collection. Through a research journal, one's personality, interest and position were documented, being transparent and obvious when research outcomes are considered by interested parties (Hennink, Hutter and Bailey, 2011; Finlay, 2002). The log of reflexive moments after each interview helped raise awareness of my experiences of caring as an individual. For example, my personality values the feelings aspects of relationships, which may have placed greater emphasis on the emotional aspects of caring and may frame the whole nature of the study. In being transparent regarding this unique researcher position, outcomes from the study could be considered objectively. With reflexive awareness, my influence may add value to the study through introspection and understanding (Scott and Morrison, 2006) yet were carefully balanced to ensure my views did not overshadow those of participants (Finlay, 2002). Personal disclosure relative to caring allowed the impact of the position, perspective, motivations and presence of the researcher to be transparent and potentially transformative, thus enhancing the trustworthiness of the study. Hennink, Hutter and Bailey (2011, p.21) suggest this is personal reflexivity, but also acknowledge the importance of interpersonal reflexivity. Here the dynamic participant-researcher relationship and the research setting can be of influence and were similarly considered as part of the research process to further enhance trustworthiness and quality.

In terms of reflexivity specifically within the process of data analysis, it was imperative to constantly question the findings and not take them for granted. Supervisors were a valuable measure when giving their own supplementary views during this stage of the study. By constantly revisiting the original data with the descriptive text obtained during analysis, the reflexive approach was maintained. Optimal use of original quotes also supported a reflexive approach as these arose from the data themselves not from my own understanding or presumptions. This approach supported bracketing, epoché, as a part of reflexivity.

During data analysis and each step of the modified van Kaam approach, journal entries enabled a structured review of my position and awareness, a constant checking and rechecking so any influence could be acknowledged. This linked with credibility of the study, which refers to the meaningfulness of the findings, the transparency of analysis and how well themes are presented, supported by quotes (Kitto, Chesters and Groich, 2008). These steps improved the credibility of the findings and the study itself. Also of relevance is transferability. This related to the usefulness and relevance of the findings, were they sound and did they add to knowledge. The broader context of the research findings, to those beyond TR education, would demonstrate relevance and usefulness through meaning-oriented themes (Sundler, Lindberg, Nilsson and Palmér, 2018).

3.7.1. The Reflexive Journal

An element of reflexivity in the research process could be considered to enhance trustworthiness (Mays and Pope, 2000) and particularly confirmability, alongside dependability and credibility (Anney, 2014). Confirmability is 'concerned with establishing that data and interpretations of the findings are not figments of the inquirer's imagination but are clearly derived from the data' (Tobin and Begley, 2004, p.392). This was achieved in part, through my reflexive journal (Anney, 2014). Two journal extracts are included within this thesis to demonstrate my feelings and experiences so they may be acknowledged and 'put aside'. Responses from participants that linked with previous interviews, or particularly resonated with me as a practitioner were documented post-interview in addition to my own feelings. Individual interview transcriptions were cross-checked with my journal entries to enhance understanding and ensure analysis of themes was based in the true experiences and perceptions of the participants, not mine as the researcher.

It may not always be possible to fully set aside any pre-judgements and preconceptions. However, if these are appropriately acknowledged any similar experiences and feelings may positively add to this study, (Mapp, 2008). The log of reflexive moments after each interview helped raise awareness of my experiences of caring as an individual. For example, my personality values the feelings aspects of relationships, which may have placed greater emphasis on the emotional aspects of caring and could frame the whole nature of the study. In being transparent regarding this unique researcher position, outcomes from this study were

considered objectively. With reflexive awareness, my influence might add value to the study through introspection and understanding (Scott and Morrison, 2006) yet were carefully balanced to ensure my views did not overshadow those of participants (Finlay, 2002). Personal disclosure relative to caring allowed the impact of the position, perspective, motivations, and presence of the researcher to be transparent and potentially transformative (Finlay, 2002), thus enhancing the trustworthiness of the study. Hennink, Hutter and Bailey (2011, p.21) suggest this is personal reflexivity, but also acknowledge the importance of interpersonal reflexivity.

The following is an extract from the Reflexive Diary after interview four:

> *'I found it hard today, maybe my emotions are high due to isolation from my parents, a bereavement anniversary, and worry about online interviews, but the experiences retold about caring for a parent who died from cancer were difficult. At times I found my concentration drifted a little. L began to get upset and being unable to enact my view of caring – a touch for example - was troublesome for me. I wanted to care for L but was also in research mode. So not to negate the need or desire, or indeed the responsibility to care, I knew I had constraints. I decided to stop probing into the caring experiences L described around caring for her mother. I have a duty of care to cause no harm to participants...'*

This extract relates to data analysis:

> *'Alan's transcript needs my constant checking reflexively, that I am not ignoring some comments due to my personal views. It's a process of acknowledging that his views differ from mine at times, thinking about my views, then considering Alan's view again. Adding the Horizon despite my view. It helped leaving a gap between checking, reading, reviewing his transcript and highlighting the unique identifiable episodes of caring yesterday. Leaving it overnight and returning afresh the next morning…better enabling objectivity and not overly influencing on my part.'*

3.8. Summary

This chapter has provided the methodological choice and rationale for this research study into caring in TR. The use of phenomenology to explore the participants'

experiences was driven by my own philosophical and professional stance, in addition to the nature of the research questions posed.

The data analysis of a descriptive phenomenological study was highly important and in using the modified van Kaam method proposed by Moustakas, the true essence of caring were revealed. An inquiry into an emotive and important subject to me as an individual, practitioner and researcher must involve a level of reflexivity and epoché or bracketing to acknowledge my views and experiences whilst aiming to set them aside. This action was essential in my study to enable participants' views and experiences and provide the true meaning or essence to the phenomenon of caring. In attempting to acknowledge and address these essential aspects the study was more trustworthy, credible, and meaningful to research, education, and the profession of TR.

4.0. Findings

4.1. Introduction

Findings are presented as a composite description, derived from the thematic categories revealed in the data and relevant to the research questions. Following the modified van Kaam procedure (Moustakas, 1994), individual textural-structural descriptions (Appendix 12) express participants' perceptions and experiences regarding the phenomenon of caring. A summary table of the core themes identified by participants is provided in Appendix 13. This study has been interpretivist in nature and so findings are my interpretation, albeit through the modified van Kaam method of analysis which seeks to acknowledge and 'bracket' researcher's views to determine the '*essences'*.

4.2. Participants

Nine participants were recruited into the study, gave consent, and were interviewed. The interviews were transcribed verbatim by a professional transcriber, then each transcription checked against the audio recording by the researcher. Any anomalies were rectified. After transcription, one participant withdrew from the study. Their transcription has not been used in analysis.

There were five women and three men. All participants had an academic role in TR education. Age was not asked, but participants (identified by pseudonym) did reveal the number of years qualified as a radiographer and length of time as an educator, displayed in Figure 10. Location cannot be displayed due to potentially compromising participant anonymity.

4.3. Composite Structural Description with Themes

All eight participants identified a range of experiences and perceptions around caring. There were some unique experiences but many shared common experiences, views, and perceptions. Individual participant stories (Appendix 12), themed experiences and perceptions, were used to generate a shared, composite description.

Pseudonym	Years Qualified	Years as Educator
Alan	43	14
Jo	18	3
Linda	13	4
Lucy	6	3
Neil	24	17
Philippa	39	33
Rob	20	11
Sam	24	15

Figure 10 Participants' Years Qualified and in Education

In reviewing the individual descriptions four main overarching composite themes emerged from the data. These may be found in Figure 11. They included 'being caring', 'caring for', 'caring about' and a final theme 'caring in curriculum and pedagogy'.

'Being caring' refers primarily to the characteristics of the clinical radiographer and academic educator, their attributes, traits, and virtues as an individual and as a practitioner. The second theme, 'caring for' patients and students includes the practicalities of caring, including tasks and processes. Thirdly, the theme of 'caring about' individual patients and students includes knowing them as individuals. The final theme is around educational practice and teaching caring. This is presented separately due to the setting of the researcher and the focus of the research questions.

Initial descriptions and linking of themes differentiated between the clinical and educational settings and responses from the participants. However, analysis is an iterative process and as further reading and linking was undertaken, it emerged that participants experiences, and perceptions of caring shared more commonality between clinical and educational roles. Thus, as the findings were refined and developed, the division between settings became blurred for the researcher as it did for participants. This tested my reflexivity as I personally felt that caring as a clinical radiographer was different to that as an educator. The section on reflexive thoughts towards the end of this chapter considers this in more detail.

Composite Theme	Core or Sub-Themes
Being Caring in Therapeutic Radiography	• Personality • Antecedents in life and clinical experiences • Traits and virtues • Emotionality and perceptiveness • Practitioner fulfilment
Caring For Patients and Students in Therapeutic Radiography	• Practical actions • Signposting • Information • Communication • Processes and tasks for patients and students
Caring About Patients and Students in Therapeutic Radiography	• Knowing the patient or student • Connecting with patients and students • Individualised practice • Relationships and rapport • Holism & Humanity • Making time and prioritising • Active listening • Above and beyond / small things • Empathy, compassion, dignity, empowerment
Caring in Therapeutic Radiography Curriculum and Pedagogy	• Enhancing innate abilities • Role models • Experiential learning • Reflection • Explicit/Implicit

Figure 11 Composite Themes

4.4. Composite Description

The following composite description explores each over-arching theme emerging from the individual descriptions. There is no hierarchy to the order, more a logical sequence of experiences and perceptions derived from the participants' data.

4.4.1. Being Caring in Therapeutic Radiography

Being a caring individual, with caring characteristics, attributes and virtue emerged from the data. Participants considered that personal and life experiences outside TR helped them to be, what they deemed, caring people and practitioners. Childhood experiences, then caring for parents and their own family, shaped the characteristics, personality and caring of participants. Their clinical experiences similarly influenced caring as an educator.

As explained within the introduction chapter, my choice of career, aspects of practice I value and indeed my views on humanity, I believe are due in part, to my childhood and my caring family. It was important for me to acknowledge these presuppositions when analysing the data and by bracketing. I was mindful not to allow my views to overshadow participants. Although any interpretation of data is personally constructed by the researcher, the chosen methodology helped to minimise my views encroaching upon the analysis. '*Being caring'* surfaced significantly from the data and was shared by all participants, so I feel reassured of the *essence* that has emerged from the data.

Each participant considered their personal and life experiences outside TR influenced caring for them as people and practitioners. These experiences began when a child for some participants and were considered as antecedents to their caring behaviours. For Alan, he believes being cared for when ill as a child developed his caring role himself: *'I think it goes back to when I was at school; I spent quite a lot of time in hospital when I was quite a small boy*.' He also has a memory of staff spending '…*quite a lot of time just sitting and talking*.'

For others, selfless acts of love and caring from parents were meaningful antecedents that Jo described as '*self-sacrifice'*, with the act of prioritising others ahead of the self, an altruistic behaviour she felt developed caring in her:

> *'But I think back to … places that my mum used to take us … and there was nothing in it for her … a lot of self-sacrifice in time, and I think that's what it was really'*

Experiences as a child were described as strong, meaningful, and shaped Neil as a person in his view, '*So, there was always caring…I think it's ingrained in me.'*. Neil also felt his family and upbringing enable him to be empathetic, a feeling or attribute many participants related to caring in any setting. *'I mean it's that empathy thing; how can you truly empathise if you have not lived another experience?'*

This view was echoed by Rob who also perceived caring to be ingrained in his personality, giving him the strength to care in his professional roles without which he felt he would not have '*survived'* as a practitioner:

> *'For me it's ingrained in me since a young age, since I started training, and I wouldn't have gone into this profession if I didn't feel an ounce of care for my patients or even my students, I wouldn't know how I would have survived 20 years without caring, if I hadn't already had that ingrained in me,'*

The data emphasises how a caring personality is perceived as important in TR education as Neil describes *'I think a lot of care that I gave came from me though as an individual, I think I would be caring even if I wasn't in radiotherapy, I am sure of that.'* For Lucy, she also felt caring came naturally to her, it forms part of her personality as '*that's kind of the way that I am made I suppose'* and it was reflected in her educator role where she felt caring was wanting students to have happiness, wellbeing, and confidence:

> *'I suppose from a caring point of view you want people to be happy … in terms of their day-to-date wellbeing, that state of happiness, which is just to do with family, knowing your place in the world, having confidence in your abilities...'*

The caring personality theme emerging from the data also relates to certain behaviours where participants would always feel the need to help, almost an innate need to care which may even be at a personal cost. This is not present for everyone, as Neil explains, only those with a caring personality:

> *'So, I guess it's behaviours, … for example if you asked me if I wanted to go and help somebody in distress, what my immediate reaction would be is to never walk on by, is to always go and help and that's caring, that's wanting to help. But for some people, they don't work like that, I know they would rather turn and run…'*

> *'Sometimes I think I can't let …this student sit and worry, I have got to help in some way, so I think there has been times when I have worried. I do worry sometimes about my own health and wellbeing, sometimes I know I have let stuff dwell on my mind and whether I should have done something extra… I have stayed late at work and fired emails at weekends at, because... I am worrying about stuff.'*

Having a non-caring personality, Neil admits, may be the '*easier'* route allowing students to '*flounder'* but he could not accept that explaining:

> *'If I didn't give a shit then that would be easier I think actually, just let them flounder but I don't have that in me, I just don't have that. I couldn't live with myself if I knew there was a student who failed because we hadn't done our bit.*'

Which again, identifies the caring personality that Sam believes is naturally within all individuals, but those altruistic personalities can better hone their caring skills:

> *'I think you see it naturally in people, but I think you can develop it further. So, I think there is a natural instinct, there are some people who are more nurturing and naturally take on that role in terms of looking out for others and putting other people's interests before theirs, so I do believe that there are personalities that are altruistic, but … that through extra work you can really hone those skills.'*

Linda also believes not all educators can demonstrate care, as their personality may mean they find the emotional conversations difficult. She explains her view that caring is an intrinsic part of an individual's personality. Linda ultimately perceives caring is part of us as people:

> *''I think caring has to be something that intrinsically comes quite naturally to you or is quite a key component of your personality… There are some members of staff who I think just maybe that's not their personality type, … just not comfortable enough to have those conversations, and … in all social interactions, perhaps not the most …open in that respect, so I can see why that would be difficult…'*

Conversely, Rob believes everyone in the profession has the capacity to be caring, as a caring personality originally draws individuals into healthcare. He also acknowledges that caring can be formalised and demonstrated through our professional roles as clinical radiographers and educators, but that the essence of care, to demonstrate true caring as he sees it, may manifest differently amongst individuals:

> *'I struggle about no one having 'no care'; they must have some essence to care but it's how they approach that care…is important.'*

> *'I think we wouldn't have come into this profession if we hadn't an ounce of caring skills or personality in ourselves, and I would really argue with anyone saying to me that ultimately we have had to learn to care; well no not really, it's something that has happened in our personalities, …it's something that we have always had, it's been inherent and we are now just utilising it …formalising it and demonstrating it so I think …it's always been part and parcel of us really,… we are now …demonstrating in this kind of educational forum really.'*

In addition to personality and childhood experiences emerging as influential for participants, another antecedent was revealed - caring for family, often parents, who were ill. This did '...*influence your practice*...' as Linda explained but was more profound for Lucy who described how family members being diagnosed with cancer '…*is why I changed career*…' to that of a TRa.

The impact of volunteer roles was also shown by participants. Many explained how they gave time to charities in a caring capacity, being '…*aware that it was a very, a very meaningful thing to be doing, to help people out.*' This may be a further link with what participants perceived as '*caring personality'*, '*traits'* and '*virtues'* and constantly seeking of ways in which to care for individuals.

A final antecedent for participants in their radiographer educator role was that of their clinical experience. This may be why attempting to separate clinical and educational roles when exploring caring was 'artificial'. In fact, some participants slipped from student to patient when describing their experiences, Rob reported '…*once I have gauged it by seeing the patients… I say patients instead of students!'* All believed their role as a clinical radiographer substantially affected caring in the educational setting. As Linda explained:

> *'I think because we are all therapy radiographers, we are kind of … it's our inbuilt nature to want to help and to want to try and solve problems where we can……. my only ability as a lecturer is to draw on my clinical experience.'*

The transition from caring in clinical practice to caring in educational practice was considered as almost naturally equipping educators with the ability to be caring with students. Skills enhanced from caring for people with cancer, in a holistic, person-centred way would transfer to caring in a similar way for students. This is acknowledged by Rob who explained:

> *'… to show the same care and support within the clinical environment as we do for our students in an education setting …*

so I think we are fully equipped in that respect, and …we need to show the same kind of caring nature for our students …as well'

Whilst Neil believes the strong influence of caring in the clinical TR setting means TR educators do not necessarily reflect other non-clinical programmes where he feels '*students are just treated like a number*'.

Alan described how when moving to education, caring for patients is replaced by caring for students, evidenced in an experience he had when a student. He explained:

'…she had moved into an academic role, and I said, 'Don't you miss the patients?' and she said 'Yes I do, but you lot have taken their place." He felt the same as an educator *'I guess that is much the same as in that clinical role which is yeah, …. it's almost been that sort of, you know, one day it's patients and the next day it becomes students.'*

Neil describes a duty of care to students as educators, perhaps because our previous clinical healthcare role fosters a caring approach:

'I think we have a duty of care to students, as educators. I wonder if that's because we are health educators and we are all from a health background? …I am pretty sure that is what it is. …I think we have …a different approach from colleagues from non-health backgrounds.'

This links with participants' perceptions of certain traits and virtues they believed to be part of and demonstrated by the caring radiographer in both clinical and educational settings. Included in this is a level of authenticity, a '*genuineness'* where educators are acting in a way that aligns to their true self, displaying traits and virtues linked to caring.

Participants considered caring to be an intrinsic part of the individual, their personality, and their life experiences. Linda describes:

'… I think caring has to be something that intrinsically comes quite naturally to you or is quite a key component of your personality. You can give people skills to help them develop and …with difficult …or conflict situations, but if someone isn't comfortable with those sorts of interactions, then they are going to find it very…difficult. It doesn't mean they don't care, but in a profession where it has to be conveyed, I think that has to be …a fairly natural skill for you.'

Lucy also views caring as intrinsic and feels that as individuals we need to '*want to care'*, and this is less of a conscious thought more part of our '*make-up'*. She also acknowledges *'we are all made differently, physically, emotionally, mentally, we all*

have different levels of acuity...'. The intrinsic ability to care is shown by feelings which links to the emotionality and perceptiveness of a caring individual:

> *'I think they have to want to do it and that's not even …a conscious thought, it is just part of their make-up.'*

As much as personality and caring were considered almost innate, the findings also showed how participants described '*a feeling'* or '*I just picked up...'*, a level of intuition, perceptiveness and emotionality with both patients and students. Some explained this as their personality, some their experiences and others as '...*honed skills...*'. It may also relate to their levels of Emotional Intelligence and an awareness of student emotions beyond their spoken word. This intuition and recognising cues is described by Jo as an awareness of need and being perceptive:

> '*Caring isn't necessarily them telling you they need help about something and you either doing something …or not, it's about having an awareness that someone might need it and might not be saying and therefore giving the opportunity for them to access that or allow you to care without them needing to say.*'

Neil also acknowledges that high order skills of Emotional Intelligence are required to be caring in clinical and educational practice:

> *'Well, that's quite high-level emotional intelligence isn't it, working out what somebody is thinking or feeling. And you do see that in students, I think they can develop that and that comes from practice, …develops through …experiential learning …'*

The need to be '*proactive'* and having '*perceptiveness'* is explained as caring by Lucy which includes picking up on the thoughts and feelings of others, including their non-verbal communication:

> *'…something that is intangible. ... it's almost like being able to read somebody's thoughts and feelings, …it's a perception …body language,…tone of voice, …eye contact from the other person, all of those things give you a perception…*'

Conversely, Jo explains a lack of caring can involve not acting on the cues that have been recognised or being unperceptive. Not picking up on cues, verbal and non-verbal, not acting on the perceived needs of individuals. Being unreceptive, not perceiving a need, which is different to being asked for something and responding. This links to the personality or traits of the radiographer:

> *'I guess perceiving things and needs of individuals and not acting on them, so not picking up those possible clues, and the clues might*

> *be not verbal clues that they need help, and not doing anything about it. It's not being perceptive …that somebody needs help...'*

The final aspect within 'being caring' relates to the fulfilment experienced by participants, a sense of worth and satisfaction as both clinical and educational practitioners.

The impact of caring on the practitioner emerged from the data as both positive and negative. A great sense of pride and fulfilment was felt, particularly when seeing students overcome obstacles and succeed to graduation. It brought a feeling of immense joy to participants, seeing the outcomes of caring for their students. Linda explained *'I think I am starting to see that there is really that gratification in seeing students achieve.'* Which is echoed by Lucy who described:

> *'I am their first point of contact so you don't want to lose that relationship, you…want to enhance it, even though they may have to engage with other people …I suppose it makes me feel that I am having a positive effect on them with my actions…*'

Neil described the joy and the effort of caring and how it can result in a personal cost to staff, often from going '*above and beyond'*. He admits '*sometimes I go too far I think, I am taking on too much for the students*' yet Neil enjoys student interactions to the routine administration as an educator:

> *'I enjoy that aspect of my job whereas I don't enjoy admin, … (sorry, put your fingers in your ears) quality assurance, monitoring and all the report writing…..'*

Caring can be difficult at times but despite the impact, the joy of caring is readily described by Neil:

> '..*it's …really difficult the responsibility we have as educators because we are not just educators. It's all pastoral care and stuff. That is a strength …to have that responsibility in your work*'

A real sense of happiness and fulfilment emerged from the data. He continued:

> '…*graduation day when you see them and if you know their study journey, some of them have been at breaking point and to pull them back and get them back on track – now that's caring…'*

Findings also revealed that despite the stress and pressure of their role as educators, it was much more than just a job and brought a sense of purpose and achievement to the radiographers' professional careers:

> *'…I don't want to have a job that is …just to pay the mortgage, I have never wanted that. I know I have a very stressful role …most of the time, but there is always that sense of satisfaction and self-worth because you do make a difference as an educator,… [it] will stay with you and be the benchmark for …your professional career.'*

An overwhelming sense of honour and accomplishment was expressed by each participant, their passion was almost tangible. This might be that by participating in a study focussed on caring, the volunteers were more focussed upon this aspect of their role than non-participants. However, their caring personalities revealed themselves throughout the interviews and their experiences.

In summary being caring in TR, for participants in this study, involves an almost natural, innate desire to care. The personality of radiographers in both the clinical and educational settings was strongly linked to 'being caring'. Caring drove their practice and provided a great sense of achievement and fulfilment. Being caring was considered a result of various antecedents. These included childhood experiences, caring for family and as educators, the previous clinical role was thought to be highly influential to 'being caring' in education.

Having explored the composite theme of being caring, we now turn to the second main theme emerging from the data. This considers what caring for patients and students looks like to the participants in this study.

4.4.2. Caring For Patients and Students in Therapeutic Radiography

This theme includes some of the practical activities participants perceived to be associated with caring in TR. They include tasks and processes related to patients and students.

Participants retold how solving problems was part of the radiographer role in both clinical and educational settings. This theme, '*caring for'* is closely linked to the next theme of '*caring about'* which has an emotional connectedness to the caring actions, but also exhibits some key differences. Lucy explains how *caring for* can lack a *'human level'* of '*connection'*, occurring simply because you are paid to do so as a radiographer:

> *'…when you just are solving the problem…. because you are being paid to do it…. but it isn't done at the human level …the humanity level. It's that one step removed…. but actually, you have …no connection at all with that person on any kind … level at all.'*

Lucy describes caring as the '*hands-on bit*' which links to this theme of '*caring for'* and the physical aspects of caring. She separates this from the emotional side of caring which includes psychological support, humanity, and connection and will be explored in the next theme:

> *'But the kind of psychosocial support is the humanity bit …to make things more emotionally …as well as physically comfortable for that person and just trying to connect with people on their own level.'*

The data shows how participants distinguish between the duality of caring with a practical, functional, task oriented and almost mechanical part which may or may not accompanied by an emotional part. This is related to doing and actions. Linda talks of these two facets to caring, it being a multidimensional concept, with a practical aspect alongside an emotional aspect:

> *'Caring can be a multi-faceted thing, is it having those conversations, or is it organising someone's appointments and… sometimes that is the role – it's sort of just fixing a small logistical problem that actually makes that patient feel you really understood and cared'*

Linda explains how she feels there are many ways of caring for individuals, not all of them emotional. Some small actions can positively improve the cancer journey for patients:

> *'It doesn't always have to be a deep …meaningful conversation, …it can just be appreciating and alleviating an expect of that cancer journey… there are lots of ways of showing you care.'*

Conversely, if the processes of caring for the patient are not accompanied by caring about them (explored in the next theme), some participants describe it to be task or process driven, lacking or an absence of caring. Linda explains:

> *'I have come across …treatments … that are very automatic, and it is very much 'What are the practicalities? We need to get date of birth, …get I.D., we need the patient to get on the bed. We need to align our tattoos,…leave the room and it feels quite limited sometimes. I don't feel the warmth, so I sort of think the patient isn't probably going to feel the warmth.'*

Although following appropriate processes can allow radiotherapy to be delivered safely and accurately, Jo reflects on experiences shared with her by a patient volunteer what involved process alone. This emerged as '*caring for'* the patient but not '*caring about'* them, '…. *if you were lying there and somebody just went on and did the things even if it was part of the process'.* Jo felt the lack of caring was particularly demonstrated when just performing tasks rather than asking permission of the patients first. The volunteer explained her experience that Jo related:

> *''I felt a bit like a piece of meat. I would lie on the bed…' …she said 'They would undo my gown without telling me they were going to do,' so although it was part of the process, she was expecting it to happen, …every day but it's those small differences between saying I just need to get to those marks and can I just… is it OK with you if I just undo the straps? …to just going and doing it.'*

A similar experience was retold by Neil who explained how technically competent radiographers can lack caring, whilst others are patient focussed:

> '*I know of radiographers who have lost it and I just don't think they have got that caring side … Technically competent and can run the treatment unit effortlessly and efficiently but you do worry about the patient care…Some of them… are absolutely patient-focused …whereas some are more technically-focused …'*

In the education setting a similar duality emerges from the data, where participants explained how they cared for the practicalities of students' learning, which included managing assessment deadlines for example. Another aspect of *caring for* them as individuals was acknowledged in the same way as in clinical practice. Again,

participants felt a lack of caring was shown when considering these processes alone, almost devoid of the individual student themselves. As Neil questions:

> *'…are there tutors who literally just teach and manage the programme? I mean you could be a robot couldn't you, working on an assembly line? It's that depersonalisation of education…'*

Jo also explains how applying the processes may not really be considered caring, as they are part of the role. It is the caring about that is meaningful to her.

> *'In education I will make sure that they have the information they need, the teaching that they need, but the caring bit, to me, is the bit that I do on top of the job I think, and I think that's probably what shows that I care more than just having the meetings…'*

Rob describes the caring for his students in a similar manner, practical aspects and emotional or pastoral aspects:

> *'So for me I had two kind of hats on; my first hat was how can we support her in terms of her personal circumstances, what can we do, what can I do as a personal tutor in that respect to help as much as I can?....'The other hat I had on was the impact that was going to have on her studies, …'*

Alan shares this view of a practical aspect to caring for students, but also explains the important role of signposting students to others for support, particularly if problems in their personal lives impact their academic life.

> '*First of all, it's about do they understand the requirements of the assessment …making sure they understand what … they need to do to make up any sort of shortfall from previous assignments…My caring role now is very much around what the students are doing. If their personal lives start to impact on their academic progress …my advice has always been if you are experiencing difficulties, then these are the people you might want to …talk to.'*

Rob also describes signposting students to support for well-being, counselling, and bereavement, enabling a more pragmatic view regarding their studies, and positive outcomes despite setbacks. This was revealed as part of *caring for* students:

> *'I have given them an opportunity to not worry about their placement, …about assignments, we have got the support mechanisms there, …but always be mindful that it's quite a delicate and really critical time for them …'*

For clinical radiographers, signposting as caring was less obvious from the data, whereas in the education role Sam highlights the importance of indicating forms of support as caring for students:

> ‘*But often it's more about signposting I think at that point, you know, not a qualified counsellor, not a … it needs medical intervention at that point, making sure that they've engaged, their wellbeing…’*

To be able to suggest other professionals as a source of support for patients and students requires a degree of communication. The data revealed this to be an important component of *caring for*, communicating information to patients in the clinical setting. As Rob identified, this is most successful if a good patient-radiographer relationship and rapport exists which is explored within the following section, *caring about*. These two themes are closely interconnected, *caring for* as a practical task being better facilitated if *caring about* the patient or student has been established. Participants believed caring to be optimal if the educator has a good relationship with the student establishing trust. The importance of relationships and rapport is also explored within the next section, *caring about*.

In summary, *caring for* patients and students in TR involves a process, action or practical task. Participants felt these tasks were an essential aspect of caring and were optimal if alongside *caring about* patients or students as individuals. Together, *caring for* and *caring about* meant improved trust and rapport, knowing the patient or student would mean caring was optimal. Caring would be a blend of the practical tasks and processes but demonstrated through empowering supportive emotional relationships. Participants also related a task-oriented focus alone to a lack of caring, often from those without the caring personality previously described. Information and communication were tasks that could be delivered with or without emotion and *caring about* the patients or students. This was described as a lack of caring.

The duality of *caring for* and *about* students were continuing themes throughout the study. Personalised help emerged significantly when *caring about* students and relates to the holistic, psychological support sometimes through a personal tutor system. Another aspect was identified as related to academic studies, the *caring for* previously discussed. The link between ‘*caring about’* which has a feelings or emotional aspect and ‘*caring for’* which includes a more practical or process aspect to caring is summarised by Jo:

> *‘I guess ‘caring for’, to me, indicates more of a practical side of it, it's the practical aspect of providing care; and ‘caring about’ is the*

emotional side of it that is actually beyond that demonstrating care, it's actually … it's the actual, yeah, the emotional bit of it that drives you doing it and also impacts on you as a result of it probably. You can provide care to somebody practically, … but whether you care about the impact that that has on them or the impact that it has on you is the 'caring about'.'

The theme '*caring about*' will now be considered in more detail.

4.4.3. Caring About Patients and Students in Therapeutic Radiography

Caring for patients and students has been seen from a practical, process or task-oriented aspect by study participants. However, they also revealed this was distinct, but intrinsically linked to the third theme of *caring about*. The 'duality' of caring emerged from the data as being either practical (*caring for*) involving almost generic tasks, to an emotional, humanistic individual and bespoke level (*caring about*). The topic of caring about connects with '*being caring'*, the first theme from this study, where participants described the qualities that constitute a practitioner with caring characteristics. Aspects of *caring about* patients and students emerged as '*knowing'* and '*connecting'* with them as individuals, suggesting an authenticity or truthfulness to the resultant relationship and rapport. This was at a human level and included holistic, individualised practice by the radiographer. Although my study is primarily focussed upon education, an understanding of clinical caring is important to academic educators. In exploring what that means we would be better placed to develop caring within our curricula and practice. Some distinction between clinical and educational settings appeared in the data so they will be considered separately.

4.4.3.1. Caring About Patients

Considering caring in the clinical TR setting, all participants spoke about the importance of building relationships with patients and their relatives. This involved a rapport and connectedness at an individual, human level. This is distinct from *caring for* because of the emotional connection with another human and the feelings involved with that relationship. The caring relationship participants described included elements of trust, which are needed to allow flourishing connections. Participants accentuated the importance of trust when retelling lived experiences. Rob explained how connecting with a young patient, building a relationship and rapport, enabled him to adapt care towards their individual needs. If trust had not been established, the '*caring process'* would suffer:

> *'…trying to develop this kind of rapport, this relationship with them and the fact that we do that for all our patients (and go over, above and beyond), but we adapt it to their particular needs'*

Making a conscious effort to remember individual details of peoples' lives outside of their treatment is an essential aspect of caring as Philippa explains:

> '…*if she told you a story about something the day before, remembering it the next day so you can carry it on, so that makes them feel like a person not just a patient or a statistic'.*

This individualisation she continued, is demonstrating *caring about* at a '…. *basic human level so that the patient doesn't become a number, they are a person…'.* The humanistic approach is important to caring as Philippa further explains:

> *'I think you have got to have that human element and I think the patients want to know that there is someone human because they …have got cancer, …they are so stressed and worried…'*

Making time to understand and *know* the patient as a human involves attentiveness and individualisation which helps a relationship to develop, needed for radiographers to be *caring about* patients. Making time will feature later in this section, but for now the description concentrates upon the individualised connections perceived as *caring about*. For Sam, the connections are '*heartfelt'*, authentic, genuine, and true:

> *'I think whenever you get involved and you find out about people's personal lives you feel that greater connection with them and it is heartfelt…'.*

The humanity of caring at an individual level is echoed by Jo who explained '*caring …. was about seeing what mattered to them as individuals*.' She continued to describe an '*emotional input'* into developing caring relationships, whilst remembering:

> '…*it's not about what we want or what we think they need, it's about establishing what they want and what they need and whether it's right for them…*'

When connections are made with patients, Lucy describes personal benefit that feels like walking '*on cushions of air…. because you have made ...that connection.'* This relates to the first theme of being caring and the benefit experienced by the radiographer because of positive relationships:

> *'You have made that connection with them, and you have made a change to their immediate experience, …a positive one, …which is the best thing.'*

Emerging from the data, participants perceived and experienced the importance of making time for patients. They spoke passionately about how making time for individuals was *caring about* patients, and that a lack of *caring about* them was characterised by rushing, not making time, and overly focussing on process and

tasks. This was a significant theme to emerge related to clinical TR. The task oriented *caring for* was almost perceived as a lesser version of caring. Participants likened it to a lack of caring, a robotic, process-driven level of practice in contrast to the crucial aspects of *caring about*. Linda explains how, even if problems cannot be solved for patients, making time is central to caring:

> '…*sometimes it is just about letting someone express how they are feeling on that day and vent to you and that can be caring as well.*'

She acknowledges the pressures of service delivery in a ten-minute appointment:

> '*But personally, I am a big advocate for thinking you can do a lot in that 10-minute slot, it doesn't have to be a totally robotic process'.*

Alan explains that despite busy schedules, in his experience a simple movement of staff can provide caring, and the time needed to provide it:

> *'… so that one of the treatment team who know the patient can then spend a little bit of time with them. And it might only need 5 minutes, and if we can't give 5 minutes, that's sad.'*

Participants described how they experienced service provision and clinical demands were detrimental to the time to care, but also felt certain individual radiographers would focus on tasks and process at the expense of caring. This may relate to the first theme where participants described what I interpreted to be '*being caring'*. Neil explained how he had seen more experienced radiographers who would sometimes allow less time to care:

> '...*they have got no patience with the patients, the rolling of the eyes, it's all that body language. Bad mouthing patients behind their back, that's what upsets the students a lot.*'

Linda gave examples of absent or non-caring, identifying them by a lack of warmth, a non-personal and robotic, task-focussed process-driven encounter. This links back to the *caring for* theme and participants interpretation of this being *lesser caring*. Neil shared his experience that service demands can cause a conflict with caring about patients. This sometimes is seen as an opportunity to provide reduced caring, especially if the patient may have greater needs:

> *'… any patient with an additional need, whatever that might be, can disrupt the flow of work on the treatment unit and some of the senior radiographers get very angry with that and I think that's… there is a*

conflict there about the service getting … keeping to time and delivering the treatment and …the caring stuff suffers…'

A further impact was described by Alan who believes the developing, innovative technology of TR can sometimes be to the detriment of caring about patients:

'…*from a workflow perspective yes, we could treat more patients, but at what cost, to all the other things that go on*.'

However, he also perceived this technology may be an opportunity to further develop the patient support aspects of the TRa role. This view was individual to Alan alone:

'Other people can have a different role and that role will be that patient support… maybe the automated technology…will change our role, …allow us to focus on …other things.'

Neil adds that the personality of the radiographer might influence the focus on either the patient or the technology. This links back to the first theme of *being caring*:

'*Some of them… are absolutely patient-focused and guided by the patient in front of them, whereas some are more technically focused I think....'*

All participants spoke with great sadness when describing examples of poor caring about patients. Linda explains:

'I feel sad for the profession because…a special thing about our role … that ability to blend communication and technical skill.'

She believes fast promotion, a lack of caring role models and an overwhelming focus on processes and practice, such as imaging and competencies, erodes our clinical role:

'I think there is a lack of [role] modelling as well of good communication style and good rapport building, ... because we are pursuing the advanced practice …but are we perhaps losing the skill of what the treatment floor should be?'

Pressures of service delivery compound any lack of caring and negatively impact staff. Linda considers:

'As radiotherapy, …becomes more technical, you are naturally driving people to work more in that way, …appointment times are cut down, machines are working at capacity or in my experience we work at over capacity…. 'I think it does definitely grind people emotionally sometimes to a point where you don't have that to give.'

Caring about is a substantial theme so it would be useful to summarise the description so far. *Caring about* patients relates to making time to know them as individuals, despite service, time, and technology pressures. Some radiographers may be more inclined to favour the process and task-oriented *caring for*, which participants perceived as a 'lesser', almost sub-optimal dimension to caring. Furthermore, as individuals, participants perceived caring to be much more than the basic requirements of practice and process. They believed that to be caring, radiographers must give a little more than the minimum. Participants described caring about as *'making an effort'*, having *'…that human element'*, going the '*extra mile'* and '*above and beyond',* linked to the relationship with patients. Linda believes caring to be *'… a daily occurrence really … where you tried to go the extra mile.'* Whilst Jo admits it can be challenging to deliver caring within tight schedules but still feels the need to go beyond the routine, to know someone, making the individual person her priority, avoiding commands and demonstrating respect. As Sam explains, caring is:

> '*Making somebody else feel valued, that they are your priority …you know them and their needs and that …you listen to what it is they have got to say, give them …time…*'

I found a need to be reflexive when considering this aspect of the findings. Although it appeared significantly within the data, I maybe over-emphasised it when first undertaking writing the composite description. It was important to, and resonated with, my views of caring. Discussion with my supervisors, then reflexively and reflectively considering my interpretation, I saw in fact my views were overshadowing those of the participants. The notion of going above and beyond is seen overtly within the data, but initially I over-emphasised it in the first drafts of the themes within this description. I now have a more objective view allowing the participants' perceptions to be paramount.

The final aspect of *caring about* patients related to the attribute of empathy which links closely to the concept of knowing the patient as an individual and building a relationship with them. Rob described an understanding of the individual and an empathy for their situation as part of the caring relationship:

> *'I think in terms of the caring kind of nature of it, it's about … the communication, the reassurance, thinking about the patient, putting yourself in the patient's shoes…'.*

Whilst to Neil empathetic caring meant trying to be one step ahead and anticipate peoples' needs which relates back to '*being caring'* and the ability to use intuition:

> '… *working with a patient just to try and support them with their family requirements because I know that was difficult …just thinking one step ahead …I can remember that quite clearly.'*

Rob explains he believes to be truly caring, there is a need to consistently demonstrate caring. This relates back to *being caring* and how genuine the person may be, their caring virtue and whether caring is authentic or inauthentic:

> *'…you can say I am caring, I am confident, I am compassionate …but actually it's about how do you demonstrate that consistently to warrant you saying that you are a caring person?'*

Having explored *caring about* through the lens of clinical practice, the final section considers the educational setting. There are some similarities but also nuanced differences between perceptions and experiences of caring in the education setting.

4.4.3.2. Caring About Students

In the educational setting connected relationships were emphasised in the findings, being present throughout participants' experiences and perceptions. The student-staff relationship was an essential part of caring about to all participants. Lucy summarises this as:

> '*People, relationships. Taking an interest because people have immediate problems… take that person and have an interaction …that leaves them with something positive, with something extra that they won't forget.'*

The relationship to enable caring needed to provide familiarity so that students viewed staff as more than just a lecturer. If this connection was made, students would '*open up'* and share within the relationship based upon trusting staff who display genuine interest. Jo explained it is a comfortable relationship:

> *'But I think …it's that slight familiarity where they do feel like I am not just there as a lecturer, …because I have to be, I am there because I am interested to listen and …interested in them and not just the process…'*

The essential familiarity to enable caring can be brought about by '*knowing'* the students, having a bond which Jo felt enabled:

> *'…knowing who they are, …their names and …a little bit about them enables you to have that bond to help develop them …as*

> *individuals, not just as part of a cohort, …I want them to do the best that they can do. I can't get that feeling across to them unless I know who they are.'*

Participants strongly felt that '*knowing'* students as individuals was caring. This works in parallel with the caring relationship as Philippa explains:

> *'I think …it's being able to know them well enough to be able to support them because they all have slightly different needs and it's not just the obvious ones …it's …often their family situation, their background, what their parental expectations are and all those sorts of things …sometimes it's helping them to get through those barriers'*

Neil refers to '*de-personalised'* education where he perceives there to be a relationship deficient in caring. Also, essential to caring is the blurring of the student-staff relationship to avoid the traditional '*them and us'*, which can be better enabled with smaller cohorts so that *knowing* students as individuals can be realised. Philippa explained:

> *'I have seen in the past lecturers come and they have a very fixed idea of what the university lecturer is, maybe based on, in some cases, on their own experiences, when it was very much 'us and them' …whereas I think now the lines vary, well certainly on our courses, …very much more blurred …partly because our …cohort numbers are very small so …you get to know them… as individuals.'*

She goes on to identify how being approachable and human is key to fostering good relationships and thus caring. This involves sharing of the self, and one's personal life experiences to foster caring relationships, *'you have got to be approachable for them to even want to come to see you.'* This may be a way of demonstrating caring:

> *'I think students will respond to you more and be more likely to come to you for help if they see you as a human being, as something other than a lecturer… if you are open and friendly...'*

The emotional aspects of caring were felt strongly by participants such as Linda who explained:

> '*It is part of our role… to be that emotional support …acknowledging and understanding their situation so we can help them move forward, because we are here to support them...'*

Rob links caring about students as prioritising and holistic in nature. He explains:

> *'…the centre, the focus of care has to be …the students, we need to always think about the student, and they need to be our number one in view of the emotional, the psychological, the physical, the spiritual – those kinds of particular multifaceted considerations.*

For Philippa, she explained the humanistic side of caring as psychology '*it's that sort of aspect of care which is …I think there's more psychology looking back than I ever thought there was when I was doing it.'* She also relates *caring about* students to connecting at a human or basic level, helping to make *caring about* personal:

> *'I think you have got to have that human element and …. break it down to that basic human level …they are a person and they have got families and …other worries ....'*

Humanity and holism were intertwined by participants, in a similar way to the relationships and rapport aspects of *caring about* an individual student. These concepts connect closely to portraying caring and can be considered, as Lucy says:

> *'It's a generosity of spirit I think, you know, it is that extra bit of time that you take to tell a joke or to talk to somebody... it could be anything really, it's just those moments …of humanity…It's not even that you take the time for it, you make the time for it because it's just part of who you are …it's your force-field, …kind of aura …the psychosocial support is the humanity bit …to connect with people...'*

Concepts applicable to patients translated to students in the views of the participants. Caring behaviours also links to the first theme of *being caring* and to the previous theme of *caring for*. Making time, prioritising, and listening to students featured within the data and may be considered ways of enacting caring. Doing the '*small things*' for people, 'above and beyond' what would constitute *caring for* emerged as ways of demonstrating caring.

In the educational setting, all participants identified the importance of 'making time' for students which was considered an integral part of portraying *caring about* the student. This links back to earlier in the section and the need to make time to know the students as individuals. Jo explains how *caring about* students is shown by taking time to be available and proactively making time to see how they are doing:

> *'I think the most important thing for me is that students know I am available and I think I… in terms of demonstrating it, it's probably about me asking about them without needing to if that makes sense.*

Sam also views caring as making time and having conversations:

> *'Sitting with them, like they have alerted us/me to the fact that they are really not coping with the demands of the course and something that …Being responsive to the call for help, making myself available… giving somebody …face-to-face time or over the phone – sitting and listening to them.'*

Conversely, a lack of caring emerged as failing to make time for students, Sam continued:

> *'You know, never being around so you are picking up on their queries, and probably making those assumptions that everybody is feeling the same or having the same experience….'*

This is echoed by Linda:

> *'I think that avoidance …students want to come and talk about an assignment, people sort of saying 'Well look at the assignment guidance… perhaps someone doesn't really need that… It might seem more of a conversation and apparently, it's not what they need.'*

When time is made for students, it facilitates the caring relationship, if open and responsive:

> '*I think just your presence and openness to have that conversation as well, so students know they can come and have a chat with you if they are feeling like they can't cope...'*

Alan explains how they may seem like small things, but making time is essential to caring:

> '*It's about having that time but also knowing that even the small things can make a big difference… so taking your time to have those conversations.*'

Similarly, Sam considers caring to involve:

> *'Body language, listening very much, looking… eye contact, making sure you smile at people, turning towards them, all of those little body language aspects, actively listening.'*

Body language has featured in previous themes, but more from participants recognising the body language cues of patients and students. In this context, the emphasis is upon educators to portray and show caring through their body language, prioritising students as individuals within the interaction.

Individualisation and listening are essential aspects of pastoral caring, as Jo identifies:

> *'…it is about listening to whatever …is …important to them, …it's what they disclose that's important. And I think being able to listen, to find out what that is, is probably the important aspect….'*

She believes the individualised caring relationship can mean students have more positive outcomes, which is echoed by Sam who says that '*hearing'* students as individuals is caring:

> *'Hearing what …is their concern, …taking it as an individual … each individual has a view so say 'Right, what is it you understand from the situation?' or 'What are your needs right now?' and trying to address those individually.'*

Sam also talks about '*coaching conversations*' to elicit students' individual feelings whilst Neil describes '*caring conversations'* believing:

> *'… caring is caring about them as individuals…I do have conversations about academic work and clinical practice, I don't just let them go through the motions.'*

Caring through a relationship is '*actual caring'* in Jo's view, it is shown by a genuine interest, to be genuinely bothered about her students:

> *'So I think …caring is actually caring, it's the difference between doing it from a process perspective and doing it because I'm interested …concerned for their welfare....'*

Participants felt a lack of caring would be shown by not considering individual student needs, not building meaningful relationships, and not having open communication. As Sam explains:

> *'…anywhere where there is poor communication is a lack of care. …not considering that individual's needs, it lacks care.'* Whilst Jo reflects, *'…the caring bit, …is …on top of the job …it's that willingness to be available for them whatever it is that they particularly need at that time, and they do take me up on it which is the nice bit!'*

Jo questions whether the process of listening and responding is because educators '*have to'* or whether they need and want to care, suggesting true caring to be authentic:

> '*We are all capable of listening, but whether we actually listen and hear and respond is the bit that actually is about the caring*'

She went on to describe how caring behaviours such as empathy and compassion were ways of showing caring about:

> *'Caring as a behaviour is about demonstrating empathy, …understanding, …compassion, it's those things… but actually the care is the way that you feel about it when you are doing it'*

The data also revealed how the wider culture or environment of the education setting would influence how caring may be demonstrated or portrayed. Linda acknowledges that showing caring can sometimes be limited or difficult with high expectations placed upon educators. It may create a tension in education practice for participants. This links back to the theme of being caring, where participants identified a personal cost to caring as well as personal benefits:

> *'I very much want to be empathetic, but I think …our role is becoming quite blurred …universities are struggling with wellbeing, so it is kind of falling back on lecturers …to …provide that support.'*

Lucy refers to the guidance and policies from universities that may enable educators to deliver them in a caring and compassionate way:

> *'… there is a framework to guide us …but it is down to us as individuals to do that in a caring and compassionate way with our students and to be fair...'*

In summary, caring in TR involves making time for the patients and students, showing empathy and compassion but authentically from a genuine desire and interest. *Caring about* would be demonstrated by 'small things', remembering events significant to people and making time for them. Other ways of *caring about* involved going 'above and beyond' the minimum, so 'going the extra mile' for the individual patient or student. The high technology focus of the clinical setting also created a tension for participants when caring. Additionally, making time and the high expectations of universities also created some tensions for participants when demonstrating caring towards students.

Having explored the themes related to the conceptualisation of caring, the final theme specifically considers caring within the curriculum and through pedagogy, including what strategies may enable that in practice.

4.4.4. Caring in Therapeutic Radiography - Curriculum and Pedagogy

The final theme identified within the study relates to teaching caring in the TR curriculum and how pedagogic practices may facilitate the development of caring in students. Within the previous themes, perceptions and experiences of participants concerned both the clinical and educational settings but this final theme considers education alone as it is my sphere of influence and the focus of my study. It should be considered alongside '*caring about students'* in the previous section. A strong theme from participants was role modelling, in terms of '*caring about'* their students.

Areas of teaching practice and how they relate to caring showed explicit and implicit topics within the curriculum, pedagogic approaches such as reflective writing and the importance of role modelling. Although participants acknowledged the important influence of caring in clinical placement, including patient interactions, their responses centred upon the academic environment. Therefore, teaching caring in clinical practice will not be explored in great depth.

Teaching caring was identified by participants as existing within specific modules and sessions forming part of the curriculum. This may be considered as explicit teaching of caring. However, participants did not focus strongly on this topic, favouring the more implicit ways of demonstrating and modelling caring. Topics such as holistic caring, interpreted from this study as *caring about* due to the individualisation, to *caring for* in terms of practical tasks to minimise radiation side effects. Educators linked clinical and academic content, highlighting the complementary relationship between the two main components of the curriculum. As Rob describes:

> *'I lead on some of the lectures on holistic care and I think that concept itself is so relevant to not just education but also for clinical …the focus of care has to be either the patient or …from an educational perspective, the students, we need to always think about the student and they need to be our number one in view of the emotional, the psychological, the physical, the spiritual – those kinds of particular multifaceted considerations.'*

He goes on to explain how caring features within the curriculum and as a thread throughout the programme. These aspects of caring can be considered as explicit and relate to both *caring for* and *caring about*:

> '*We have specific modules for…say, holistic care, where we talk about care of the patients, we also have caring as a thread throughout their degree, whether it be through all the common*

> *learning modules, …talking about the patients' care when we talk about management of oncology; whether it be the care they receive in terms of any kind of psychological modules … how we …support our patients.'*

Developing and enhancing caring skills within students also emerged from the data. Participants considered being caring to involve personality, and perceived applicants, applying to TR programmes, would have their own experiences of caring. Such antecedents, described in this study as '*being caring'*, would mean students possessed the caring virtue, attributes and character that could be further developed and nurtured during their education. Participants did not discuss the recruitment process at their HEI. However, values-based interviews are practiced within UK HEIs to recruit students with the capacity for '*being caring'*.

In terms of more implicit caring within curricula, which featured more strongly within the data, participants perceived academic educators should portray *being caring*, *caring for* and *about* students as individuals and as a cohort. Considering the importance participants placed upon experiencing caring themselves as antecedents to being caring practitioners, this may be a significant yet implicit way of teaching caring. Linda identifies the importance of role modelling in teaching practice but again, subject to the student already having the personality, characteristics, and virtues that participants interpreted as '*being caring'* so that caring might be '*honed'*:

> *'I think … there's all those sorts of things we can teach students, but …caring has to be something that intrinsically comes quite naturally to you or is quite a key component of your personality.'*

For Philippa, having smaller cohorts in TR was perceived as helping to foster caring whilst larger cohorts might be a barrier to educators demonstrating caring to students, *'…the sheer numbers of the large courses is a barrier for sure…unless you have …an equally large number of staff'*. Participants described how *caring for* and *about* their students would influence caring in them as growing professionals.

The concept of developing caring in students rather than directly teaching it was shared by participants. Teaching caring could imply it was not present within students before the teaching sessions, that they would learn caring in its entirety. Participants did not support this notion, more that caring may be refined or

enhanced as part of the altruistic personality that initially brought the student to the profession. Enhancing caring skills required experience and important interactions with patients and staff in the clinical and academic settings. The tensions around whether caring can in fact be 'taught' were explained by Lucy, who suggested authentic caring relates to '*being caring'* and is genuine:

> *'So I don't necessarily think that you can teach a person, an individual to care, because… I think they have to want to do it and that's not even …a conscious thought, it is just part of their make-up, …how they are made and I mean the sort of caring/nurturing thing… when it's genuine you can …absolutely see it.'*

Sam also links self-awareness and altruism to caring and considers it can be enhanced but not taught. She believes caring is naturally within individuals, but those altruistic personalities can better hone their caring skills:

> *'I think when people have a better understanding of themselves and why they act in certain ways, …then they are more intuitive about other people and understand …needs because they can compare with themselves... I think you see it naturally in people, but …you can develop it further …there is a natural instinct, …some people …are more nurturing and naturally take on that role …putting other people's interests before theirs, so I do believe that there are personalities that are altruistic, but… that through extra work you can really hone those skills.'*

Participants viewed caring within teaching practice as multi-faceted. The synergy of patient interactions in the clinical setting supported by explicit teaching in the academic curriculum, together with '*being caring'* modelled by educators. Rob explained:

> *'…that's all built into their curriculum complemented by their clinical placements, and then complemented even further by the clinical staff and academics who are obviously practitioners themselves …I think …that kind of caring development and progress…'*

Participants considered experiential learning in clinical placement, role modelling and each patient interaction an opportunity for educators to enhance caring in students, alongside reflection. Linda suggests *'I think you can model good behaviour, good examples of caring, and give people the practical skills…'* whilst Jo believes:

> *'…. you can help to develop people's ability to allow themselves to care and ….if you feel it, you know what it feels like to be cared for or not cared for and then you do that yourself to support somebody*

> *else to be the same, so I don't think you can necessarily teach someone care, but I would say in an academic setting, I would give examples of occasions and how that impacted on me.'*

Patient and educator experiences, interactions, and placements emerged as a significant influence on teaching practices related to caring. Neil links these to reflection and experiential learning. He explains how experience can help students develop caring, identify caring behaviours, and pick up on cues. Reflection upon and discussion of experiences with patients can feature as part of the academic curriculum building upon the explicit elements of the curriculum and facilitated by academic educators:

> *'..seeing these patients and learning from the patients actually. There is so much I can't teach in front of a class of students…You can't have a generic approach towards patient care, it comes from remembering back to how I reacted… that's reflective learning'*

Caring in educational practice, in terms of teaching caring, strongly interconnected with *caring about* and *being caring*. Authentic or genuine caring appeared multiple times within the findings, with participants returning to the theme of '*being caring'* and having a caring personality. Participants described how their own caring attributes and behaviours, demonstrated as '*caring about'* students would model the characteristics and virtues of what they perceived to be a caring TRa. Sharing stories of caring from their own clinical practice with students also demonstrated caring. These stories and similar accounts from patients could be the subject of reflection and discussion in the academic setting. Caring through relationships with students, with the emphasis upon role modelling, emerged more strongly as the implicit rather than an explicit curriculum.

In summary, teaching caring in TR practice involves discreet modules and sessions within the academic curriculum, but also less discrete methods of enhancing caring in students. These approaches were more prevalent in the data and include role modelling by both academic and clinical staff. In *caring about* students, through relationships academic educators would demonstrate caring to their students. Participants did not perceive caring could be taught to students in its entirety, more that students have the caring characteristics, personality, and virtues as part of '*being caring'* which would be enhanced as part of the TR curriculum in both clinical and academic settings.

4.5. Chapter Summary

The findings emerging from this study are presented as Figure 12 below. This indicates potential links and inter-relationships between themes and areas as interpreted by participants and me as the researcher. The next chapter will discuss these findings and situate them within the context of the previously reviewed literature.

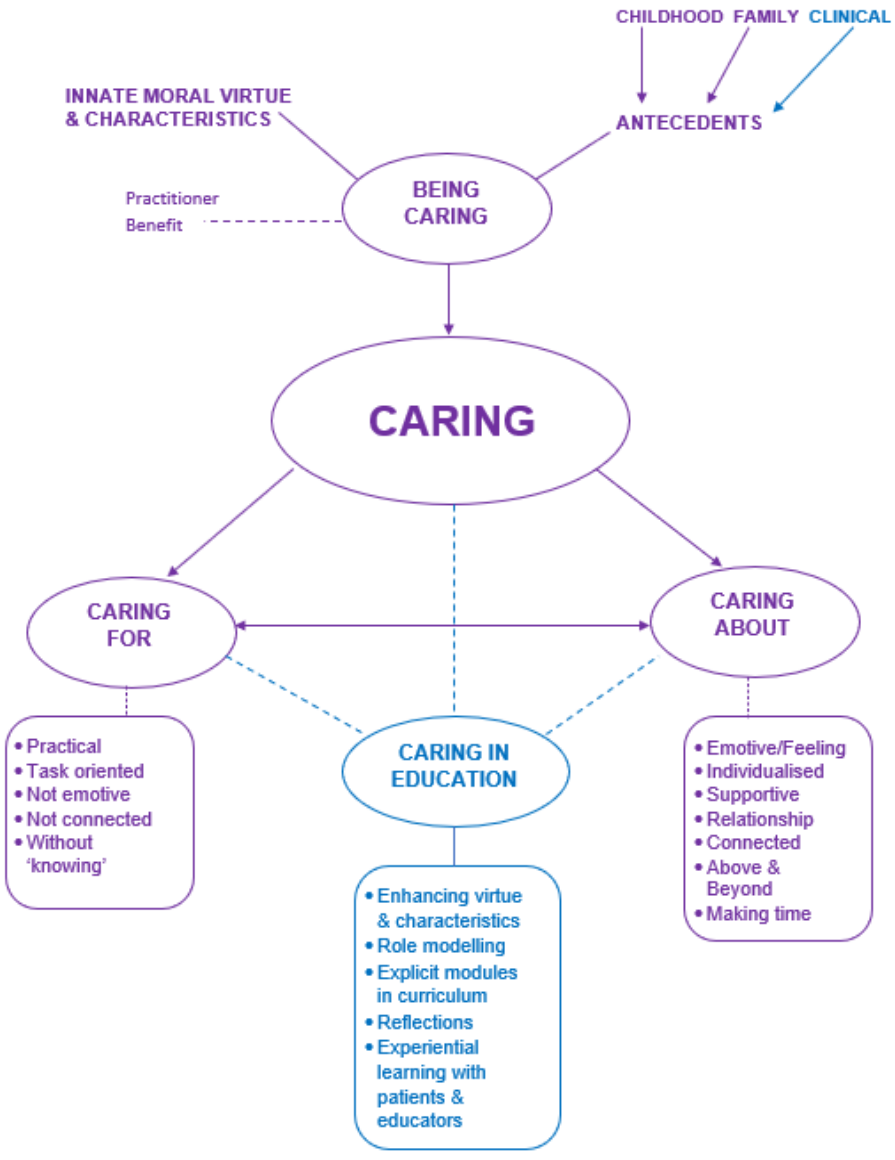

Figure 12 Representation of Caring from the Study Findings
Arrows and lines suggest links. Purple represents caring in therapeutic radiography whilst blue relates specifically to academic education.

4.6. Reflexive Thoughts

Reading and re-reading the transcripts allowed an immersion in the data that I believe would have been more difficult if coding software had been used. I felt I knew the participants as they came to life through their transcripts. I noticed it was easier to apply the modified van Kaam process to some than others. I discovered myself (having listened to the recordings again) deciding which interview I would start to analyse first, because their views mirrored my own. My journal reflected that as I avoided one transcript multiple times. Through my reflexivity I saw how I imposed or directed the analysis, and so moved to an alphabetical approach from then on, avoiding undue influence on the findings.

In my 'interview', recording my views to better enable 'bracketing' I expected a difference between caring in clinical and in education. I realised that at times it might manifest practically in a slightly different way, inherently it had the same underlying principles. So initially I resisted when reading transcripts, trying to determine what participants' felt about caring in clinical and then in educational settings. A first draft of themes split them, but then reading comments from my supervisors I realised I needed to step back and be open to the true essences that phenomenology can reveal.

I extracted as much of my influence as I could and then themes began to fall better into place. I suppose because previously I was 'forcing' them in a certain direction. In the findings and analysis of the data, I feel the choice of Husserl over Heidegger has been essential. Bracketing and using a very structured process in the modified van Kaam has allowed the data to truly speak for itself, reflecting participants' perceptions and lived experiences.

5.0. Discussion

5.1. Introduction

The expectation, requirement, and responsibility for caring features in Codes of Professional Conduct for healthcare students and practitioners whilst frequently appearing in healthcare policy. Additionally, HEIs are expected to develop the attribute in healthcare students (Willis, 2015). This phenomenological study aimed to discover the perceptions and lived experiences of caring from the perspective of academic TRa, including the influence these may have upon their teaching practice. The study will add to what is already known within contexts other than TR (Chapter 2) and bring new knowledge to this discipline.

This chapter will situate the findings in the context of previously reviewed literature, through the lens of the research questions posed and the themes emerging from this study. Underlying the main research question and aim of this study, the following sub-questions were posed:

- How do academic educators perceive the notion of caring in clinical and educational TR practice?
- What are academic educators lived experiences of caring in the clinical and educational contexts?
- How might academic educators' perceptions, experiences and conceptualisations of caring influence their practice in the education setting?

Three overarching themes emerged from the findings around the notion of caring in TR. A final theme concerning teaching practice also became apparent. The main themes were, 'Being Caring', 'Caring For' and 'Caring About', supplemented by a final theme of 'Caring in the Curriculum and Pedagogy'. Participants were genuinely passionate and forthright when discussing what caring meant to them as individuals, and their experiences of caring for patients and students. In considering the following discussions it is important to acknowledge that, although individuals' perception and experiences are unique, the study does seek to draw conclusions that might enhance knowledge and practice in TR education. Participants interested in the study who volunteered to take part will doubtless have been attracted to the nature of the study focussing upon caring. It is feasible that the participants were possibly self-selected as more caring radiographers and educators. An educator

disinterested in the notion of caring would be unlikely to participate in the study. This may be a limitation, or a better way to unravel the complexities of caring simply because participants are naturally interested in the topic, and it is meaningful to them. The opportunity to discover the perceptions and experiences of students, clinical radiographers and patients would enable all actors in the unique TR setting to have an important voice. This could be an area of future study.

The discussion will firstly consider perceptions of caring and caring experiences, including highlighting some possible tensions around the concept. A suggestion of the notion of caring in TR will be made. Finally teaching practice and how caring influences academic educators is explored, with a suggestion of what being a 'caring educator' might entail concluding the section.

5.2. The Caring Individual in Therapeutic Radiography

My interpretation of the study data suggests that caring is an importance dimension to both clinical and academic TRa and their practice. Being a caring individual was perceived by participants as a multifaceted concept. It emerged as a way of being, intuitive to the personality of the individual and suggestive of subconscious virtue. Individuals in this study perceived caring to be an innate component of the person that could be enhanced and developed. The desire to help and nurture emerged as a form of altruism which participants believed was present, to various degrees, in everyone who becomes a TRa. More widely they perceived all individuals might have the capacity for caring, but for some this would be more developed than in others. Caring characteristics emerged from life experiences, both as children and adults and for some that lead them to a caring profession such as TR.

Participants frequently used the term 'personality' to describe an individual with a caring concern, and a commitment to caring through caring thought, acts and processes. However, I would interpret their perceptions and subsequent descriptions to be more indicative of the characteristics or virtues of that individual, although acknowledging that concepts of personality, traits, attributes, and characteristics may be used as synonyms. The Cambridge Online Dictionary (n.d.) defines personality as a way of thinking, feeling, and behaving. Although this may well encapsulate a caring personality to participants, for the purpose of this study I will unravel the term further. As highlighted in the literature review chapter, virtue

may be considered a trait of character and the ‘core’ of the individual (Gelhaus, 2013).

Personality is understood by Gelhaus (2013, p.127) to be the balance of virtues and all the required attitudes of caring, but with emphasis upon the emotive virtues. So, although participants readily used the term personality, my interpretation is that the more appropriate terminology is character and virtue. Character is the enduring essence of an individual, which may change over time, and describes how that person is inclined to be, act, feel and to value (Gelhaus, 2013, p.126). Gelhaus further describes virtue as connected aspects of skills, habits, and ideals, integrated within an individual. In a similar way, attitudes can involve a cognitive, thinking element and an emotive, feelings element, but the important difference here is the action aspect of character. Furthermore, the emphasis of virtue is upon the agent, whilst attitude focuses upon the relationship with the patient or student. Although relationships feature within the data, there is a subtle difference, relationships will be explored in later sections. Kerasidou *et al*. (2020) also refer to personal virtue in their discussion paper around empathetic healthcare systems. Thus, the terms virtue and characteristics will be adopted for this discussion.

Virtues can be considered moral dispositions linked to the intrinsic parts of an individual and related to appropriate feelings. Their importance is seen from the literature review. As early as Aristotle’s Nicomachean Ethics, written in 340 BCE republished in 2009, virtues have been noted to be at the core of caring, proposing them to be a desire for the wellbeing of others beyond a mere goodwill, *wanting* to do good as part of a cognitive process (Aristotle, 2009). Although not described as caring virtues, Aristotle’s work has been subsequently developed over time. More recently, and in a current healthcare setting, Kerasidou et al. (2021) considered empathy and compassion as an expression of virtue and related professional skill. They explain how practitioners engage both cognitive and emotional dimensions alongside the intention and desire to do good. Similarly, being intuitive and ‘picking up cues’ from patients and students would originate from a desire to be caring as part of character and virtue (Kerasidou et al., 2021; Aristotle, 2009; Watson, 2006; Morse *et al*., 1990; Roach, 2002) and suggests a level of emotion. Of particular importance is the moral imperative revealed by the early exploration of caring in nursing by Morse et al. (1990). They describe caring as a fundamental value, not just an array of traits or behaviours, more a way of being that underpins all actions

of the nurse. This I would interpret to be related to moral virtue or as Morse *et al.* (1990) describe, a 'moral imperative'.

The connection with patients and students, through the ethics or virtue of caring was described by Branch (2000b) in relation to medicine. He referred to the caring approach and the emotive, moral 'orientation to caring' and 'moral character' (Branch, 2000b, p.128). A caring person had a '…desire to be receptive to and responsible for others…' (Branch, 2000b, p.128). These concepts were also later supported by Gelhaus (2013, p.125) who again referring to doctors, espoused 'morally emotive attitudes…and tacit values' make up the caring characteristics of a practitioner.

The findings from this study also confirmed these concepts and have shown how they might to transfer to the clinical and educational TR settings. There was a desire in participants to be caring which was interpreted as their character and virtue, being part of them as individuals. This is shown with the *'want to care'*, being perceived as almost innate and altruistic, providing a natural nurturing that was beyond conscious thought. This would be suggestive of the caring person. Participants perceived variation in 'personality' or a difference in the caring disposition of students and TRa. Those with a greater disposition or virtue may demonstrate *caring about* in addition to *caring for* individuals. Another similarity is that of intuition and awareness of cues which emerged from this data. The emotionality involved in caring emerged from the perceptions of TR educators and reflected findings by Gelhaus (2013) in the medical profession. The humanity and values aspects of caring are also discussed by Gelhaus (2013) and feature in Roach's Caring – The Human Mode of Being (2002, p.56) as 'The morally sensitive self, attuned to values' which relates to an authentic moral consciousness. It is worthy to note that in my study, the participants' language emphasised a caring personality and being caring in preference to having caring values. The concepts are clearly related but it is interesting that they did not use the term 'values' despite their emphasis within my profession (Strudwick *et al*., 2018). The absence of the term 'values' may also indicate the individual conceptualisation of caring and its related dimensions. This would be worthy of further future exploration with students and educators.

The caring personality of an individual practitioner was reported as a sub-theme within the study by Bolderston, Lewis and Chai (2010). This is important as their

study is one of few in the TR clinical setting and the significance of this seminal publication may explain why participants in my study referred to the 'caring personality'. Bolderston, Lewis and Chai (2010) also briefly mention the workplace setting as influential with respect to caring. Kerasidou *et al*. (2021) further explore the individual and institutional responsibilities around caring. With a particular focus upon empathy and compassion, Kerasidou *et al*. (2021) explained how, despite the importance of individuals' empathetic virtues, there is also influence from the whole healthcare environment in which practitioners work. They also suggest that despite empathy and compassion being considered a virtue rather than skill, if the environment or culture is not supportive of expressing that virtue, it is less likely to be developed. Habituation of the skills to facilitate empathy and compassion, in addition to the moral development of caring virtue would therefore be considered hampered (Kerasidou *et al*., 2021).

My study findings showed a similar perception from participants. The importance of a moral imperative from the caring individual was evident, which supports that dimension of caring described by Morse *et al.* (1990). Conversely, the dimension of Human Trait described by Morse *et al*. (1990) was reflected more as 'personality' by participants. The meaning I would suggest is the same, although the terms used differ. Possibly knowledge of trait varies within a specific context and could be a more nuanced explanation of the caring virtues espoused by other authors such as Branch (2000a) and Haslam (2015). There were concerns from participants around the culture of caring, which have also been expressed by Bolderston, Lewis and Chai (2010) and Kerasidou *et al.* (2021). The decline in caring suggested by Kerasidou *et al.* (2021) is not merely due to individual practitioner failings, more that the institutions are creating barriers to caring through culture and workload. This was shared by participants, but in contrast, they maintained such barriers could be overcome by the TRa. Culture will be explored later in the chapter. Caring virtue was interpreted by participants as having elements of skill which could be facilitated or 'honed' within practitioners which supports the views espoused by Kerasidou *et al*. (2021).

In summary, academic educators perceived being a caring person was a result of the individual's personality but interpreted by the researcher as character and virtue. Caring included being intuitive and 'picking up cues' from patients and students as part of a moral imperative. Caring virtue was also perceived as enabling honed skills

in both the clinical and educational context. These notions supported the literature around caring in other healthcare professions and settings. However, they add to new knowledge in TR as other than the seminal study by Bolderston, Lewis and Chai (2010), there have been no studies exclusively within the TR setting. Their study related to clinical practitioners so findings from my study add to the previously unresearched academic setting. Thus, the moral imperative of a caring TRa contributes to new knowledge. Although participants did not emphasise values, present in the literature, they discussed 'being caring' and having a 'caring personality'. This would be interesting for me to further explore in future research.

5.3. Antecedents Shaping Caring in Therapeutic Radiography

Antecedents may be considered previous experiences and influencing factors within an individual's life and practice. As Maben *et al*. (2012, p.166) explain these can include the climate (culture) of the workplace, wellbeing, and the individual differences of the practitioner. Individual differences can include skills, competence, affective views of patients and dedication to work. Culture or climate will be considered separately in this chapter. The work by Maben *et al.* (2012) supports the seminal writings of Aristotle (2009) who also considered certain antecedents as influential to patient interactions and caring. Scotto (2002) also mentioned antecedents as the intention to care, in addition to time and respect for individuals.

The purpose of *being caring* emerged from the findings of my study in the TR setting. Much aligned to Scotto's (2002) intention to care, participants were resolute in their perception that previous childhood and family experiences of being cared for influenced their ability of *being caring* people and practitioners. This relates to the innate ability to be caring, or the caring personality (virtue) discussed in the previous section. Participants described how they perceived virtues and caring characteristics developed as part of experiences within individuals' lives. Academic educators related this to family and childhood encounters which they described as receiving of caring from others so that the virtues of caring could develop in them as individuals. All participants revealed a series of experiences and aspects of their earlier lives perceived to have engendered caring in themselves. The importance of experiences has until now, and to my best knowledge, not been previously explored in the TR educational setting. The findings of this study indicate how the participants entered the profession with the moral imperative to be caring, stating

previous life experiences may have helped shape their virtues and attributes in addition to character or personality. They may be reflected as potential empathetic expressions of caring deep within our being, as the core of the radiographer.

The data in my study demonstrated tendencies towards the ideas of caring families and in particular caring from parents, enabling caring in participants as children. It appears to be the earliest opportunity through which caring was experienced by and modelled to participants. These findings may help to consider whether any individual can be caring, or if without certain antecedents there may be a threshold to the ways of being caring. The idea of caring being a threshold concept was first espoused by Clouder (2005). The findings from my study around the importance of receiving and experiencing caring in participants' lives before becoming a TRa should be considered with some caution. There are many caring professions within healthcare, and what may have driven participants to become TR was not the focus of my study. However, this has revealed an interesting area of my future research. To explore why individuals become TRa and how their personal experiences of caring and empathy might impact them '*being caring'* and demonstrating this to others.

The themes emerging from this study included '*caring for'* and '*caring about'* which may provide a means of distinguishing between the individuals who are caring due to innate and refined virtue, compared to those who see caring at a different level. My study identified that the academic individuals perceive that care in TR has arisen out of personal experiences and requires *'caring about'* when delivering care. This could be considered caring at a more connected level. According to the academic educators, the perfunctory elements of caring as practical actions need to be underpinned by an authenticity beyond the professional limitations of treating a patient correctly or identifying assessment needs for students.

A further finding emerging from this study and, to my knowledge, not explained or evidenced elsewhere, is the importance of being a caring clinical TRa. Participants indicated how their clinical role influenced their educator role, enabling them to be a 'caring educator'. In addition to the role of personal experiences and the caring characteristics of the clinical TRa, *being caring* with patients formed the foundations of *being caring* with students. Participants perceived a natural transition from clinical to the educational setting, they did not need to consciously consider caring, it again

came naturally to them as individuals. The importance some academic educators placed upon *being caring* as a clinical TRa may have influenced their perceptions that others may not care. TRa who were *caring about* patients in the clinical setting could transfer this to *caring about* students in the educational setting. This could explain those educators who participants perceived to lack caring with students, acting from a process and task approach.

In summary, academic educators lived experiences of caring influence them as individuals and as caring practitioners in the clinical and educational settings. In childhood and as part of family life, early experiences were perceived as shaping the person and their caring. These findings have not been previously evidenced within the literature to my knowledge and so can help clarify greater understanding of caring in TR and how this influences academic educators. Experiences of caring in early life and in their clinical career directly influence the teaching practice of academic educators. Data showed that educators perceived their skills and experiences in the clinical environment enabled them to be caring in the academic setting with their students. Thus, clinical experiences in additional to the life experiences of educators further facilitate caring in their teaching practice.

5.4. A Caring Culture in Clinical and Educational Settings

The importance of being caring as an individual has been highlighted within the literature and from my study findings. However as mentioned earlier, caring may not solely rest with individuals; the environment or culture within the workplace can also have an impact. Several articles have referred to the culture of the clinical department and its influence on caring (Branch, 2000a. Murphy, 2006. Kerasidou *et al*., 2021). Although few relate this culture to the educational setting, I would suggest culture could translate from clinical to the educational setting, just as participants in my study considered caring transferred.

In general healthcare, Kerasidou *et al*. (2021) proposed that institutions should be required to facilitate caring, rather than relying upon individuals and their own practice. The impact of the team and the workplace environment may further influence caring due to the '…*moral agents other than individuals, …systems and institutions*.' (Kerasidou *et al*., 2021, p.3). The need for a focus upon caring, is also supported by Gelhaus (2013, p.125) who believes the whole system or institution should be '*about care'*. Similarly, Nyholm *et al*., (2018) suggested healthcare might

only be sustainable if ethical caring values alongside good, compassionate leadership exist. This creates an engaged, educated workforce that enables a culture of caring. Such culture is not limited to patient care but includes the whole organisation and community (Nyholm *et al*., 2018). An enabling culture may not always exist as Branch (2000a) explained, the lack of empathy and respect in wards created an inhospitable culture with reduced moral virtues and ethics. These reflected upon not only patient, but staff and students too.

Bolderston, Lewis and Chai (2010) reported that within the TR clinical setting the work environment and organisational culture reduced the ability of practitioners to care. This included time pressures when treating patients and the potential for caring to be sacrificed for technology. Murphy (2006) and Naidoo, Lawrence, and Stein (2018) revealed similar tensions around time and technology in diagnostic radiography. Whilst Williams, Kinnear, and Victor, (2016) described how in high technology healthcare environments, habitual tasks may erode caring more than the technology itself.

Findings from my study revealed similar tensions around the culture for caring. Participants also experienced concerns that technology and time constraints may be eroding caring in the clinical setting. Data showed the impact of workplace and team culture, and how related time pressures have potentially caused a dichotomy of choice for TRa. This preference is perceived to be between caring or technology echoing Bolderston, Lewis and Chai's (2010) views. Participants in my study felt if practitioners had the desire to be caring, it was possible to negotiate the technology and time constraints to deliver a culture of caring. However, participants recognised there could be a tendency to prioritise technology over caring because of the habitual nature of it, which concurs with Williams, Kinnear, and Victor, (2016). Therefore, it is important for TRa to recognise this and not succumb to it.

My data also further supports the ideas that a culture for caring does not lie solely with the individual TRa. Participants perceived a variation between and within departments, hospitals, and universities. Some patients and students might be treated like a number in either clinical or educational settings which aligns with the early work of Branch (2000a). A poor culture of caring could influence staff and students, almost exacerbating the ethos of reduced caring. Considering the concepts proposed by Kerasidou *et al*. (2021), that '*honed skills'* or virtues may be

enhanced by habituation, the target, technology and process driven environment could be suggestive of occupational socialisation where individuals may adapt to their setting. This would be an area of future research, to explore what might create an environment with an ethos or culture of caring, and if indeed caring is enhanced. Participants perceived role models might influence culture and caring which will be discussed in a forthcoming section of this chapter.

Of interest to note, is that findings from my study did not particularly demonstrate the importance of a caring team in the education setting. Participants did express belief that in education the caring clinical radiographer transferred to be a caring educator. Similarly, actions and interactions occurring within both clinical and educational settings creating a caring culture, were not overtly revealed in my study. Also absent was the potential influence of technology in the educational setting and how that might influence the caring culture. These areas are worthy of future exploration, maybe as a case study considering one TR education department. My study was purposefully focussed upon individual experiences and perceptions which may be why influences such as HEI leadership and culture did not emerge. Having established a clearer view of caring in the academic setting from my study, the nuances that are being revealed could be explored in more detail as part of subsequent research.

In summary, academic educators mostly expressed '*being caring'* as an individual notion, less influenced by the workplace culture. Participants experienced constraints in the clinical setting that they perceived to be eroding caring, these included technology and lack of time. They also acknowledged that if there were individual role models present with a desire to be caring, it was possible to negotiate such constraints to deliver a culture of caring. Participants' experiences reflected that for some TRa, habitual tasks and processes took precedence over caring. The caring culture varied between individual departments, hospitals, and universities but interestingly data did not specifically demonstrate the importance of a caring team in the education setting. I intend to explore this in future research.

5.5. Caring Behaviours in Therapeutic Radiography

Interpretation of the findings showed how academic educators perceive '*being caring*' towards patients and students to include a range of behaviours. This was particularly evident in the theme '*caring about'*. Before discussing these behaviours,

it is important to acknowledge the scope of this study. Establishing how patients or students may interpret, perceive or experience caring from their radiographer or educator has not been undertaken. This would be an important area for my further research. The study intended to explore experiences and perceptions of academic educators; it is from their perspective that the concept of caring has been considered.

Behaviours perceived as caring by participants were significant in the data. A variety of thoughts, feelings and actions emerged that educators believed portrayed *caring about* the patient or student. Caring behaviours included making time, prioritising, and listening to patients and students. Knowing students and connecting with patients and students emerged prominently from my findings as emotional caring behaviours. It may be that in making time and listening to patients and students, TRa enable '*knowing'* of the individual.

Findings demonstrated how participants hold significant importance to making time and prioritising patients and students. This was particularly evident in participants' views within the education setting where they would be available to students, demonstrating what they perceived to be prioritising them as individuals, and so *caring about* them. My interpretation of the study findings reflect those reported by Naidoo, Lawrence, and Stein (2018) who describe caring as a humanistic way of interacting with people, making time, listening, and enabling empathy and compassion. It is interesting to note that their study involved diagnostic students' perceptions of caring, but the similarities are clear when compared to my study. The congruence of perceptions from both studies would suggest this notion of caring may be significant to practice.

Making time emerged strongly from my data, sometimes to the detriment of the TRa and their wellbeing, more so in the education setting. Making time enabled emotional '*heartfelt'* connections and a humanistic relationship with both patients and students. Participants described a sense of going '*above and beyond'* the basics of caring for patients and students and the importance of the '*small things'*. Both phrases will be explored later within this section. Participants did consider these behaviours as being authentic '*caring about'* individuals and an essential aspect to their role in both clinical and academic settings. These findings support aspects of the earlier work by Bolderston, Lewis and Chai (2010), one of the few

studies in clinical TR. They suggested '*empathetic human connection'* constituted aspects of caring, although their themes of technical care and TRa identity are not overtly demonstrated within my study. Nevertheless, aspects of their '*technical care'* theme may align with the practical '*caring for'* interpreted from findings in this current study. Similarly, personality appears within '*identity'*, which may align more with elements of this study and the theme of '*being caring'*. Additionally, these subtle differences may be that Bolderston, Lewis and Chai's (2010) participants were clinical therapists in Canada rather than UK educators. However again, the relationships and connection aspects of caring are evident and important in both clinical and educational settings. I would suggest the current study adds to the previously unresearched academic setting proving a new lens through which to view caring.

Making time enabled and facilitated empathetic connection, perceived by participants in the current study to include individualisation, and knowing patients and students as people. The humanising aspects of caring emerging from my study show much similarity with the work of Haslam (2015) and more recently with that of Moudatsou *et al*. (2020). Humanity is borne from being authentically caring and facilitated by '*knowing'* and '*individualisation'* which enables a connectedness with patients and students. In my study it is interpreted as '*caring about'* patients and students. Other similarities emerged with findings from Eklund *et al.*'s (2019) exploration of caring which revealed nine themes encompassing person-centredness. Although Eklund *et al.*'s study is situated in the clinical world, the concepts overlap into the academic educational world of my research. My study has already revealed how participants interpreted caring in clinical and academic settings to be similar, thus person-centredness may also be similar. Themes such as '*Empathy, Engagement, Relationship, Communication, Holistic and Individualised Focus'* emerging from the study by Eklund *et al*. (2019, p.7) have been demonstrated in my study as applicable to both patients and students. Relationships and an individualised focus creating connections were prominent in both Eklund *et al.*'s study and from interpretation of the current findings. Connections can build a partnership, resulting in mutual trust that enables a therapeutic relationship whereby both patient and practitioner benefit. My study findings demonstrated the importance of relationships, in both clinical and educational settings. Participants spoke of trust, understanding, individualisation

and shared experiences that would bring a sense of fulfilment to the educator and wellbeing to the patient or student.

The connectedness and relationship aspects emerging from my study are worthy of further discussion, being part of person-centredness and the human connections previously considered. '*Knowing'* patients holistically at physical, emotional, social, intellectual, and spiritual dimensions brought satisfaction and a sense of emotional reward to participants in Bolderston, Lewis, and Chai's (2010) study. This was echoed by participants in my study, not only with respect to patients, but with students too. Participants perceived the reciprocity of a caring relationship brought meaning to patients, students and educators which again concurs with findings from Bolderston, Lewis, and Chai (2010). Considering the more prominent findings from this study and how they align with person-centredness reported by Eklund *et al.* (2019), I would suggest the concept of 'student-centred caring'.

Academic educators perceived caring in TR to be multifaceted with functional, task-based '*caring for'* and the personalised, emotionally connected, '*caring about'*. In *caring for* students, participants described ensuring assessments and learning were understood and supported students in doing so. This would enable learning and potentially successful graduation. However, they perceived this as the natural basics of their role as educators, suggesting that for them the 'real caring' was demonstrated by *caring about* students. Considering these aspects of caring in TR education, the concept of student-centredness is proposed. Like the clinical setting, person-centredness does not specifically identify practical details such as accurate treatment, so student-centredness might not reflect the practicalities of learning. It does propose individualised *caring about*, facilitated by relationships, connectedness and emotions, mirroring person-centred caring which naturally supports student-centred learning. It is important to acknowledge this idea is borne from educator perceptions so further research involving TR students would be essential to garner their views. Additionally, it may be that student-centred learning cannot occur unless student-centred caring is present. However, participants did identify variation, albeit anecdotal, between other programmes, which again should be explored in future research. To my knowledge, this conceptualisation of caring in education has not featured within the literature and so may be considered to contribute to new knowledge.

In summary, I have interpreted that participants in my study perceived caring to be facilitated by caring behaviours as part of the '*caring about'* theme. This included a humanistic way of interacting with people, making time, and listening to foster empathetic human connections. Participants' experiences were that connections and caring were enabled by '*knowing'* and '*individualisation'* of patients and students.

Within their teaching practice, participants spoke of trust, understanding, individualisation and shared experiences that would bring a sense of fulfilment to the educator and wellbeing to the student. They felt caring involved going '*above and beyond*' the minimal expectations of their professional role. At times this could be to the detriment of their own health and wellbeing but felt they were unable to address this due to '*being caring'*.

5.6. Tensions Around the Notion of Caring in Therapeutic Radiography

Findings from this study have previously highlighted the joy and fulfilment participants experienced from caring. However, there were also several emerging tensions which will now be considered within this section.

The importance of '*the little things'* (Williams, Kinnear and Victor, 2016, p.787) or '*little gestures of caring'* (Naidoo, Lawrence, and Stein, 2018, p.165) in the clinical healthcare setting bring humanity to caring, being meaningful to patients. In the education setting Hendry (2019, p.271) considered these part of '…practicing compassionately …doing the small things…'. These ideas were supported by findings from this study. Participants perceived the TRa would go '*above and beyond'* when caring for patients and students which was envisaged as '*making the effort'*, going the '*extra mile'* and ensuring the *'small things'.* These phrases were used by almost all participants and could be interpreted as almost being an expectation of caring. To be '*caring for'* patients and students without the elements of '*caring about'* and going *'above and beyond'* were interpreted as reduced or lesser caring by participants. These concepts were significant in the findings.

Such concepts may be interpreted as educators making a choice to be either '*caring for'* or '*caring about'* and going '*above and beyond'*. The '*caring for'* theme emerged as task based practical elements of caring without the emotional humanistic connections and relationship that signified '*caring about'*. Interpretations by both researcher and participants are more that those TRa who were *'being caring'* would

engage in the duality of '*caring for'* and '*about'*. Whilst in contrast, those practitioners who maybe did not have the character, virtue and attributes emerging as '*being caring'* might more naturally favour *caring for* patients and students. Yet this conscious or subconscious choice is unlikely, it may be a result of the individual's virtue or may be that caring in the '*above and beyond*' sense is hindered by '*workload pressure, time constraints and poor role models*' as described by Naidoo, Lawrence, and Stein (2018, p.165). Participants did reflect upon tensions working with colleagues they perceived as less caring. They acknowledged some practitioners did not '*care about'* but '*cared for'* patients and students in a perfunctory and process driven way, devoid of emotional connection and humanity. It may be the culture of caring is not conducive to '*caring about'* as my study and Naidoo, Lawrence, and Stein (2018) have explained.

Participants perceived the heightened focus upon technology in the clinical setting, reduced appointment times and machines working over capacity meant caring suffered to the detriment of the TRa as well as the patient. Some participants experienced this as emotionally grinding them down, so that they had little left to give. However, there was also some optimism in that staff would endeavour to adapt working practices and maximise the time with patients to deliver a caring experience. Participants believed that when '*being caring',* with the related caring virtue, barriers could be overcome to an extent. Findings revealed a genuine sadness around the overwhelming focus of the profession on technology, imaging and competencies which eroded the caring aspects of the clinical role. Although within different professions, these findings support the ideas emerging from earlier studies by Williams, Kinnear, and Victor, (2016) and Lindberg *et al.* (2018). Whether due to a high technology focus or habitual tasks remains to be seen in TR and would need additional exploration.

Further interpretation and understanding of these tensions and concepts will be the subject of my future research. As my study is the first, to my knowledge, within the academic education setting it has served to initially discover the essences of caring in TR. Exploration of caring has just begun, and I intend to continue further unravelling of ideas and concepts within education and clinical settings.

Some tensions around caring remain, but the prime focus of this research was to explore the experiences of academic educators and their perception of caring in TR

practice. This study revealed a duality of caring, two aspects to the notion of caring. *Caring for* relates to practical tasks or process aspects of caring whilst *caring about* involves an emotionality and connectedness closely related to the individual *being caring.* Participants in this study perceived *being caring* developed through previous life experiences, in addition to the individual having caring virtue and characteristics.

Caring about patients and students includes an emotionality borne from knowing and prioritising individuals through heartfelt connections and relationships. The authentic nature of *caring about* arises from moral virtue bringing fulfilment to the TRa. Caring involves a person-centredness, for patients and students which includes empathy, compassion, and empowerment. In the education setting this study suggests the notion of student-centred caring which aligns with aspects of patient-centred care in the healthcare setting.

5.7. How Caring Might Influence Teaching Practice

Having discussed the perceptions and experiences of caring for participants within this study, this section will now consider how those findings might influence TR education. A separate theme of caring in curriculum and pedagogy emerged from the study and in addition, the features of a caring educator surfaced which will be discussed bringing the chapter to a close. Caring through an educational lens includes the academic curriculum, explicit and implicit, in addition to potential pedagogic practices. It can also be considered to include the relationship aspects of the student-educator partnership. Although experiential learning within the clinical setting was perceived as an important part of students' education by participants, it will not be explicitly discussed here as the focus of my study was the academic setting. However, the notion of whether caring can be taught within TR programmes begins this discussion.

Caring is an expectation of the NHS Constitution (2015) and is well established within the professional and statutory bodies related to TR codes of conduct and practice (SCoR, 2013a; 2013b; 2016; HCPC, 2016). The responsibility of teaching caring to students also lies within such policy and was in part a catalyst for this research study. The notion of whether caring can be taught from a non-existent presence to professional caring in the clinical healthcare setting has been debated (Buckman, Tulsky, and Rodin, 2011; Hendry, 2019). Participants in this study perceived this was not entirely possible. Findings in this study supported the

enhancement and refining of caring in students through a variety of means. It was not considered something that could be taught in totality, rather it related to developing and enhancing *being caring* in altruistic students who were initially drawn to a caring profession in a similar manner to that experienced by participants. The expectation was therefore that the innate caring virtue was already part of student radiographers to enable '*caring about'* patients. '*Caring for*' in terms of management of radiation side effects was slightly different due to the process and task-oriented nature of that dimension of caring.

Participants perceived that transforming caring students from novice to practitioner was possible through an implicit and explicit curriculum with related pedagogic practices. This supports the transformative teaching concepts espoused by Mezirow (2003) and Clouder (2005). The explicit curriculum could already contain aspects of person-centred caring, holism and the importance of an approach that is individualised, with humanity, and relationships at the core, as identified by Pluut (2016) and Eklund *et al.* (2019). However, aspects such as *caring for* and *about* may provide a new lens through which to consider caring in TR. Relationships featured strongly within my findings, but specific strategies to develop the 'therapeutic relationship' were not reported by participants. This is discussed further as the section progresses.

Novice students who may be developing their professional knowledge to manage side effects and accurately treat patients, in terms of '*caring for'*, can '*hone*' and develop their skills in '*caring about'* patients. Suggesting this multifaceted approach to caring in TR may serve to enhance the skills and knowledge of our students and better enable caring in the clinical setting. This relates to initial concerns at the outset of this study. Little knowledge of caring in the unique TR setting could create greater challenges for educators who should encapsulate what caring is, and how it might be enacted by students. Additionally, participants considered how students would have the realisation as they approached the latter part of their education, that they had refined caring from its early core conceptual level to that of practitioner level. Clouder (2005) suggested that methods of teaching caring do not sufficiently include emotional and relational aspects. These have emerged as being significant in my study. Participants perceived these aspects of caring might be enhanced through role modelling of '*caring about'* in both clinical and academic settings alongside explicit teaching within the curriculum.

Participants in my study experienced and delivered teaching of caring and its concepts through specific modules focussed upon the person and the patient within their practice. This may vary across programmes at different HEIs, but as each university must meet policy and professional body expectations these may be more nuanced variations rather than robust differences. Participants explained how teaching in the academic setting included concepts such as compassion, and empathy but these were best taught, in their view, alongside experiential learning within the clinical and academic setting. Learning and enhancement of caring in both the HEI and placement would be through reflection, sharing experiences with peers and service user stories. These findings align with pedagogic practices suggested by Gramling and Nugent (1998, p.48) who explain how care situations and scenarios can shine a lens '…through which students experience and learn about caring' from academic and clinical staff.

Although therapeutic relationships were revealed as being an important part of *caring about* individuals from my study, the explicit use of a framework to enable these was not experienced by participants. Richardson, Percy, and Hughes (2015) and Percy and Richardson (2018) utilised Muetzel's Model of Therapeutic Relationships as a framework to deliver a module within the curriculum around caring, compassion, and empathy. This may be an interesting area to explore with students in the future when combined with current findings around concepts of '*caring for'* and '*about'*.

Themes emerging from my previous discussion paper (Hendry, 2019, p.271) suggest three routes to facilitating compassionate caring in TR students. These were 'compassionate practice' to develop the emotional connected relationships with patients, 'individual and relationship factors' concerned with patients' values and finally 'leadership factors' which included role modelling from academic educators. It is interesting to note role modelling, individual and relationship factors were prominent in the current study yet some aspects, such as a values-based curriculum were less prevalent. This too was absent from the findings related to the caring individual and the emerging theme, '*being caring'*, although caring virtue was perceived as important by participants. The concept of values may not have come to the fore within this study but may be part of the curricula in HEIs, as it is in my own programme.

An aspect of implicit teaching within the curriculum and practice was that of role modelling. Adam and Taylor (2014) found that role modelling by academic educators was important for students to understand concepts such as compassionate care. This was particularly successful when used alongside reflection. Here discussions with students around episodes of caring in practice could help students reflect upon and develop their skills with the input of a more experienced TR educator. Furthermore, it could involve the student experiencing *caring about* from their educator supplemented by *caring for* and *about* patients in academic teaching sessions and case studies. Participants perceived caring role models to be significant when enhancing caring in students. They were viewed as creating a caring education environment whereby students would experience caring from educators, enabling the enhancement of caring in student radiographers. The concept of the caring TR educator is discussed in the next section. Conversely participants perceived poor role models, in clinical and education settings, could negatively impact students' experiences of caring. This could involve reduced humanity, connectedness and rapport, supporting findings by Naidoo, Lawrence, and Stein (2018).

The influential nature of role models as suggested by the literature and my study findings may illuminate the reasons why there is a perceived reduced or lack of caring in clinical TR. Student reports of perceived poor caring from some clinical placements inspired, to an extent, my current study. If clinical role models are portraying more process and task oriented '*caring for'* rather than the emotionally connected '*caring about'*, students who may not have a strong caring virtue may adopt a preference towards '*caring for'*. If *caring for* rather than *caring about* becomes normalised in the time-pressured, process-driven clinical setting, providing a reduced culture of caring, the importance of *being caring* in the academic setting arguably becomes the more important experiential learning for students. Thus, the importance of academic educators modelling '*caring about'* could be of great significance and potentially negate any reduced caring behaviours participants experienced in the clinical setting. This may only be contemplated at this stage; I would hope to conduct further research with students to explore their experiences and perceptions of caring as individuals. With the importance of role models being established within the literature and from this study, it brings to the fore the concept of the caring educator and how they may appear to students.

5.7.1. The Caring Academic Educator in Therapeutic Radiography

Participants in this study explained how their skills and attributes related to caring in the clinical TR setting, translated to the education setting. Caring as an academic educator included harnessing the characteristics of *being caring* revealed earlier. Those who were not perceived as *being caring* would not deliberately avoid caring, more they enact caring based upon their own construction of the concept which would be more process oriented. Participants felt their abilities from '*being caring'* naturally enabled caring in their teaching practice, transferring their 'need to care' from patients to students. This was a shared perception across all educators in my study. It must be acknowledged that although participants shared the transfer of *caring about* from clinical to education practice, it may not be universal nor indeed true for all educators. Moreover, the demands upon clinical TRa may be the catalyst for a move into education. This was not a question for this current study but may provide a further lens through which to explore our practice as part of future research. Considering the importance of role modelling, this could create a tension in HEIs if some educators do not share the caring virtues espoused within this study. If so, the enhancement of caring in students may be reduced as they do not benefit from the modelling of caring behaviours. The combination of various pedagogic methods in our approach to teaching caring within the curriculum may be optimal. These were suggested by Bleiker, Knapp, and Frampton (2011) and Hendry (2019) and include reflection, values, role modelling, patient stories amongst other approaches. Including new emerging elements of '*caring for'* and '*about',* alongside explicit teaching of person-centredness, empathy and compassion remains important. A focus on developing the ability to foster therapeutic relationships could also be considered.

Returning to the notion of caring as a finding from this study, a caring educator would be perceived as have caring characteristics with moral caring virtue, being altruistic and prioritising students as individuals through caring behaviours. Caring has a practical aspect whereby the educator ensures students have information for learning and assessment to be successful in their programme. This is considered *caring for* and is practice oriented. However, the authentic *caring about* students by educators involved making time, a connectedness and rapport at an individual humanistic level borne from *knowing* students. *Caring about* included behaviours that are '…*demonstrating empathy … understanding … compassion…'* and are

accompanied by the educator connecting with students, whilst experiencing feelings and emotions related to the individual at a humanistic level.

The ability to be caring as a clinical TRa was perceived by participants as translating into education enabling caring educators, connecting with students as individuals from moral desire and virtue rather than merely performing a role. The conceptualisation of student-centred caring emerged from the study findings. Feelings of fulfilment and pleasure result from *heartfelt* connections with students. *Caring about* does require educators to '*go the extra mile',* above and beyond merely executing their role. At times this may be construed as detrimental to the individual, but not doing so would be perceived as more difficult.

Authentic *caring about* and *being caring* were influential to all participants in this study. This may be due to self-selection when volunteering, the nature of the study and their caring character. A wider study could be undertaken to explore how other academic educators perceive caring, but it nevertheless raises the question, to what outcome. If being caring results from early antecedents and experiences within an individual's life, they are delivering caring as they interpret it themselves. This supports the findings of Quirk *et al*. (2008, p.364) as '…*caring is in the eye of the beholder*' and suggests the individualised construction of caring can be influential to academic educators. However, the importance of a culture or environment of caring may also influence *being caring*, as demonstrated by Kerasidou *et al*. (2021). As my study revealed, virtue acquired by habituation and the importance of institutions as moral agents could help foster an education environment and teaching practice that delivers student-centred empathetic compassionate caring.

In summary, findings from this study showed caring as a clinical radiographer influenced teaching practice and enabled participants to be 'a caring educator'. They perceived students would have altruistic caring virtue having chosen to study a healthcare profession. Teaching would enhance students' caring, concepts related to caring such as holism, and person-centredness would be explicit within the curriculum in specific modules. Participants perceived the hidden or implicit curriculum to meaningfully enhance caring in students. This was primarily through role modelling by themselves as caring educators. It included portraying caring through their caring characteristics including moral caring virtue, being altruistic and prioritising students as individuals through caring behaviours. This enabled

educators in my study to experience feelings of fulfilment and pleasure from *heartfelt* connections with students. Participants perceived poor role models in clinical and education practice could negatively impact students' caring experiences, demonstrated by reduced humanity, connectedness, and rapport.

A finding emerging from my study and not evidenced within the literature to my knowledge, is that caring educators transfer '*being caring'*, and '*caring about'* individuals from their clinical role to their teaching practice. This may be what enables the conceptualisation of student-centred caring also emerging and interpreted from the study findings. I would suggest this contributes to new knowledge.

5.8. Summary

This study explored academic educators' perceptions and experiences of caring in TR. It is suggested that academic educators perceive the notion of caring to be an important multi-dimensional aspect of both clinical and educational practice within TR. The theme of '*being caring'* emerged from the individual's personality but interpreted by the researcher as character and virtue. Caring included a moral imperative and honed skills in both the clinical and educational context. Lived experiences of caring influenced participants as individuals and as practitioners. Early life experiences were perceived as shaping the person and their caring. These findings can be considered to contribute to new knowledge.

Perceptions of '*being caring'* were that it is an individual notion but influenced by the workplace environment or culture. Tensions and constraints in the clinical setting were perceived by participants to be eroding caring, these included technology and lack of time. Participants also acknowledged that if individual role models with a desire to be caring were present, it was possible to negotiate such constraints to deliver a culture of caring. Participants' experiences reflected that for some TRa, habitual tasks and processes took precedence over caring. I have interpreted that participants perceived caring to be facilitated by caring behaviours as part of the '*caring about'* theme. This involved humanistic interactions, listening, and making time for individuals to foster empathetic human connections. Connections and caring were enabled by 'knowing' and 'individualisation' of patients and students.

Participants perceived trust, understanding, individualisation and shared experiences within their teaching practice portrayed caring. They experienced a sense of fulfilment as educators and perceived these caring behaviours enabled student wellbeing. Caring involved going ‘above and beyond’ the minimal expectations of their professional role.

Emerging from this study is the notion of caring in TR and the concept of the caring educator. Caring behaviours enacted by a caring educator would be role modelling caring to students as part of the implicit curriculum. Teaching within the explicit curriculum and in specific modules, would include concepts related to caring such as holism, and person-centredness.

Tensions remain in both the clinical and academic settings related to caring. The impact of a culture for caring would be worthy of further research alongside establishing both patient and student constructions of caring and how they might be portrayed. Time and technology pressures are perceived as creating tensions particularly in the clinical setting, whilst the expectation of going ‘above and beyond’ could negatively impact educators. These aspects of caring emerging from my study have identified areas for me to further explore.

6.0. Conclusions, Recommendations, and Implications for Practice

6.1. Introduction

This phenomenological study explored '*How do academic educators' perceptions and lived experiences of caring influence their TR teaching practice?'.* This final chapter will return to the research questions posed in the introduction to provide a summary. It will close with recommendations, possible study limitations, potential implications for practice and contribution to knowledge. Personal reflections around the research may be found in Appendix 14.

6.2. Perceptions of Caring

There was an overwhelming commonality in participants' perceptions and experiences in this study, although some differences did emerge. Themes arising from my study included '*being caring', 'caring for'*, and '*caring about'* patients and students. Some of these interpretations supported findings from earlier studies in healthcare, such as caring virtue (Gelhaus, 2013; Kerasidou *et al*., 2020) and the importance of making empathetic human connections (Bolderston, Lewis and Chai, 2010; Haslam, 2015; Moudatsou *et al*., 2020).

The theme of '*being caring'* related to the caring characteristics perceived to develop within individuals when exposed to antecedents or predisposing experiences in their lives. Participants felt such caring characteristics alongside an almost innate altruistic desire to be caring, were borne from moral virtue. These were nurtured by experiences of caring as individuals.

A duality to caring emerged which included the practical process-oriented action of *caring for*. Participants and the researcher interpreted such actions to include information-giving, appropriate communication and performing professional tasks. This was evidenced in both the clinical and academic settings and was perceived as perfunctory in nature, lacking the connectedness shown by *caring about*. *Caring about* was perceived as an outcome of *being caring* and involved a variety of caring behaviours. These included empathy, compassion, and individualised practice that are manifested by *knowing* individuals, through *heartfelt* connectedness, trusting relationships and rapport.

Aspects of *caring about* confirmed findings by previous studies, (Eklund *et al.,* 2019; Watson, 2006) although it is important to note none of these were in the clinical or educational TR setting. Such behaviours form frameworks of caring for nursing students and practitioners (Watson, 2006; Roach, 2002). None exist in my setting but as my study has begun to unravel caring in TR clinical and educational settings, this may now become possible.

6.3. Academic Educators Lived Experiences of Caring in the Clinical Context

Within my study, caring in the clinical context was considered optimal if it involved *caring about* individual patients. Although participants also experienced *caring for* the patient, it did not give rise to the emotionality, trust, rapport, and relationships that emerged when *caring about* patients. Participants expressed pride, pleasure and fulfilment when connecting with patients at an individual level. Similar connections with patients were described in the nursing and medical settings by Gelhaus (2013) and Branch (2000b). Being able to provide support during TR for the devastating disease that is cancer, involved more than practical caring to deliver treatment. Participants experienced humanistic connections with patients and their families. There was a shared sadness that the caring aspects of the TR profession were being eroded by a focus upon tasks, processes, and ever-increasing technology. These findings reflect early work by Murphy (2006) and more recent research by Naidoo, Lawrence, and Stein (2018), both in the sister profession of diagnostic radiography. Participants in my study experienced a culture of audit and targets within the clinical setting but remained determined to continue *caring for* and *about* patients, ensuring people experienced person-centredness during the short time available for their appointment. They also talked about colleagues who failed to be caring, shown by a lack of respect and dignity, disempowering patients, and treating them as a number rather than an individual. Over focussing upon imaging, promotion and efficiency were considered detrimental to the profession alongside a lack of good role models in the clinical setting. However, participants experienced hope that this focus had not yet entirely removed caring from the unique role of the TRa where the highly technological environment could thrive within a culture of caring. *Caring about* individual patients resulted in the practitioner experiencing fulfilment, connection, and pride but there was also a degree of tension around the culture of caring which was considered by participants to vary within teams, departments, and institutions.

6.4. Influence of Academic Educators Perceptions and Experiences Upon Teaching Practice

A strong influence upon practice revealed by this study was that experiences as a clinical radiographer were perceived as an important antecedent of *being caring* as an educator. *Caring about* patients in the clinical setting, and the related behaviours, were transferred to *caring about* students as a TR educator. Participants believed this to be a sub-conscious transfer based upon their caring character and moral caring virtue. Concepts of person-centred care associated with patients became student-centred care to participants in this study. Their notion of *caring for* and *about* students closely resembled *caring for* and *about* patients. This included making time, prioritising students, individualised practice, demonstrations of empathy, compassion, and respect. As clinical radiographers, participants described going '*above and beyond'* at times, stressing the importance of '*the small things'* which ensured patients felt like valued individuals, not as a number. These perceptions and experiences influenced their teaching practice where participants reported going '*above and beyond',* so students might also experience individualised caring. Some participants did acknowledge feeling their wellbeing might sometimes suffer from going '*above and beyond'* yet admitted being unable to stop due to an inherent need to be caring.

Teaching caring in its entirety was considered unlikely by my participants. However, caring was present within both the explicit and implicit or hidden curriculum. Teaching caring featured as part of explicit modules and sessions. Some also contained elements of *caring for* patients side effects. Participants also felt that through experiential learning, reflection, and teaching topics such as holistic care within the curriculum, students' caring skills could be further developed or enhanced.

The conceptualisation of the caring educator delivering student-centred caring, as previously highlighted, emerged from my study. It also demonstrated the importance of nurturing the enhancement of students' caring implicitly through role modelling, being influential to participants and their teaching practice. This was also reported by Naidoo, Lawrence, and Stein (2018) in their study involving diagnostic students. It may be interpreted that educators who are *being caring* may practice *caring about* students whilst for those who have less of a caring character, and

maybe have not experienced such caring antecedents, would practice more *caring for* students and patients. I would suggest this is not rigid and would vary as evidence has shown with culture, environment, other demands upon the educator, and their individual wellbeing at the time. This would be an interesting area of further study.

6.5. Recommendations, Limitations, and Implications for Teaching Practice

The following section will consider the main recommendations arising from this study of caring. Any research study has some limitations which will be explored in detail alongside potential implications of the findings regarding teaching practice in TR and beyond.

6.5.1. Recommendations

My findings reveal how academic educators perceive caring, yet they are but one actor in the professional setting, albeit my sphere of influence. To fully explore what caring in TR means it would be important to similarly investigate the conceptualisation by patients and students, and indeed clinical radiographers. It is recommended that perceptions and experiences of caring are comparably explored through the lens of patients receiving TR and students on TR programmes.

The unique findings from my study around the concepts of *caring about* and *caring for* offer an opportunity, for both qualified TRa and students in education, to consider how they might 'deliver' caring towards patients. The importance of connectedness and therapeutic relationships with patients in the clinical setting is recommended as a form of professional development. Reflections upon practice as individuals and within radiotherapy departments would help with self-awareness of being a caring TRa. This could be facilitated through an online learning module specifically for TRa and students. Such a module would be a direct output from this study. Additionally it is recommended individual Trusts may explore the culture within departments and whether these are enabling, facilitating caring and centredness or promote the tasks and targets revealed as a tension within this study.

Using the findings from this first study of caring with academic TRa, it is recommended that a framework for a '*Caring Educator'* is developed. Not only might this help within the TR academic setting, but it may also serve as a useful basis for other healthcare programmes in delivering 'student-centred caring'. This also

emerged from my study as a conceptualisation of student-centredness, making the student the heart of educators' practice in a similar manner to that of person-centred caring in the clinical setting.

Caring about patients would offer novice students a useful role within the clinical setting. As students develop their professional knowledge through their educational programme, elements of *caring for* patients in terms of radiation reactions and their management will expand. However the importance of relationships and connections can be nurtured from the outset, ensuring educators help to hone the attributes and values of *being caring*, which may have brough students to TR initially.

6.5.2. Limitations

Various recommendations and implications have emerged from the study of caring. However all studies have some limitations which will now be explored.

Considering the participants recruited into this phenomenological study there may be some element of bias. Interviews were conducted with self-selected volunteers who were practising educators at the time of their interview. In self-selecting to take part in this study it must be acknowledged that those with an interest or preference for the subject of caring might have come forward. This may provide a particular lens through which the study has been conducted, that participants would appear to have caring characteristics revealed through the study will doubtless have influenced the findings. The study does not seek to generalise, as lived experiences and perceptions are unique but nevertheless commonalities have revealed some new knowledge within the TR profession.

In any qualitative research the researcher plays an important and unique role, not only in selecting the topic under scrutiny but also framing the research questions and the methods used. From the outset of the study I was reflexively aware of the importance caring played in my practice and for me as an individual. When considering the phenomenological approach, the significance of bracketing aligned to the descriptive methodology seemed most suited to minimise any bias from my views overshadowing participants'. However bracketing and reflexivity can only serve to acknowledge and attempt to set aside my strong views, so it is possible that in my approach to the study I may have overly influenced the findings. Yet the use of the modified van Kaam method for data analysis was robust and executed to minimise my influence when interpreting findings. All qualitative research is

interpretive in nature, the researcher undertakes their own interpretation of the data retrieved but I believe all possible ways to minimise my undue influence have been undertaken and were embedded within the study design.

With a paucity of knowledge around caring in TR, a method utilising unstructured interviews may have better allowed a free-flowing exploration of participants lived experiences. However the semi-structured interviews undertaken were framed around the personal, clinical, educational, and conceptual aspects of participants' caring perceptions and lived experiences. The questions were broad and open to elicit authentic responses and allow the participants time to tell their stories.

The influence of the pandemic and multiple lockdowns during the data collection period of this study may be a limitation. A change from face to face to online interviews could have slightly shifted the dynamic of the interactions and potentially created more of a barrier when online due to a real or perceived lack of rapport and relationship. Similarly, the pandemic and the heightened awareness of the role of healthcare professionals and our own vulnerability may have created a slightly nuanced view of caring for participants. It is impossible to know if this was indeed the case. However data collection face to face compared with that collected online would suggest no immediate obvious differences during the process of analysis, yet this cannot be known definitively.

6.5.3. Implications for Teaching Practice

The notion of caring suggested by this study provides a potential framework through which TR educators could explore their curricula and teaching practices to ascertain if they do serve to enhance, develop, and hone the skills and attributes in students.

The study identified what a caring educator may be in TR. Even if we consider ourselves to be caring educators, the opportunity to discuss and explore this concept across one's team and the wider healthcare education setting could enable us to review, consider and potentially enhance teaching practices. As caring educators and role models, this could further improve students' experiences and learning as their skills and attributes develop during their degree.

This study was conceived in part due to my feeling that, as an educator responsible for teaching caring in TR, I had no evidence of what that concept would mean in the unique setting of clinical practice nor in my educator role. We are expected to teach

caring to student radiographers but also be caring towards those students and nurture both dimensions as they progress through the programme. This study has given me a new lens through which to consider and teach caring. Previously my teaching would rely on evidence drawn from other healthcare professions, now my study adds its unique findings to profession-specific knowledge. With this new knowledge the programme at my institution will consider how caring is explicitly taught within the curriculum. Reflections, patient or service user involvement, and person-centred care are explicit but can be reassessed and updated with my findings in mind. The emerging knowledge can feature in the upcoming revalidation of our programme to reflect currency. Already, planning my teaching for the next academic year, I will deliver sessions related to *caring for* and *caring about* patients receiving radiotherapy. It might be easy to consider the management of side effects and forget the person, so *caring for* the patient in a task and process-oriented way, students can learn selected medications and interventions. Their proficiency in this may only come as they progress from novice to practitioner. But the importance of *caring about* the person can be meaningful at any time, making time to connect and know that patient as an individual is something I am excited to share with my team, my students and the wider institution.

Alongside the potential explicit curriculum changes, this study has helped enhance my knowledge as an individual practitioner and as a team leader. Greater knowledge concerning the importance of role modelling in teaching practice has come to the fore. Although not an entirely new concept (Hendry, 2013; 2019), it now has a new dimension focussed upon caring and derived from educator experiences and perceptions. This study has shown that implicit demonstration of *caring about* by TRa was perceived to develop and nurture that virtue in the students experiencing *caring about*. Sharing this finding with my team is useful professional development for us all. Similarly, the emergence of the concept of student-centred caring from this study and its relationship to person-centred and patient-centred caring in TR could be shared with other healthcare programmes within my institution. This could help educators consider the concept of student-centred caring and how it might influence their practice and relationships with their students.

Within the wider TR profession, findings and conceptualisations arising from my study will be shared. Conferences and publications in our professional journal will be important for dissemination.

6.6. Contribution to Knowledge

This study makes a unique contribution to knowledge as it is the first study of caring, to my understanding, in TR in the UK academic setting. Although all findings may therefore be considered to add to the paucity of research, some findings resonate and reflect with work in other settings. Themes of *being caring, caring for* and *caring about* emerged from my study. The forthcoming subsections relate to the new knowledge emerging from this study in relation to caring in TR educational and clinical settings.

6.6.1. Being Caring

To my knowledge, the concept of *being caring* is a new contribution to knowledge in the TR field. It is linked to an individual's subconscious virtue, an almost innate way of being and moral personality. The caring characteristics developed from life experiences as children and adults brought individuals to the profession of TR. Participants believed the capacity for caring may be present in all individuals, yet some were more altruistic with a strong desire to help and nurture, thus their caring characteristics were perceived as more developed than others.

Another area of new knowledge revealed by my study, was the strong influence previous experiences of being a clinical radiographer brought to participants' educational practice. This emerged as an important antecedent of *being caring* as an educator.

6.6.2. Caring For and About

Another important area emerging from my study is the conceptualisation of a duality to caring in TR. The duality of *caring for* and *about* has been suggested in other aspects of healthcare clinical practice, yet it has not been acknowledged within the educational setting prior to this study. Indeed the 'transfer' or similarity between perceptions and experiences of caring in the clinical and educational settings is also new knowledge, having not been identified prior to my study of caring in TR.

Caring for patients within the clinical TR setting revealed a practical task-based aspect of caring that did not specifically include connecting with the individual, being more perfunctory in nature. Whilst *Caring about* patients in the clinical radiotherapy department involved humanistic interactions, listening, and making time for individuals to enable empathetic human connections. From knowing and

individualising patients, caring and connections would be fostered. The importance of the *small things* perceived as meaningful to patients and students also enabled *caring about*. These conceptualisations of caring in the TR setting are all new knowledge emerging from this study.

6.6.3. Culture for Caring

Culture in TR is another theme developed from this study that has not previously been discussed. The importance of a culture for caring, particularly within the clinical setting, was revealed by the findings from my study of caring. Although the importance of culture has been previously described in the literature (Branch, 2000a; Kerasidou *et al*., 2021) within other clinical settings, it is a new contribution emerging to the TR setting. Participants perceived that if the caring culture was absent in the clinical setting, tensions were created with some sharing their remorse for the TR profession. They perceived caring was being eroded by overly emphasising tasks, processes, and ever-increasing technology, possibly demonstrating a preference towards *caring for*. These tensions were somewhat balanced against the practitioner experiencing a sense of fulfilment, connection, and pride when c*aring about* individual patients.

6.6.4. The Caring Educator

In the experiences and perceptions of participants, the notion of the caring educator was developed. Such conceptualisation has not been suggested in TR prior to this study. Elements of the behaviours of caring practitioners has been seen in nursing and related professions, but this is new knowledge in TR. Such findings include the value of a caring curriculum and caring pedagogy but certain individual behaviours of academic TR that were revealed and interpreted as a caring educator. Role modelling *caring about* to students was fundamental to being a caring educator. Findings have shown that the implicit demonstration of *caring about* by TRa was perceived to develop and nurture that virtue in the students experiencing *caring about*. This is new knowledge offering the potential development of a framework or toolkit aimed at practitioners, possibly linked to the concept of student-centred caring mirroring that of person-centred caring. ‘Before my study, the notion of caring in TR was more implicit. The findings from this research therefore add to the conceptual knowledge in this specific setting and profession as new knowledge and may provide a structure for future practice.

6.6.5. Caring Teaching Practice

Linked closely to the caring educator is the conceptualisation of caring pedagogy and curriculum. The ways in which caring might be taught in TR education have not been explored prior to my study. Participants felt students possessed some caring virtue which had lead them to TR, acknowledging that this would differ due to previous life experiences, as their own previous encounters varied. Caring would be nurtured by educators, being enhanced and developed through both the explicit and implicit curriculum. Participants described *caring for* and *about* students through *heartfelt connections* and in so doing, modelling caring to them, implicitly. Alongside explicit teaching within the curriculum, reflection and experiential learning, participants perceived nurturing and enhancing caring in their students. The elements of *caring for* and *about* patients would provide a pedagogic framework to enhance teaching practice in TR, with therapeutic relationships and connectedness a priority.

This study adds to the previously sparse knowledge base around caring in TR. It has provided much needed evidence of how educators perceive and experience caring and how this influences teaching practice. Through carefully crafted explicit teaching and important implicit teaching, caring behaviours, relationships, and role modelling to student radiographers, the profession would have a greater knowledge of caring. This could subsequently enable enhanced *caring about* from students who are *being caring,* thus assisting to redress the concerns that TR practice has lost some of its humanity to processes and technology.

7.0. References

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9.0. Appendices

Appendix 1 - Search Strategy Literature Review

Phase 1 Search

Search 1 - Caring, Empathy or Compassion AND Radiotherapy, Radiation Therapy OR Therapeutic Radiography

Databases – CINAHL, Medline, Education Research Complete (ERC)

No date selected (starts 1992 online access)

Humans, Peer Reviewed, English

Database	Retrieved	Title Screened & Include
CINAHL	88	8
MEDLINE	264	23
ERC	8	0
TOTAL		31
Duplicates removed		(n= 8)
Total		**23**

Table 1 Literature Search 1

Search 2 - Caring, Empathy or Compassion Within Specific Journals

Separate search of two key Journals: Radiography and Journal of Radiotherapy in Practice (JRTP) to ensure no profession specific articles were missed.

No date selected

Journal	Retrieved	Title Screened & Include
Radiography	1091	**25**
JRTP	122	**15**
Total		**40**

Table 2 Literature Search 2

Search 3 - Caring, Concept AND Healthcare

Databases – CINAHL, Medline, Education Research Complete (ERC)

No date selected (starts 1992 online access)

Humans, Peer Reviewed, English

Database	Retrieved	Title Screened & Include
CINAHL	306	55
MEDLINE	272	74
ERC	135	87
TOTAL		216
Duplicates removed		(n= 128)
Total		**88**

Table 3 Literature Search 3

Combined Phase 1 Search

Search	Articles Included	TOTAL
Search 1	23	23
Search 2	40	63
Search 3	88	151
Duplicates removed		(n = 29)
Total to Enter Phase 2 Search		**122**

Table 4 Combined Literature Search Phase 1

Phase 2 Search

Scrutiny of abstract to confirm relevance for inclusion.

- Explores concept of caring.
- Related to radiography / radiotherapy.
- Related to healthcare.
- Pedagogic exploration of caring.
  Removed at Phase 2 search = 52

Each selected article after the Phase 2 search was appraised in detail by

- Thorough reading of the whole article
- Summarising key points
- Critique of methodology, methods, sample or participants
- Summary made of possible links and relevance to the study of caring

5 ‘new’ articles were added resulting in a total of 70 for the iterative review of the caring literature. These were ‘themed’ into topics: general healthcare (16), nursing

(18), medicine (5), diagnostic radiography (14) and finally radiotherapy and cancer combined (17). With these themes, 21 articles related specifically to teaching, however they remained themed by discipline/topic for purpose of the review.

All retrieved articles were identified on an Excel spreadsheet. These were themed and identified for inclusion of exclusion as above. The spreadsheet is included below.

Additional (limited) search post viva for '*caring and higher education teaching practice'*, '*patient advocates and teaching caring'*, '*simulation and teaching caring*' and '*caring pedagogy'* revealed a further 26 articles that were similarly screened as indicated above. Of these a further 12 articles were included and short sections added to the literature review chapter.

Article Spreadsheet

Article Title	Author	Comments / Theme	Area
"Double reflection": a practical approach to teach patient-doctor communication in oncology.	Mannhardt AK; Ogbonnaya L; Gieseler F	EXCLUDE - a letter	EXCLUDE
"It's what's behind the mask": Psychological diversity in compassionate patient care,	J. Bleiker, K.M. Knapp, S. Morgan-Trimmer, S.J. Hopkins	Diagnostic patient views of Compassionate Care	Diagnostic
A Concept Analysis of Holistic Care by Hybrid Model.	Jasemi, Madineh; Valizadeh, Leila; Zamanzadeh, Vahid; Keogh, Brian	EXCLUDE - poor quality attempts to	Diagnostic
A Concept of Caring Aiming at Health.	Söderlund, Maud		Diagnostic
A cross-cultural study of the concept of caring through behaviours: patients' and nurses' perspectives in six different EU countries.	Papastavrou, Evridiki; Efstathiou, Georgios; Tsangari, Haritini; Suhonen, Riitta; Leino-Kilpi, Helena; Patiraki, Elisabeth; Karlou, Chryssoula; Balogh, Zoltan; Palese, Alvisa; Tomietto, Marco; Jarosova, Darja; Merkouris, Anastasios	EXCLUDE - Caring Behaviours patient vs nurses views	EXCLUDE
A culture of caring: the essence of healthcare interprofessional collaboration.	Wei, Holly; Corbett, Robin Webb; Ray, Joel; Wei, Trent L.	EXCLUDE - HCP focus on interprofessional working	EXCLUDE
A humanistic approach to paediatric radiation therapy – One family's journey	David Collier	EXCLUDE - case study paediatric with CNS tumour	EXCLUDE
A model to facilitate the teaching of caring to diagnostic radiography students: Original research.	Naidoo, Kathleen; Lawrence, Heather; Stein, Christopher	teaching caring in DR	Diagnostic
Care studies—A learning method and an assessment tool,	Margaret Gratton,	teaching	Diagnostic
Compassion in healthcare: A concept analysis	Taylor, A., Hodgson, D., Gee, M., & Collins, K	compassion	Diagnostic
A social purpose model for nursing.	Ball E		nursing
Compassionate care in radiography recruitment, education and training: A post-Francis Report review of the current literature and patient perspectives,	J. Bleiker, K.M. Knapp, S. Hopkins, G. Johnston	compassion and teaching	Diagnostic
Addressing the information needs of patients with prostate cancer: A literature review	Mc Parland, N	EXCLUDE information giving only	EXCLUDE
Diagnostic radiography: A study in distancing,	Pauline J. Reeves, Sola Decker,	emotions	Diagnostic
An exploration of the extent of inclusion of spirituality and spiritual care concepts in core nursing textbooks.	Timmins, Fiona; Murphy, Maryanne; Neill, Freda; Begley, Thelma; Sheaf, Greg	EXCLUDE spiritulism in books	EXCLUDE
An innovative way of caring: palliative radiation therapy rapid response clinic.	Andersson L; Sousa P	EXCLUDE service improvement palliative waiting times	EXCLUDE
Patient centred care in diagnostic radiography (Part 1): Perceptions of service users and service deliverers,	E. Hyde, M. Hardy,	caring behaviours and diagnostic	Diagnostic
Teaching patient care to students: A blended learning approach in radiography education,	Jill Bleiker, Karen M. Knapp, Ian Frampton	caring and teaching	Diagnostic
The concept of caring amongst first year diagnostic radiography students: Original research.	Naidoo, Kathleen; Lawrence, Heather; Stein, Christopher	concept of caring and teaching	Diagnostic
Audit of the job satisfaction levels of the UK radiography and physics workforce in UK radiotherapy centres 2012.	Hutton D; Beardmore C; Patel I; Massey J; Wong H; Probst H	EXCLUDE staff focus	EXCLUDE
Can Empathy Be Taught in Radiation Therapy?	Stief, Emily; Ho, Emily (Po-Hui); Farrell, Tom; Smoke, Marcia	EXCLUDE summary not study	EXCLUDE
Canada's Evolving Medicare: Patient-Centred Care.	Montague T; Nemis-White J; Aylen J; Torr E; Martin L; Gogovor A	EXCLUDE general questionnaire	EXCLUDE
The paradox of imaging technology: A review of the literature,	F.J. Murphy,	caring and technology	Diagnostic
The radiographer-patient relationship: Enhancing understanding using a transactional analysis approach,	Lisa Booth,	caring relationship	Diagnostic
Understanding the humanistic interaction with medical imaging technology,	F. Murphy,	humanistic caring	Diagnostic
Patient centred care in diagnostic radiography (Part 3): Perceptions of student rads and radiography academics	E Hyde and M Hardy	person centred care and DR	Diagnostic*
Compassionate communication: Keeping patients at the heart of practice in advancing radiographic workforce	A. Taylor, J. Bleiker, & D. Hodgson	compassionate communication	Diagnostic*
"Same same or different?" A review of reviews of person-centered and patient-centered care.	Håkansson Eklund, Jakob; Holmström, Inger K.; Kumlin, Tomas; Kaminsky, Elenor; Skoglund, Karin; Höglander, Jessica; Sundler, Annelie J.; Condén, Emelie; Summer Meranius, Martina	Person Centred Care	general
Caring for children undergoing radiotherapy,	Patricia Pimm, Edward Fitzgerald, Lesley Taylor,	EXCLUDE as focus on role of rad also old!	EXCLUDE
Caring for innovation and caring for the innovator.	Unterschuetz C; Hughes P; Nienhauser D; Weberg D; Jackson L	healthcare culture from staff aspects	EXCLUDE
Caring for one of our own.	Schapira L; Blaszkowsky LS; Cashavelly BJ; Kim CY; Riley JP; Wold MC; Ryan DP; Penson RT	EXCLUDE case studies in Schwartz rounds	EXCLUDE
Caring for the cancer patient.	Fitzpatrick G; Bethel T	book	EXCLUDE
Caring for the cancer sufferer: a survey of therapy radiographers' problems.	Card IR; Fielding RG	staff focus	EXCLUDE

Caring for the radiation oncology patient.	Sandberg S	EXCLUDE personal reflection	EXCLUDE
Caring for the Transgender Patient.	Clark, Kevin R.; Vealé, Beth L.; Zaleski, Frank A.	generalised provision for TG person	EXCLUDE
Caring or uncaring--meanings of being in an oncology environment.	Edvardsson D; Sandman PO; Rasmussen B	EXCLUDE environmental only	EXCLUDE
Comforting children during radiotherapy.	Bucholtz JD		EXCLUDE
Communication skills training for the radiotherapy team to manage cancer patients' emotional concerns: a systematic review.	van Beusekom MM; Cameron J; Bedi C; Banks E; Humphris G	EXCLUDE comms skills	EXCLUDE
Communication: Preparing undergraduate radiation therapy students for initial clinical patient interactions,	T. Kelly, Y. Surjan, M. Rinks, J. Beech, H.M. Warren-Forward,	EXCLUDE clinical reasoning focus	EXCLUDE
An introduction to health care ethics	Smith, G.	care ethics	general
Differences that matter: developing critical insights into discourses of patient-centeredness.	Pluut B	Person Centred Care	general
Dignity at stake: Caring for persons with impaired autonomy.	Rejnö, Åsa; Ternestedt, Britt-Marie; Nordenfelt, Lennart; Silfverberg, Gunilla; Godskesen, Tove E	dignity	general
Exploring the concept of 'caring cultures'.	Gillin, Nicola; Taylor, Ruth; Walker, Susan	caring culture	general
Health and social care educators' ethical competence.	Koskinen, Camilla; Koskinen, Monika; Koivula, Meeri; Korpi, Hilkka; Koskimäki, Minna; Lähteenmäki, Marja-Leena; Mikkonen, Kristina; Saaranen, Terhi; Salminen, Leena; Sjögren, Tuulikki; Sormunen, Marjorita; Wallin, Outi; Kääriäinen, Maria	caring values	general
'It's the little things that count': healthcare professionals' views on delivering dignified care: a qualitative study.	Williams V; Kinnear D; Victor C	dignity and care	general
Cross-cultural validation and psychometric properties of the Greek version of the Caring Behaviors Inventory: a methodological study.	Papastavrou, Evridiki; Karlou, Chrysoula; Tsangari, Haritini; Efstathiou, Georgios; Sousa, Valmi D.; Merkouris, Anastasios; Patiraki, Elisabeth	caring behaviours	general
Designing a curriculum for the assistant practitioner of the future: Ensuring interprofessional care aspects and other stakeholder requirements are met,	D. Baker,	EXCLUDE assistant practitioner focus	EXCLUDE
Determination of concept technology - the ontology of the concept as a component of the knowledge development in caring science.	Korhonen, Eila-Sisko; Nordman, Tina; Eriksson, Katie	EXCLUDE concept of technology	EXCLUDE
Patient autonomy in a high-tech care context-A theoretical framework.	Lindberg C; Fagerström C; Willman A	person centred care and technology	general
Patient-centred orientation of students from different healthcare disciplines, their understanding of the concept and factors influencing their development as patient-centred professionals: a mixed methods study.	Rosewilliam S; Indramohan V; Breakwell R; Liew BXW; Skelton J	person centred care and teaching	general
Promoting patient-centred fundamental care in acute healthcare systems.	Feo R; Kitson A	person centred care and technology	general
Putting the 'patient' back into patient-centred care: An education perspective.	Ferguson, Linda M.; Ward, Heather; Card, Sharon; Sheppard, Suzanne; McMurtry, Jane	person centred care and teaching	general
Does the intervention of mindfulness reduce levels of burnout and compassion fatigue and increase resilience in pre-registration students? A pilot study.	Clarkson M; Heads G; Hodgson D; Probst H	EXCLUDE burnout focus of staff	EXCLUDE
Effective communication and information provision in radiotherapy—the role of radiation therapists	Halkett, G., Merchant, S., Jiwa, M., Short, M., Arnet, H., Richardson, S., Kristjanson, L	EXCLUDE focus on communication information when anxious pt	EXCLUDE
Effectiveness of Supervised Intergenerational Service Learning in Long-term Care Facilities on the Attitudes, Self-transcendence, and Caring Behaviors Among Nursing Students: A Quasiexperimental Study.	Hwang, Huei-Lih; Wang, Hsiu-Hung; Lin, Huey-Shyan	EXCLUDE setting not relevant	EXCLUDE
Sustainability in care through an ethical practice model.	Nyholm L; Salmela S; Nyström L; Koskinen C	caring and values	general
The art of loving and the therapeutic relationship.	Stickley T; Freshwater D	caring relationships, love	general
Empowering patients for radiation therapy safety: Results of the EMPATHY study.	Bibault JE; Pernet A; Mollo V; Gourdon L; Martin O; Giraud P	EXCLUDE pt safety	EXCLUDE
Environments of Care: A Curriculum Model for Preparing a New Generation of Nurses.	Ervin, Naomi E.; Bickes, Joan T.; Schim, Stephanie Myers	03/05/2021 EXCLUDE environmental model for curriculum	EXCLUDE
Evaluation of quality of life/life satisfaction in women with breast cancer in complementary and conventional care.	Carlsson M; Arman M; Backman M; Flatters U; Hatschek T; Hamrin E	EXCLUDE qol study not caring	EXCLUDE
Expert patient perspectives on radiotherapy: A phenomenological comparison	Carmichael, M., & Bridge, P.	EXCLUDE pt satisfaction	EXCLUDE
The conceptual structure of physical touch in caring.	Sung Ok Chang	caring and touch	general
The interaction between learning and caring - the patient's narrative as a foundation for lifeworld-led reflection in learning and caring.	Ekebergh, Margaretha; Lindberg, Elisabeth	caring relationship, lifeworld (Husserl)	general
Graduate Student Perceptions: Feeling the Passion of CARING Online.	Leners, Debra Woodarda; Sitzman, Kathleen		EXCLUDE
The relation between patient-centeredness and patient empowerment: A discussion on concepts	Holmström, Inger; Röing, Marta	person centred care	general

Applying patient perspectives on caring to curriculum development.	Hatem D; Mazor K; Fischer M; Philbin M; Quirk M	teaching	medicine
Help, I'm losing patient-centredness! Experiences of medical students and their teachers.	Bombeke, Katrien; Symons, Linda; Debaene, Luc; De Winter, Benedicte; Schol, Sandrina; Van Royen, Paul	EXCLUDE	EXCLUDE
Holistic nursing management of pain and suffering: a historical view with contemporary applications.	Matteliano D	EXCLUDE off topic	EXCLUDE
Honesty is the best policy. A radiation therapist's perspective on caring for terminal cancer patients.	Kagan AR; Levitt PM; Arnold TM; Hattem J	focuses on how to tell a pt they are dying	EXCLUDE
Compassionate care? A critical discourse analysis of accreditation standards.	Whitehead, Cynthia; Kuper, Ayelet; Freeman, Risa; Grundland, Batya; Webster, Fiona	compassion and teaching	medicine
Guarding against dispassion for doctors in the NHS.	Das A; Charlton R	compassion and medicine	medicine
How patients perceive a doctor's caring attitude	Quirk, Mark; Mazor, Kathleen; Haley, Heather-Lyn; Philbin, Mary; Fischer, Melissa; Sullivan, Kate; Hatem, David	caring and medicine	medicine
The desired moral attitude of the physician: (III) care.	Gelhaus P	caring, empathy, compassion, ethics	medicine
A New View of Caring.	Scotto, Carrie J.	concept of caring nursing	nursing
A spoonful of care ethics: The challenges of enriching medical education.	van Reenen E; van Nistelrooij I	care ethics	nursing
Meta-synthesis of presence in nursing.	Finfgeld-Connett D	EXCLUDE presence not caring	EXCLUDE
Nursing students' perspective on a caring relationship in clinical supervision.	Honkavuo, Leena	EXCLUDE student supervision focus	EXCLUDE
Caring and technology in an intensive care unit: an ethnographic study.	Price, Ann M	care and technology dicotomy	nursing
Compassion: The missing link in quality of care.	van der Cingel, Margreet	compassion and nursing	nursing
Concept analysis: patient autonomy in a caring context.	Lindberg, Catharina; Fagerström, Cecilia; Sivberg, Bengt; Willman, Ania	caring attributes	nursing
Finding a Focus for Nursing.	Cook, Laura Beth; Peden, Ann	concept of caring and nursing	nursing
In pursuit of quality of nursing care.	Redfern, Sally J.	concepts of caring and nursing	nursing
Patient perceptions of communication with diagnostic radiographers,	N. Pollard, M. Lincoln, G. Nisbet, M. Penman,		
Nursing therapeutics: Teaching student nurses care, compassion and empathy.	Richardson, Cliff; Percy, Marcus; Hughes, Jane	caring compassion empathy and teaching	nursing
Patients' experiences of radiotherapy: Insights from Twitter,	K. Meeking,	EXCLUDE no discussion of caring experiences	EXCLUDE
Perception of caring among nursing students: Results from a cross-sectional survey.	Fernández Trinidad, Miriam; González Pascual, Juan Luis; Rodríguez García, Marta	perceptions of care and nursing students	nursing
Problem based learning in radiography education: A narrative review	O. Lawal, A. Ramlaul, F. Murphy,	EXCLUDE	EXCLUDE
Caring Behavior and Patient Satisfaction: Merging for Satisfaction.	Calong Calong, Kathyrine A.; Soriano, Gil P.	care and technology dicotomy	nursing
Caring behaviours of student nurses: Effects of pre-registration nursing education.	Loke, Jennifer C.F.; Lee, Kah Wai; Lee, Bryant K.; Mohd Noor, Asmah	caring behaviours and teaching	nursing
Levinas's ethics as a basis of healthcare - challenges and dilemmas.	Nordtug B	care ethics	nursing
Radiation therapists' perceptions of the concept of caring...Proceedings from the 6th annual Toronto Radiation Medicine Conference, Friday, March 6, and Saturday, March 7, 2009		summary of poster	EXCLUDE
Radiation therapists' perspectives of the role of reflection in clinical practice.	Cashell, A	EXCLUDE	EXCLUDE
Radiographers' and students' experiences of undergraduate radiotherapy practice placement in the United Kingdom,	M. McPake,	EXCLUDE placement model not discuss caring	EXCLUDE
Patient experiences of caring and person-centredness are associated with perceived nursing care quality.	Edvardsson, David; Watt, Elizabeth; Pearce, Frances	caring behaviours and nursing	nursing
Teaching caring within the context of health.	Gramling L; Nugent K	caring teaching and nursing	nursing
An approach to the phenomenological analysis of data.	Priest H	concept of caring and Husserl	nursing and AHP
Supporting staff to deliver compassionate care through Schwartz centre rounds: a therapeutic radiographer's perspective,	Urvina Shah, Humaira Jamal,	poster summary only	EXCLUDE
Caring as a 'threshold concept': transforming students in higher education into health(care) professionals.	Clouder, Lynn	teaching	nursing and AHP
Teaching Communication Skills and Empathy Through Engaged Scholarship.	Trad, Megan	not for inclusion activity of writing not about caring	EXCLUDE
COMPASSIONATE CARE IN NURSING: A CONCEPT ANALYSIS	Ilarde, M et al	compassionate care	nursing*
Determinants of compassion in providing care to older people: educational implications	Sanj Nathoo, David G. Shaw, Peter Thomas Sandy	compassion and teaching	nursing*
The Concept of Care in Oncology Nursing: A Literature Review.	Kariou, Chrysoula; Patiraki, Elisabeth		EXCLUDE
A qualitative focus group study to explore the information, support and communication needs of women receiving adjuvant radiotherapy for primary breast cancer	Hendry, J	caring and support needs RT	RT
Are radiography lecturers, leaders?,	Julie Anne Hendry,	teaching	RT

Compassion satisfaction and fatigue: An investigation into levels being reported by radiotherapy students	Flinton, D., Cherry, P., Thorne, R., Mannion, L., O'Sullivan, C., & Khine, R.	compassion	RT
The Courage to Teach Caring.	Maine, Lucinda; Vogt, Eleanor	EXCLUDE short editorial	EXCLUDE
Do factors of emotion-focussed patient care and communication impact job stress, satisfaction and burnout in radiation therapists?	Diggens, J., & Chesson, T	emotions	RT
The economic value of caring.	Issel LM; Kahn D	focused on finances	EXCLUDE
The Impact of Interprofessional Shared Governance and a Caring Professional Practice Model on Staff's Self-report of Caring, Workplace Engagement, and Workplace Empowerment Over Time.	Olender, Lynda; Capitulo, Kathleen; Nelson, John	related to caring of/for staff	EXCLUDE
Embracing service user involvement in radiotherapy education: A discussion paper,	Gareth Hill, Gillian Thompson, Susan Willis, Denyse Hodgson,	service users and teaching	RT
The nurse in the caring in nurse relationship: a critical social theory perspective.	Sumner J	critical social theory	EXCLUDE
Emotional intelligence development in radiation therapy students: A longitudinal study	Carmichael, M., Bridge, P., & Harriman, A	emotional intelligence and teaching	RT
The patient experience of radiotherapy for breast cancer: A qualitative investigation as part of the SuPPORT 4 All study	H. Probst, K. Rosbottom, H. Crank, A. Stanton, H. Reed,	caring	RT
Involving patients and carers in developing the radiotherapy curriculum: Enhancing compassion	Hodgson, D., Taylor, A., Knowles, V., & Colley, M.	person centred compassion and teaching	RT
Living with cancer and perception of care: Icelandic oncology outpatients, a qualitative study.	Hjörleifsdóttir E; Hallberg IR; Gunnarsdóttir ED; Bolmsjö IA	caring cancer	RT
Promoting compassionate care in radiography – What might be suitable pedagogy? A discussion paper,	J. Hendry,	compassionate care and teaching	RT
The Term 'Critical' Helps to Sharpen Consequences when Life is Threatened --A Hermeneutic Concept Analysis.	Gabrielsen, Elisabeth; Lindström, Unni Å.; Nåden, Dagfinn	EXCLUDE icu focus	EXCLUDE
Transforming the patient experience in radiation therapy.	Jarvis JA	physical arrangement of department	EXCLUDE
Radiographers relationship with head and neck cancer patients	Egestad, H	caring and RT	RT
Using a phenomenological perspective in radiation therapy research	Halkett, G., Scutter, S., Arbon, P., & Borg, M	methodology	EXCLUDE
Radiotherapy: Developments, contradictions and dilemmas,	Chris Short, Sue Griffiths	caring and technology and RT	RT
Results of a Canadian study examining the prevalence and potential for developing compassion fatigue and	Gillies, Carol; Bristow, Bonnie; Gallant, Francois; Osmar, Kari; Lange-	caring, compassion fatigue and RT	RT
The concept of caring: Perceptions of radiation therapists,	Amanda Bolderston, Donna Lewis, Martin J. Chai,	concept of caring and RT	RT
The role of counselling and communication skills: How can they enhance a patient's 'first day' experience?	Martin, K., & Hodgson, D	caring experience and RT	RT
Defining compassion and compassionate behaviours in radiotherapy	Amy Taylor	compassion and RT	RT*
Caring for cancer patients: relatives' assessments of received care.	Eriksson E	Caring cancer (relatives views)	Cancer
Oncology patients' and professional nurses' perceptions of important nurse caring behaviors.	Zamanzadeh V; Azimzadeh R; Rahmani A; Valizadeh L	caring concept, behaviours and cancer	nursing and cancer

Appendix 2 – My Epoché

My views of caring are part of me as an individual, as a daughter and mother, as well as a TRa and educator. My Masters focussed upon patient care. My daily practice with students and my team has a caring focus. I like to think everything I do has caring embedded within it, professionally and individually. That is why my methodology needed to include acknowledgement and bracketing of my perceptions, I feared the importance of caring to me as a professional would otherwise overshadow the participants. In writing this epoché, I feel it will have helped my study.

Caring has always been a part of me as a person. As a child I felt protected, loved, and prioritised. My family would always put me first, I felt safe, and I knew they were looking out for me. After my grandad died, my nan lived with us, and it felt almost like having two mums. We always had cats and I would be caring for them as a child. I remember a desire to help, I hated to think of any living being suffering in any way. I am unsure when it began, but the death of my grandfather was certainly significant for me. I did not want anyone to experience the distress I felt. So, a career helping people was essential.

In my clinical career I felt it was natural for me to help patients, I found it hard to see them in pain and distress so at times it was a little overwhelming. However, I managed to remain calm, keep a hold of my emotions and carry on with the tasks and processes of helping deliver radiotherapy. Sometimes I cried. An early memory is as a student during our ward placement when I got especially close to two patients having radiotherapy. They loved speaking with me, and we shared much laughter. A nurse warned me that one of the duo had a very poor prognosis and I should prepare myself for what would come in the next year. When my placement ended V gave me squirrel earrings as a gift, a thank you for making his time on the ward more pleasant. P, the other half of the duo had an almost benign tumour so was expected to do well. I purposefully went to see them both when they came for radiotherapy to say hello. We had a wonderful bond. I will always remember the day I discovered P had died after a massive heart attack, unrelated to his tumour. I felt an immense sadness, but V reminded me of the positives both he and I had brought in our friendship with P. I realised that was caring to me, the connection and emotion from our relationship. Over 35 years later I still remember how it felt.

Another memory is treating a little girl S, whom I adored, and she adored me. I connected with her and her grandfather who brought her for radiotherapy. We rode the sunshine seesaw together each day (the treatment couch), I took time to speak with her and knew her so well. I will always remember her telling me how she loved me, and she wanted to take me home, put me at the end of her bed with her toys and look after me forever and ever. I struggled to hold back the tears as she said that but thought how I genuinely loved this beautiful little six-year-old girl. I connected with her grandfather too, so much so that when S sadly died, he came back to the department to tell me. He said she spoke about me always, right to the end. We both cried together that day and I am crying as I write this, but I feel I was privileged to know S and her grandfather.

Caring about every person as an individual was a strong part of my clinical practice. Some patients I connected with much more than others as if an invisible bond existed. Many people would return to visit and say hello when at follow up appointments, and this was a joy because the rapport we had meant so much to them at such a difficult time.

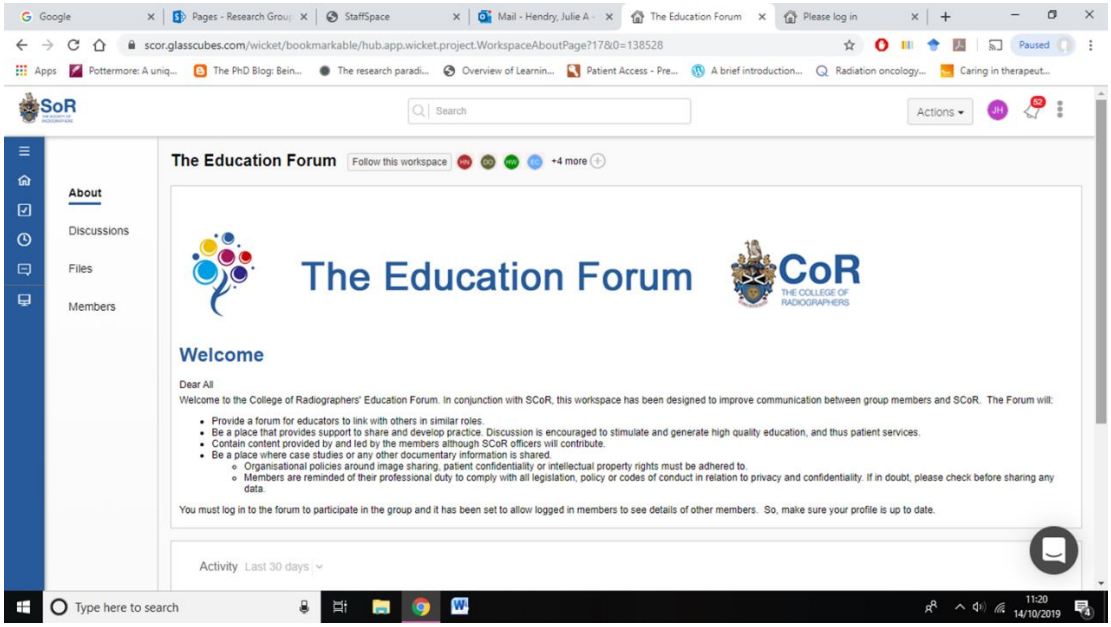
When I moved to education my main concern was missing patient contact. As I had been in a Superintendent role for many years, the bonds with patients on the Linac did not exist in the same way. But I joined our profession to help people and I worried how I would cope without that contact. I knew about caring with patients, I did not expect caring to be in anyway similar in education. I soon discovered my students replaced my patients and if anything, the bond was stronger. I was able to build a rapport with my students, some more than others, but always taking time to know them, their interests, family situation and them as individuals not ‘just students’. I would and still do make as much effort as I can to support and nurture students through their education. This involves making sure they are informed about practical details, as much as being their friendly supportive educator. Many call me their ‘Uni Mummy’ and that makes me very happy. The relationship, partnership, and closeness with students means many will come to me with problems and worries. Some have involved serious events including honour killings, forced marriage and other safeguarding issues. I feel a sense of pride at being there to support them, and knowing they have someone to turn to. It is not because it is my job, but because I truly am caring for them as individuals.

Not every student is suited to becoming a TRa, but every student deserves the chance to succeed and exceed their goals and ambitions. In caring about them, supporting them and giving of myself, I can enable their dreams to graduate. Caring to me means doing all the things I have to do, like assessments and marking, but doing it with the student as an individual at the heart of what I do. Being compassionate, listening and supporting them with empathy, friendship, time and a shoulder to cry on. Seeing them succeed brings me joy and knowing that individual's journey can make it even more meaningful. Caring in the clinical and educational settings were originally perceived as different notions to me, despite some similarities.

I also feel my unique role as an educator means that I can help instil and enhance the values and attributes of a caring radiographer in each student. Of course, they need to be receptive and have the desire to be caring themselves. But in sharing stories of V, P and S, and showing caring to my students as people I truly believe it will help them be the caring radiographers our profession and every patient needs.

Appendix 3 – Glass Cubes

Forum through which educators could contact peers.



Appendix 4 – Email Invitation

Dear colleagues,

I am presently undertaking an Educational Doctorate at Kingston and Roehampton Universities. My study

'Caring in therapeutic radiography – an exploration of academic educator perceptions and experiences'

seeks to explore how academic therapeutic radiography educators construct caring through their lived experiences and individual perceptions. The study will involve a semi-structured interview of around 1 hour at your HEI at a mutually convenient time. The study has received ethical approval from the Faculty of Health, Social Care and Education Research Ethics Committee, Kingston and St George's University of London. I attach a copy of the participant information sheet here, for your consideration. I would be grateful if you could forward this request to any academic staff within your teams.

If you would be able to support this study, please do email me to arrange an interview. Participation is of course voluntary, and confidentiality will be maintained throughout.

If you would like any further information please do get in touch.

I appreciate your time and consideration regarding participation in this study.

I look forward to hearing from you soon.

Many thanks

Julie

Julie Hendry SFHEA
Therapeutic Radiographer
Associate Dean for Student Outcomes
Associate Professor /Course Director Undergraduate Therapeutic Radiography Programme

Kingston and St George's Joint Faculty
Health, Social Care and Education
Department of Radiography
Faculty of Health, Social Care and Education
Kingston University & St George's, University of London
6th Floor, Hunter Wing
Cranmer Terrace
London.
SW17 0RE

Appendix 5 – Participant Information Sheet

HEADED PAPER

Study title:
Caring in therapeutic radiography – an exploration of academic educator perceptions and experiences

Invitation and summary
You are being invited to take part in this study using semi-structured, face to face interviews as you are an academic therapeutic radiography educator. Your email was accessed through the Course pages of your Higher Education Institution or through the Society of Radiographers Education Forum.

The aim of this research is to explore how academic therapeutic radiography educators construct caring through their lived experiences and individual perceptions.

What are the possible benefits of taking part?
Emerging themes from this research would enable a greater awareness of teaching caring to undergraduate students. Developing new professional knowledge from this study could influence undergraduate curriculum design within Higher Education Institutions (HEI) or indeed nationally through our professional body.
You do not have to take part, there will be no impact upon you should you decide against participation.
If you do decide to take part, you are able to withdraw from the study at any time up to the point of data analysis. All data relating to you will be deleted/destroyed.

What are the possible disadvantages and risks of taking part?
As participants within this study, caring experiences relating to professional, clinical or individual emotions would be discussed. These lived experiences could create tension or possible distress for you. Thus, after the interview, you will be provided with the contact details of their local counselling / support service (identified in the appendix). Although it is unlikely that you would be distressed in such a way, it is essential to mitigate for potential problems. If at any stage you wish to stop the interview or withdraw from the process this will not be a problem.

What's involved?
As the researcher I will organise a convenient date and time with you to conduct a face to face interview of around 1 hour duration. I will come to your place of work and use a booked room I have organised, to conduct the interview. It will take around one and a half hours of your time in total. The face to face interview will be audio recorded by me. I will anonymise the recording and transcribe verbatim. You will not be identified, neither will your institution. I ask you to be as honest and open with your responses as possible. I will ask open questions such as: '*What does the term caring mean to you..?'* and *'Can you talk me through some of your experiences of caring in your teaching practice?'*

What will happen to the data collected?
In order to comply with the General Data Protection Regulations (GDPR) and good research practice, the audio recording will only be available to me and my research supervisors. It will be anonymised and kept on a secure password protected

university server. No other person will access the audio recordings. The recording will be transcribed verbatim by me and also stored on the secure university server. The transcript will be thematically analysed and quotes may be used (anonymised) in any resulting dissemination.
Audio recordings will be deleted upon successful transfer to the university password protected served. Written, electronic data will be kept for ten years in line with the institutional research data policy (Kingston University, 2016) after which it will be destroyed. GDPR will be observed throughout the study process and dissemination.

Further supporting information
If you wish to withdraw during the process you may do so.

All information will be anonymised. Only the researcher and supervisors will access the data. When the study is reported, any quotes used will not identify you or your university in any way. It is anticipated that the outcome of this research will result in publications, for example, a suitable peer-reviewed journal. The study may also be presented at National Conferences.

This study is part of an Educational Doctorate.

After consenting to attend the interview, a paper consent form will require a 'wet signature' from you before we commence the interview process.

If you would like a copy of the study outcomes a separate list or email addresses will enable study outcomes to be disseminated to participants.

Thank you very much for your time.

Julie Hendry

If you have any queries relating to this study please contact:
Julie Hendry Principal Investigator [Redacted email]
Associate Professor / Associate Dean for Student Outcomes
Course Director Undergraduate Therapeutic Radiography Programme
Department of Radiography
Faculty of Health, Social Care and Education
St George's, University of London
Cranmer Terrace

If you wish to make a complaint about this study, please contact:
My research supervisors Dr Marcus Jackson (redacted email]) and Dr John Hammond ([redacted email]) in the first instance.

If you are not satisfied with the response you receive, please contact the Executive Dean of the Faculty,
Professor Andy Kent ([redacted email])

Appendix 6 – Consent Form

HEADED PAPER
Informed Consent for

Please tick the appropriate boxes	**Yes**	**No**
1. Taking part in the study		
I have read and understood the study information dated **24/08/19**. I have been able to ask questions about the study and my questions have been answered to my satisfaction.	☐	☐
I consent voluntarily to be a participant in this study and understand that I can refuse to answer questions and I can withdraw from the study at any time, without having to give a reason.	☐	☐
I understand that taking part in the study involves participating in a face to face interview for around an hour. The face to face interview will be audio recorded. Some basic hand written notes may be taken by the researcher. The audio recording will later be anonymised and transcribed verbatim. Participants and the institution will not be identified. When the study has successfully concluded the audio recordings will be deleted. All other study data will be destroyed within ten years. Giving honest and open responses as possible would be most beneficial to gain an insight into your experiences and perceptions.	☐	☐
I understand that taking part in the study has little potential risk to me as an individual except possible distress when reliving experiences and events around caring.	☐	☐
2. Use of the information in the study		
I understand that information I provide will be used for at least one peer-reviewed publication and possible conference presentations.	☐	☐
I understand that personal information collected about me that can identify me, such as my name or where I work, will not be shared beyond the researcher.	☐	☐
I agree that my anonymised information can be quoted in research outputs.	☐	☐
3. Future use and reuse of the information by others		
I understand my anonymised data will not be used for any other studies nor kept within a data depository. It will be destroyed within ten years of study completion.		
4. Signatures		
I consent freely to participate in this study.		

_____ _____ _____

Name of participant [IN CAPITALS] Signature Date

I have witnessed the participant freely read and sign the consent form after I have confirmed the contents of the information sheet to them. To the best of my ability, I have ensured that the participant understands to what they are freely consenting.

_____ _____ _____

Name of researcher [IN CAPITALS] Signature Date

Study contact details for further information

Julie Hendry Principal Investigator
Associate Dean for Student Outcomes
Course Director Undergraduate Therapeutic Radiography Programme
Department of Radiography
Faculty of Health, Social Care and Education
St George's, University of London
Cranmer Terrace
[redacted email]

Appendix 7 – Interview Protocol

HEADED PAPER

Overview of Interview Protocol

(in conjunction with Participant Information Sheet and Consent Form)

'Caring in therapeutic radiography – an exploration of academic educator perceptions and experiences'

OPENING

1. **Establish Rapport**
   My name is Julie Hendry. I am an educational doctorate student at Kingston University....

2. **Study Background**
   Give background for the study.....

3. **Purpose of the Interview**
   The purpose of this interview is to explore how academic therapeutic radiography educators construct caring through their lived experiences and individual perceptions. There are no right or wrong answers; I am interested in your own experiences.....
   Do you have any questions from the Participant Information Sheet....?

4. **Recording and Confidentiality**
   If it is okay with you, I will be recording our conversation. The purpose of this is so that I can get al.,.l the details but at the same time be able to carry on an attentive conversation with you. I assure you that all your comments will remain confidential. You will not be identified in any way....

5. **Consent**
   Can I reconfirm your consent to take part in this interview/study? Just to reiterate, you can withdraw at any time. I have a consent form for you to sign please.....

6. **Timescales**
   As in the information sheet, the interview will last around an hour. Are we okay to proceed?

INTERVIEW NUMBER .....

Question	Example	Notes
Ice breaker **General question to help settle participant and gain better rapport**	*Thank you for taking part in this study. We can take a break or stop whenever you wish.* *How long have you been a therapeutic radiographer?* *When did you specialise in education?*	*Notes made during interview process*
Open ended questions **Asked of all participants** **Related to each of the research sub-questions** **Prompts to elucidate more detail or to clarify**	*What does the term caring mean to you..?* *Can you tell me about your understanding of caring in the clinical radiotherapy environment?* *What are your experiences of caring for or about others?* *Can you tell me about your experiences of being cared for or cared about by others?* *Can you talk me through some of your experiences of caring in your teaching practice?* *How do you feel your own perceptions and experiences of caring might influence your professional teaching practice?*	
Planned follow-up questions **Asked of all participants** **Related to each of the research sub-questions**	*It sounds like you have ....can you tell me more about...?* *How did it make you feel when...?*	
Unplanned questions **Asked of participants during the interview depending upon their responses**	*You mentioned a particular time in your practice when ....*	

ENDING

Thank you very much for your time. Is there anything else you would like to add?

Acknowledge the study subject may raise emotions and feelings, provide details of local support services / leaflet.

Your involvement is much appreciated.

Would you like a summary of the results when they are available?

Thank you again.

Research Questions

How do academic educators perceive the notion of caring in clinical therapeutic radiography practice?

What are academic educators lived experiences of caring in the professional, clinical context?

How might academic educators' perceptions and experiences of caring influence their professional teaching practice?

Appendix 8 – Ethics Application

Kingston University Research

RD3b

REGISTRATION AND PROJECT APPROVAL FORM: RESEARCH DEGREES

To be completed by the First Supervisor working with the applicant and the rest of the supervisory team. When complete this form should be emailed to the Faculty Research Student Coordinator to be added to the online application for review and approval by the Head of School and FRDC.

1. Research degree details

Name	Julie Hendry
Student ID number	
Project Title	Caring in therapeutic radiography – an exploration of academic educators' perceptions and experiences
JACS Code (must be provided for SEC)	
Project Synopsis (for students required to apply for ATAS certification) ***200 words maximum***	Caring is a value that is part of the NHS Constitution and included in the professional code of conduct for therapeutic radiographers. It is expected that academic educators in universities, teaching students to be radiographers, include this essential attribute in their curriculum. However little is known about what caring means to academic staff as it can be a very individual concept. This could make it difficult to 'teach' students in the art of caring. Much research exists around caring in nursing but little is known in the therapeutic radiography educational setting. This study seeks to explore the views of therapeutic radiography educators through semi structured interviews. It is hoped to gain a better understanding of what they perceive caring to be and how their experiences influence their views and practice as educators. This could then be used in the curriculum to inform future student learning and teaching.

2. Are you applying for Advanced Standing/APEL?

~~YES~~/NO If no please go to Question 3.

a) If yes, please attach documentation that demonstrates the progress you have made in your research so far. This may be in the form of a report prepared for progression monitoring, your MPhil to PhD transfer report, a draft paper or journal article, or a draft chapter(s) for your thesis.

Please note that, depending on the level and stage of study for which you are applying, you may be required to undertake a viva or assessed presentation in order to confirm transfer to PhD. The timing of the viva is dependent on the outcome of this application.

b) Please attach a brief description of the work you wish to be taken in to consideration. If the proposed project title has changed, describe the relevance of your previous work to the new title.

3. Does the proposal have any ethical implications? YES/~~NO~~

If the proposal contains research using human subjects, this form should be accompanied by an RE4 which must be submitted to the Faculty Research Ethics Committee (FREC) for approval. Please note that, where applicable, specific aspects of the project proposal may be varied following review by the FREC. Projects with NHS approval do not need to go through the full KU ethics process.

Ethical approval has been gained. (please find attached a letter confirming this)

4. Does the nature of the work mean there may be a requirement for the thesis to be kept confidential for a period of time? This may be due to commercially sensitive or personal data.
~~YES~~/NO

If yes, please speak to the Faculty Business Engagement Manager or the KU Legal team to ensure the necessary agreements are in place.

5. Please state the resources required to complete the project, eg specialist equipment, including funding and location, giving details of any collaborating establishments.
Please comment of the availability of these resources. The Head of School will be asked to confirm their agreement.
Travel to interview the participants will be required. No other resource requirements are anticipated.

6. Supervision Team
The University requires each postgraduate researcher to have a supervisory team of at least two supervisors. The role of the supervisors will vary. At least one member of the supervisory team must have previously supervised at least one postgraduate researcher to successful completion of a research degree at the same level.
If a member of the supervisory team is external to KU or new to KU a CV should be attached. If the external has previously been part of a supervisory team at KU this should be stated with student name/dates.
If there are more than 3 supervisors please add extra boxes.

6.1 First Supervisor

Name			Marcus Jackson		
Qualifications					
Post held at KU					
Date of most recent attendance at Research Supervisor Training:			2017		
Current supervisions (give numbers)	(as First Supervisor)	(as other supervisor)	**Previous** successful supervisions	(as First Supervisor)	(as other supervisor)
MA/MSc by Research			MA/MSc by Research		
MPhil			MPhil		
PhD/EdD	1	2	PhD		

I confirm my support for this application: YES	Signed and dated M T Jackson 14th October 2019

6.2 Second Supervisor

Name			John Hammond		
Qualifications					
Post held at KU			Associate professor / Head of department of rehabilitation Sciences		
Date of most recent attendance at Research Supervisor Training:			Not known		
Current supervisions (give numbers)	(as First Supervisor)	(as other supervisor)	**Previous** successful supervisions	(as First Supervisor)	(as other supervisor)
MA/MSc by Research			MA/MSc by Research		
MPhil			MPhil		
PhD	2		PhD		
I confirm my support for this application: YES			Signed and dated 14/10/19		

6.3 Other Supervisor/s

Name tbc					
Qualifications					
Post held and location					
Date of most recent attendance at Research Supervisor Training:					
Current supervisions (give numbers)	(as First Supervisor)	(as other supervisor)	**Previous** successful supervisions	(as First Supervisor)	(as other supervisor)
MA/MSc by Research			MA/MSc by Research		
MPhil			MPhil		
PhD			PhD		
I confirm my support for this application:			Signed and dated		

7. Will the applicant be based overseas?

~~**YES/**~~**NO**

If no, please go to Question 8.

If yes, please answer the following questions:

a) Please comment below on the planned frequency and nature of contact between the student and supervisory team (especially First Supervisor).

b) Is a local supervisor required? YES/NO If yes, please give details of local supervisor and rationale for the choice of local supervisor and include a CV.

c) Please comment below on arrangements made for the student to attend the compulsory University research student training, faculty research student training, and any additional training identified as necessary:

d) If relevant, please comment below on the local availability of library and other appropriate resources and attach correspondence confirming the arrangement.
Please attach a completed RD3b Supplement - Students based Mainly Overseas which agrees the responsibilities of local and external supervisors and of the student.
Arrangements do not include a local supervisor- first and second supervisors have been allocated from the Faculty

8. Does the project involve collaboration with an external institution?

~~**YES/**~~**NO**
If yes, please provide details. If the collaboration is formal, for example in order to access resources, data etc., a confirmation letter or legal agreement from the collaborating institution must be attached to this form. Any costs to the University or the candidate must be clearly stated.

9. Personal Training and Development Programme

Give brief details of the agreed programme of training, including any exemptions sought on the basis of previous training. It may be useful to refer to the Graduate Research School Canvas site for lists of training available.

(i) Attend the core University postgraduate researcher development programme sessions
(ii) Attend relevant optional University postgraduate researcher development programme sessions
(iii) Details of subject specific training or other development to be undertaken:
https://canvas.kingston.ac.uk/courses/498/pages/core-researcher-development-programme

Julie Hendry has successfully completed the taught component of the EdD

10. Project Plan
Please attach the outline project plan (with timetable) to this form and return it to your Faculty Research Student
Coordinator.

Please see attached documents from the PPRP module which include a project plan. Also Ethics submission with outcome from September 2019 FREC.

11. Statement of the Head of School

I confirm that the School supports this application for registration as a candidate for a research degree of Kingston University. The School undertakes to provide the facilities detailed in section 5 of this form (except where specific facilities are being provided by a collaborating institution as stated), and to support the candidate in carrying out the research project specified in this proposal.

SIGNED: DATE: Head of School

12. Statement by the Chair of the Faculty Research Degrees Committee

I confirm this application has been approved by the Faculty Research Degrees Committee:

SIGNED: DATE: Chair of FRDC

Appendix 9 – Ethics Confirmation Email

From: Mein, Gill
To: Hendry, Julie A
Cc:
Fri 13/12/2019 11:32

Dear Julie,

Thank you. I can confirm you have amended your study documents to include the recommendations made by the Faculty Research Ethics committee in September. As chair of FREC I approve your application.

I wish you good luck in your study and look forward to hearing your results.

Best wishes Gill

Gill Mein
Senior Lecturer in Health and Wellbeing

[Redacted contact details]

www.healthcare.ac.uk

Please note: to comply with the Faculty standard you should anticipate a response to your e-mail communication within 5 working days

Appendix 10 – Data Management Form

Caring in therapeutic radiography – an exploration of academic educators' perceptions and experiences

A Data Management Plan created using DMPonline

Creator: Julie Hendry

Affiliation: Kingston University

Template: Digital Curation Centre

Last modified: 08.09.2019

Caring in therapeutic radiography – an exploration of academic educators' perceptions and experiences

Data Collection

What data will you collect or create?

Names of academic educators from public domain (HEI websites) to email them individually to invite to participate in the study
Signed hard copy consent forms from participants (ten)
Digital audio recording of interviews (ten)
Anonymised digital audio recording (ten)
Typed electronic anonimysed transcription of interview (ten)

How will the data be collected or created?

Names of academic educators from public domain (HEI websites) to email them individually to invite to participate in the study
Signed hard copy consent forms from participants (ten) collected just before commencing interview of each participant. Consent form created by researcher
Digital audio recording of interviews (ten) created by recording interview with each participant
Anonymised digital audio recording (ten) after completing interview researcher will anonymise recording and upload digital audio file to University secure
server with password protection
Typed electronic anonimysed transcription of interview (ten) after anonymising interviews, each with by transcribed verbatim by the researcher. Files (word
documents) will be stored on university network secure server/drive

Documentation and Metadata

What documentation and metadata will accompany the data?

Hard copy signed consent forms with participants' name and signature (paper)
Audio recording prior to being anonymised (deleted when anonymised and uploaded to secure network server) (MP3 or similar audio file). Will include participant's
first name
Anonymised verbatim transcript for each interview (word document)

Ethics and Legal Compliance

How will you manage any ethical issues?

FREC application submitted.
Participant information sheet developed and sent to potential participants with invite email, allowing time to consider whether they wish to voluntarily take part in
the study
Some sensitive experiences may be revisited by participants who will be supported by the researcher and directed to university counselling as required.
Consent form (signed just before interview commences) to participate in study and for quotes to be used with confidentiality of institution and participant assured.
No identifiable data will be stored other than the consent form (in locked secure room in university)
Audio recording before anonymisation will be deleted when anonymised and uploaded to the network secure server

How will you manage copyright and Intellectual Property Rights (IPR) issues?

As part fulfillment of a Doctor of Education course from Kingston University, the institution will retain intellectual property of the data generated.

Storage and Backup

How will the data be stored and backed up during the research?

Hard copy consent forms will be kept in a locked secure storage facility in the Faculty
Anonymised audio recordings and transcribed data will be password protected and stored on the secure university network which is routinely backed up allowing
data to be restored in lost by IT failure
No other identifiable data (than consent forms) will be stored.

How will you manage access and security?

Network access is secure and additional security will be added by means of a password protection at each transcript/audio recording level, even though they have
been anonymised.

Selection and Preservation

Which data are of long-term value and should be retained, shared, and/or preserved?

After successful completion of the Doctoral Thesis, data can be destroyed. However to facilitate professional dissemination at conferences and via publications,
anonymised data will be kept for ten years. It is not expected to be further retained or used for any other additional studies.

What is the long-term preservation plan for the dataset?

It is not expected that data is retained under longterm preservation

Data Sharing

How will you share the data?

identifiable data will not be shared by anyone, only the researcher will access this data. Consent forms will be retained in a secure storage facility at the faculty.

Anonymised audio and transcribed data may be accessed by the research supervisors

Quotes may be used in dissemination but the participants and their institutions will not be identified.

Are any restrictions on data sharing required?

No other individual will have access to the data

Responsibilities and Resources

Who will be responsible for data management?

Myself, Julie Hendry, as principal researcher

What resources will you require to deliver your plan?

Access to the secure faculty storage facility

Access to the university network drives (provided as an employee)

Appendix 11 – Kingston Grant Application Email

From: Graham, Rachel
To: Hendry, Julie A;
Mon 11/01/2021 22:56

Dear Julie

I am pleased to confirm that you have been awarded £400 from the Graduate Research School Activity Fund towards transcription costs.

A condition of this award is that you submit a brief report after you have completed the research activity, maximum 500 words, detailing how the experience has benefited your research and personal development. The report should be sent to me, your First Supervisor and to your Faculty Research Student Coordinator who will report it to the next FRDC meeting. The report should also be attached to your next Annual Monitoring Report.

If you agree to these conditions, please email me to confirm acceptance of the award.

Please complete and return the attached payment form to me along with your receipts. If this is not possible (if you need the funds first in order to book) I am happy to transfer you the money now and you may submit receipts later when available.

Next steps:

1) confirm acceptance of award
2) send receipts and return payment form
3) submit report

Best wishes
Rachel Graham

Rachel Graham
Graduate Research School Manager
Kingston University
[redacted email]

Appendix 12 – Individual Textural-Structural Descriptions

Each participants' transcript and themed Validated Invariant Constituents (extract below) were used to create an individual description of experiences and perceptions. Quotes were taken from the transcript to give voice to the participant and to better enable my perceptions and experiences to remain bracketed.

about your time now as an academic educator, can you tell me about any of your experiences of caring in your role?

Yeah, where do I start? I have always … I mentioned it previously, I have always prioritised the wellbeing of the students that I work with. I think caring is caring about them as individuals. I like to see happy students. They are not at university for a very long time and I keep saying to them 'You are allowed to enjoy yourself.' I mean it's stressful, I mean therapeutic radiography is so demanding, I mean it's all that pressure of clinical practice, some of the… I mean we get a lot of younger kids now who the demographic has changed, some of them are not particularly well socialised, they do need that pastoral care, they need that additional responsibility.

In fact sometimes I go too far I think, I am taking on too much for the students. It was raised in my appraisal actually, you need to learn how to signpost and refer – don't… you know, you can't solve these problems. But I enjoy that aspect of my job whereas I don't enjoy admin, I don't enjoy … (sorry, put your fingers in your ears) quality assurance, monitoring and all the report writing. Conversations with students have been the best thing through lockdown actually, and making sure of their health and wellbeing - it's really stressful for them.

Caring as educator is prioritising wellbeing of students

Caring about students being happy Caring for them as individuals

Need for pastoral care of students especially if not well socialised

Possibly going too far and taking on too much for students

Need to signpost and refer as you cannot solve everything, but conversations with students brings personal rewards more than admin!

Example Transcript

Pastoral Care Role

it's difficult, really difficult the responsibility we have as educators because we are not just educators. It's all pastoral care and stuff. That is a strength isn't it, to have that responsibility in your work?	Responsibility of pastoral care as educator is also a strength
it's stressful, I mean therapeutic radiography is so demanding, I mean it's all that pressure of clinical practice, some of the... I mean we get a lot of younger kids now who the demographic has changed, some of them are not particularly well socialised, they do need that pastoral care, they need that additional responsibility.	Need for pastoral care of students especially if not well socialised

Above and Beyond, Students the Priority

the students, I hope they find me caring in respect of ... I do have conversations about academic work and clinical practice, I don't just let them go through the motions	Desire to be seen as caring by students. Caring conversations not 'just going through the motions.
For example if you have got a failing student, now I don't have it in me just to sit by and watch them flounder, I just... and I have seen colleagues do that, it's just the easy solution to let a student go and I don't work like that. It's all about going the extra mile isn't it caring, and going beyond the call of duty	Going the extra mile, beyond the call of duty even if harder and more demanding as it is the right thing to do BEYOND DEONTIC
I have always prioritised the wellbeing of the students	Caring is prioritising students
what we are all about, we do go the extra mile with our students, and I wouldn't want to lose that, I think that's really important	Caring is going the extra mile with the students
she was a nice person and she had the attributes to be a good radiographer and a lot of the issues were not of her doing, but I could have just let her go. I could have just said 'Yes, she can go with the rest of them' but I think she was worth... they are all worth the effort but I was so proud to see her graduate, really proud because it was worth the effort and I needn't have done what I did, and she said that to me 'You didn't have to do that.'	Could have let a troubled student go but the extra effort and seeing the potential in student 'You didn't have to do that' **Above and beyond**
going that extra mile, I was so proud because I thought oh God, we have done something right here.	Going the extra mile. Pride

Making Time

for us to sit down in the café with them and have a chat about clinical practice or a debrief when they come back into practice, some of them are a little bit ... 'Oh OK' and they learn to [share]... I think that's a learnt skill for the students	Taking time to sit and talk with students over a coffee helps students open up and learn to share experiences

Example Validated Invariant Constituents Extract

Alan – Textural – Structural Description

Alan is an experienced radiographer and educator, being qualified for over thirty years. He is currently the course leader for the undergraduate programme.

Alan's experiences of caring in his personal life include caring for his parents-in-law when ill, but also caring for his wife through her parents' illness. He acknowledges being in healthcare can mean a greater expectation is made of you '…*you have that medical background and you have that knowledge and that understanding, people come to you and say 'tell me about this*..''.

Alan feels he developed his caring role from school and being in hospital himself *'I think it goes back to when I was at school; I spent quite a lot of time in hospital when I was quite a small boy*.' Alan experienced caring as a child from staff spending '…*quite a lot of time just sitting and talking*.' But also, caring to Alan was them knowing what interested him as an individual, and sharing a sense of humour. The concern of staff Alan experienced when a young patient, forged his desire to work in the hospital setting. 'I don't suppose I even thought about it in terms of care, but I wanted to do something to help people.'

As a clinical radiographer, Alan felt drawn to the technology and equipment and how he might use that to benefit patients, rather than drawn by the caring directly.

'They put patients under that stuff, that must be scary, and so the story I tell to the students now is, I was hooked in by the technology but I knew … my philosophy is how can I use that technology to the best advantage for the patients?' rather than … some people will come in because they are driven by the sort of … the patient contact, the caring aspect.

So, for me that demonstration of caring, particularly for patients, is to make sure that the kit does the best thing we can make it do for those patients, so it's more perhaps about the technique and technique development that sort of hooked me'

Describing a significant caring experience, Alan remembered how even a short interaction with a patient can convey much meaning and impact.

'I walked into the treatment room and the patient had just finished treatment and I said something like 'Alright flower, that's your lot, up you get, go on, off you go' and a little while later I got bleeped …. 'We have got somebody who wants to talk to you'. This patient had finished treatment and she said 'There is the little card, and I don't want you to read it until you get home' and 'that's for you.' It was a little posy of silver flowers and I read the card and it just said something like "each time you look at these, you will

remember me because I will always remember that day that you called me flower and it made me feel real again" and I thought wow. I think it's just one of those silly throw away lines isn't it, that you can use with some people? And I didn't realise how much impact that had actually made on her until she finished treatment.'

Alan also retells an experience with a young mother whom he treated for breast cancer. When she returned a few years later, Alan '..*stayed late and treated her and she did survive for quite a while afterwards, it wasn't months, it was longer than that*.' He felt a connection with the young patient …*that person … it was important for me I think first of all to stay and treat her because I had treated her during her first course of radiotherapy* and felt it was the right thing to do, to be a familiar face because he picked up her non-verbal cues of fear. '*I delivered her first course of treatment, she was frightened, she needed a friendly face*.'

'So, she had been scanned, we knew it was positive, she was scared and you could sense that, and because I was a familiar face, she recognised me. Now I could have found somebody else, but I thought no, because she recognises me, because she knows me, then it's right for me to do that and a number of patients have said that to me over the years…..'

In exploring his feelings about the return of the young patient, Alan describes a professional barrier '..*there is always that barrier and it's 'this is work, this is everything else"*. Alan talks about maintaining a distance but also getting close enough to patients to offer comfort, reassurance, and care.

'There was always that … there is me, the professional me who is looking after people but there is always that 'don't get too close.' You can get close when you need to, when they need that comfort, reassurance, care, whatever, but that's it. They leave the department, and you move on. If they come back the next day you carry on, you pick up from where you left off but there is always that separation and I think it's something I learnt quite early on. Sometimes it's difficult but it is always there, I think it's probably always been there.'

Alan explains how his ability to maintain a professional distance stems from childhood experiences and being able to '*switch off from a whole lot of stuff.*'

'So it's a natural extension of I am comfortable on my own, and to say I don't worry too much about things wouldn't be correct, but there is that ability to segregate and partition off all of those different things that are going on.'

Thinking of experiences of reduced or absent caring, Alan believes a lack of time can have a negative impact on caring in radiotherapy. This can especially be when appointments are running late or a machine has broken down.

'There are always occasions where perhaps you have got a machine break-down or you are running late and so you need to catch up and it's at that point where I think we don't take enough time.'

He also believes and experienced a lack of staff negatively impacting caring '*we perhaps had two people on the machine, and we just didn't have the time to address those issues and I think looking back on that, we could have done that, or we could have handled that a lot better.'*

Alan also feels patients perceive staff as busy so they avoid asking questions '*They perceive that we are busy, they perceive that we are rushing around and so they don't ask us questions because their perception is we haven't got time to answer them, so they don't even ask them in the first place*. But that when it is recognised by staff, time is made to sit and talk to patients in need. '….*there are occasions where you do recognise the patient is having difficulties and you find somebody to sit with them and talk to them.'*

Alan feels a lack of time can be worked around to provide care to patients when needed, to make time.

'So for me it will be about having somebody from the team, even if they were doing other… if they are doing sort of out of room tasks, stop doing those and go and sit and talk to that patient because for me, out of room tasks – some of them need to be done – well we can always find somebody else to cover them, particularly when we have sort of a central prep area and bring people in to the treatment team, so that one of the treatment team who know the patient can then spend a little bit of time with them. And it might only need 5 minutes, and if we can't give 5 minutes, that's sad. And it might be… it could even be less than that, but as long as that patient knows that we are there and that we can spend the time, that's the important message to get across.'

For Alan, the culture presently in radiotherapy promotes a lack of time '…*a term that I don't like - I was running.*' It perpetuates a lack of time. '*I don't like that phrase running, it conjures up rushing and rushing equals the risk of getting things wrong – that doesn't feel right with me*.'

As technology continues to develop, Alan feels this could be to the detriment of caring ' … *from a workflow perspective yes, we could treat more patients, but at what cost, to all the other things that go on*.' But he is also hopeful that the new technology could better enable patient caring and support.

'Other people can have a different role and that role will be that patient support which … you know, we have already talked about but the perception is we don't have time to give it, and so maybe the automated technology, it will change our role, it won't get rid of us, but it will allow us to focus on those other things that we need to, and patients' needs are probably getting more complex now because, you know, patients are getting older, they have more complex needs in terms of other long-term conditions so maybe it gives us opportunities to sort of do other things, or do the things that we should be doing and devote a little bit more time to.'

In his role as an educator, Alan experiences a feeling of responsibility to look after and care for students. '…*when I was talking about students, I was talking about my students. It's not from an ownership perspective but it's from… it is that translation of… I have got a group of people who I need to look after*.' His view of caring for students echoes that of a senior radiographer who became an academic when Alan was a student. He explains '*she had moved into an academic role and I said 'Don't you miss the patients?' and she said 'Yes I do, but you lot have taken their place*.' where students took over from patients as the focus of care.

'I guess that is much the same as in that clinical role …So yeah it's almost been that sort of, you know, one day it's patients and the next day it becomes students.'

Alan describes his caring role now as talking with students and signposting on if problems in their personal lives impacts their academic life.

'My caring role now is very much around what the students are doing. If their personal lives start to impact on their academic progress and they choose to tell me, then I am happy with that, but my advice has always been if you are experiencing difficulties then these are the people you might want to go and talk to.'

Alan explains what 'looking after students' means to him. He describes the different aspects of caring as practical and assessment focussed but also in terms of pastoral support and offering time to talk.

'*I think it works at a number of levels. First of all it's about do they understand the requirements of the assessment package. But it's about making sure they understand what it is they need to do and what they need to do to make up any sort of shortfall from previous assignments*. *It's about when they are out on clinical placement, it's about going out and visiting them to make sure … not so much around the support they are getting in the department, but it's about all the other stuff, so they might be living away from home or they might be commuting and that might be a bit of a nightmare and has an impact on their attendance and things. It's gathering*

that information so you can have a dialogue with whoever you need to because sometimes the students will just struggle on and not tell anybody and so part of that 'looking after' is to recognise when they are struggling and say 'Look, come on, sit down and talk to me, tell me what is going on.'

To Alan, 'looking after' also involves picking up on cues from students and signposting them on as needed.

'… I suppose it's being able to pick up on those cues and yeah, in its widest sense, 'looking after' is about knowing what to do, when to do it and if you can't do anything about it, recognise that but know where they should be going to or who they should be talking to so it sort of encompasses all of those things.'

Alan retells an experience with a student angry over feedback on an assessment. The relationship enabled a conversation which included Alan making time to discuss concerns, he described this as caring. He also felt fulfilment watching the student then go on to succeed and grow.

'… we went through the feedback and the conversation goes 'The feedback says this, and I have written this' and I said 'Yeah, well read it again and then look at the feedback, and you have not really told me exactly what I needed to know.' And after that conversation this character just took it and flew and is now a consultant radiographer. And you think I didn't care, I wouldn't have had that conversation but because we had that conversation (and I wish more students would do it), if we hadn't had that conversation, I am convinced that that person wouldn't be where they are now because once they understood where we were coming from, they got it and away they went.'

Alan also describes his experiences of barriers to caring for students, related to them not acknowledging support is needed, nor accessing it.

'There is a barrier that I can't get through to make them realise that actually they need to do something about it and they have to be … and this is the difficult bit I suppose because if you are in a situation like that, it's very difficult sometimes to acknowledge that and then be proactive… the support of the Wellbeing Service but I don't know how well they are engaging with them and in a way, that frustrates me because I don't know whether they are getting the level of care that they should be getting..'

Alan offers a supportive pragmatic approach to caring for students, suggesting interruptions and breaks to take time out and manage the complexities of life.

'We have had students who for all sorts of reasons have got into crisis and we say 'Well take some time out, it doesn't matter' and I think that is part of

that looking after, it's getting across to them that yes, it might be a disaster now, but in 2 or 3 months when you have taken some time out, it won't be.'

As a concept, Alan describes the importance of small things making a difference to individuals '*It might not be very much at all but it's going to make a difference to their care. If you can make a difference to somebody's care, then that's got to be a good thing.*'. He also believes '…*it's about making the information we give to our patients specific to their own individual needs*.'

Another aspect of caring to Alan making time and having conversations with individuals. '*It's about having that time but also knowing that even the small things can make a big difference. You might not think they are that important, but they're seen as massive, yeah…..so taking your time to have those conversations*.'

When asked about a lack of caring, Alan explains how he feels this involves ignoring people or talking down to patients '*I don't know, this might be the wrong phrase but it's probably the only way I can describe it, is thinking that you are superior to the patients that you have under your care.'* He goes on to explain how the technology in radiotherapy can be a barrier to caring '*I think for us both in radiotherapy and in diagnostic imaging we have that technological interface between us and the patient and that can create a barrier*.' Conversely, he explains how in providing people with information '…*specific to their own individual needs*…' we are caring for them.

Jo – Textural – Structural Description

Jo leads the undergraduate programme in her institution. She speaks of knowing her students as being one of the most important aspects of her role as programme lead.

'I would say that one of the most important things related to caring probably is that I know who they all are from the beginning, and I make it my job to know who they all are'

Jo goes further to say she prioritises students first and foremost, not that it is expected as part of her role, but because she wants to do so.

'I think showing them that you are willing to put your time into them, not because you have to but because you want to, and I think that particularly with the students is possibly where my idea of my role differs from other people, in that I don't see it as 9-5'

For Jo, caring for her students, '…is *caring for them, it's prioritising them and their thoughts and feelings'.* These strong feelings of prioritising others, maybe a selflessness or altruism, is clear when Jo speaks of her relationship with her children. When describing caring, Jo explains '*I think for me caring about people is putting them ahead of you',* even if the time and effort given can be detrimental to herself. This is further reflected in her caring for her students

'I think that's probably what I'd say with the students as well, there is no time that I don't allocate to them'

In her personal life, Jo always felt loved and supported by her parents

'*..I mean I have always been cared for, my parents have always demonstrated that I have been loved throughout childhood, I don't ever feel like they didn't care. …I don't remember a time where they wouldn't have given me the time that I needed, I don't remember being lonely, I don't remember being left.'*

But admits she is more comfortable doing the caring rather than needing it herself. '*I do feel cared for but I am the kind of person that tries not to need it, if that's not too honest.'*

Jo speaks fondly of the experiences in her past when her mother would take her out and have no personal gain from their outings and visits, Jo refers to this as 'self-sacrifice'.

'But I think back to things, you know, places that my mum used to take us and she would take us and there was nothing in it for her and there was a lot of self-sacrifice in time, and I think that's what it was really'

A further meaningful experience Jo retells is when her Mum did a test drive with Jo to give her a practise run, again a form of self-sacrifice for nothing in return.

'….because she wanted me to have had a practice run at it first, so she drove all the way there… it was like a 45 minute drive there and back just to drive with me so that I had done in once so that when I went that night on my own.'

In her clinical role, Jo recounts caring for a patient with a complex home life and end stage cancer. Jo relates caring to demonstrating a more individualised personal approach focusing on all aspects of the patient's life not just those related to radiotherapy.

'she had got quite end-stage cancer and it was about trying to … not just treat her, it wasn't about treating her, it was about considering all of those other things and just trying to be… not a friend to a patient, but somebody that they felt actually cared beyond coming in'

She explains how patients are not worrying about being treated correctly, they almost expect accuracy and competence, but patients are worried about more personal issues impacting them as individuals. Addressing these issues is part of 'caring' to Jo.

'..they are thinking about everything else that goes on with it, and it might be the side-effects, it might be their personal life, so caring for them was about seeing what mattered to them as individuals.'

Other aspects of caring include sharing experiences, Jo relates this to a shared sadness, shared humour and shared understanding. Recalling a patient with an advanced pelvic tumour using special netted hospital underwear,

'…he burst out laughing and we burst out laughing to the point where we just cried because he was obviously suffering through the experience of the side-effects of treatment and he was… but he was lying on the bed prone and the couch was bouncing up and down, we were crying and laughing at the same time because it was funny and sad all in one go but we were kind of in it together.'

'I think to me that kind of indicated that that experience was about a shared understanding of what was important but how to try and show that we cared,'

She also acknowledged that caring for people could cause a wave of emotion to staff involved *'I couldn't help but cry and we had kind of loved and cared for her and*

nurtured her through, but when I got back in, I just couldn't help it'. which was shared within the radiotherapy team and important for newly qualified radiographers to witness and accept as 'okay'.

'..one of the things that one of these newly-qualified said to me is 'I am so glad that you feel like that as well, because I do and I didn't think I was allowed to be… like I didn't think I was allowed.' I was like 'It's fine, we do it, we feel it,' – she didn't have to see that bit, she saw the bit that meant that we looked after her and would… they didn't need to see that it upset us at the end, but it's OK to feel like that and I think that shared experience with the team as well, not just with the patients, it was allowing the other people in the team not to feel like you are too hardened to it and too cold to care I think'

Jo also explained how the end of treatment bell[5] would always be an emotional thing for her,

'*there is not a single time that bell has been rang that it hasn't brought a tear to my eye, whether I have treated that patient or not, because it's the feeling… it's [when the rest of the room clap]…but honestly it gets me every time because there is such a wave of emotion that goes with it, and it is the support of the other people that are in the room as well,'*

Jo shares this experience and emotion with her students to help create an empathetic environment. '*I think that's part of the caring as well, you actually get them to think what they might be feeling like or what their experiences are.'*

The bell is an individual choice, and as Jo explains, it is not the view of staff that is important but that of the individual patient. Individualised care features strongly in Jo's account.

'I guess that comes into caring as well; it's not about what we want or what we think they need, it's about establishing what they want and what they need and whether it's right for them, knowing that we will go down and do it with them in case they are thinking oh I don't want to go and ring the bell by myself, I will look stupid, it's not for me, it's not supposed to be for me.'

Jo felt that service provision and demands worked against caring. Time is needed to be caring in Jo's view, to avoid people feeling pressured but also to go 'above and beyond'.

[5] The end of treatment bell is a physical bell in some radiotherapy departments. Often started to signify the last treatment for children, the use has spread and is frequently taken up by adult patients too. Staff and other patients may applaud and celebrate with the individual ringing the bell as their treatment completes.

'I think time is such an important bit of caring. It's about going above and beyond the immediate what you have allocated, and it can be quite difficult in radiotherapy because you might have 10 minutes for somebody but it's about allowing them the time that they need to not feel under pressure.'

Having an '*emotional input'* into developing a relationship with patients as individuals is important to Jo and she sees it as demonstrating caring.

But Jo acknowledges that patients can allow that caring and a caring relationship to develop.

'You can put the same or be willing to offer the same to everybody but it's how people … whether people choose to take that from you or not, and how that transpires in terms of that relationship that you build up with them. So I think a lot of it is what they have allowed us to gain from them by allowing us to care I think.'

This caring relationship has benefits for the staff as well as the patients

'…*where we have kind of gone above and beyond maybe what would be expected as part of the role, most of it is about how much you get back in return and that's not the intention of the caring bit of it, but how much you get in return far outweighs… So I think all of those memories of caring really are about what I have gained from them in an unintentional way, they all leave me with feelings of kind of warm in association with those particular people and those situations and I think part of it is the fact that they had allowed us to care.'*

Jo shares this satisfaction or benefit from similar relationships she builds with students. Seeing students graduate, especially when times have been hard *;*

'it's seeing those people (particularly the ones who you have seen struggle and have got really justified reasons that they might have struggled through), seeing them get through graduation and getting their first job and settling in…

Jo likens this to being a proud parent, ' *It is a bit like a proud parent moment isn't it?'*

Although Jo does not recall experiences of absence of caring in the clinical setting, she does feel for some staff, with personalities, the practical task-driven processes of radiotherapy come more naturally than other aspects of the radiotherapy role. Personality features as important in much of Jo's storytelling, in both the clinical and academic setting.

'*..they are much more process driven, they are much more about kind of like 'call this patient in, hello Mrs So-and-So, give us your name and date of birth, get onto the bed, in that 10… we have got 10 minutes to spare and this is what I am doing''*

Jo feels in this case, there is no time to allow the patients' needs to be established.

'It's not necessarily that somebody has shown that they need it and haven't been given it, it's that they have not necessarily had the time to establish whether they need more than the process, if that makes sense.'

Jo recalls an experience of a patient volunteer who would speak with students about their cancer journey. Jo felt the volunteer's experience showed a lack of empathy and understanding from staff, which Jo considered a lack of caring

'I don't think it's necessarily a huge lack of care but I think it's a lack of understanding and a tiny bit of that… yeah, I think it is, it's the empathy, it's the ability to understand what they would feel like if you were lying there and somebody just went on and did the things even if it was part of the process'

Jo felt the lack of caring was particularly demonstrated when just performing tasks rather than asking permission of the patients first. The volunteer explained her experience that Jo related:

''I felt a bit like a piece of meat. I would like on the bed…' she was a breast cancer patient so they would undo her gown and it was just things like… she said 'They would undo my gown without telling me they were going to do,' so although it was part of the process, she was expecting it to happen, it was what happened every day but it's those small differences between saying I just need to get to those marks and can I just… is it OK with you if I just undo the straps? …to just going and doing it.'

Moving onto her experiences as an educator, Jo explains that part of caring for students means being available, proactively asking them without needing to, for no particular reason, just getting in contact to see how they are doing.

'I think the most important thing for me is that students know I am available and I think I… in terms of demonstrating it, it's probably about me asking about them without needing to if that makes sense.

I will always contact them in the middle of the semester just saying 'Just to check up how you are doing;' when they start on clinical placement I send them an email just saying 'Just checking in, just want to know how you are, let me know if you want to talk to me.''

Caring is not shown by the processes but what lies on top of the work of an educator, Jo previously described this as going *'above and beyond'.*

'In education I will make sure that they have the information they need, the teaching that they need, but the caring bit, to me, is the bit that I do on top of the job I think, and I think that's probably what shows that I care more than just having the meetings and just… it's that willingness to be available for them whatever it is that they particularly need at that time, and they do take me up on it which is the nice bit!'

Listening to students is important to Jo and features strongly in pastoral care

'*I mean it is about listening to whatever it is that's important to them, I think like caring in all situations; it's not necessarily about what I think is important to them, it's what they disclose that's important. And I think being able to listen, to find out what that is, is probably the important aspect of that.'*

Caring is about *actually* caring as Jo explains, not because she should but because she is genuinely interested and bothered. To enable this to happen a relationship is needed in Jo's opinion.

'So I think to me caring is about actually caring, it's the difference between doing it from a process perspective and doing it because I'm interested to know, I am concerned for their welfare, it actually bothers me.'

She recalled one experience where a student took a long time to bond with her, but when she did, the student then reached out when unwell and in need, ' *there was a sense and I could tell she suddenly felt comfortable enough that she didn't know who else to talk to, so she thought I will contact Jo and see what she can say*.' Jo felt this bond enabled her to '*… have developed that understanding of them as a person. I know about their academic grades, and I know about their clinical skills, but I think I know them all as people by the time that they finish.'*

'…knowing who they are, knowing their names and knowing a little bit about them enables you to have that bond to help develop them and help kind of … for them as individuals, not just as part of a cohort, you know, I don't want all of them to just pass, I want them to do the best that they can do. I can't get that feeling across to them unless I know who they are.'

Jo believes that the relationship with students, as individuals helps give positive outcomes for the students being treated as individuals, knowing that their educators care.

'I generally think students respond to the fact that they are individuals to you and as much as I know other people might debate it, I honestly think they work harder if they think we care about how they do as an individual and not just a grade that they get and what it means.'

The joy of supporting students to graduation was important to Jo, in addition to graduates keeping in contact with her to share their progress in their careers. This too was a demonstration of caring for Jo,

'*I heard from one this week, one of this summer's graduates kind of emailed and said 'I hope you don't mind me emailing still when I have finished, but I just thought I'd let you know this is where I am up to, this is what I am doing, I have settled in now, I am feeling confident,'….I guess that's part of the caring bit, the fact that she has bothered to email me to tell me how she is doing hopefully means that she knows I care enough to want to know and I think it's nice.'*

To Jo, caring involves showing an interest and making time for students. This also involves blurring the barriers and building relationships so that students feel comfortable asking to share a coffee and say hello.

'But I think it's that, it's that slight familiarity where they do feel like I am not just there as a lecturer, I am not just there because I have to be, I am there because I am interested to listen and it is... yeah, it's being interested in them and not just the process I think.'

Professionalism is maintained, but building a close relationship is a demonstration of what caring means to Jo.

When considering the concept of caring, Jo describes caring as a feeling; something that you feel not necessarily what you do. She believes actions can be performed without '*feeling'* care itself:

'*I think caring in itself is how you feel and it's not necessarily… it's not particularly what you …. I think caring is what it feels like and you can demonstrate caring traits without actually feeling like you care, and I think that the caring bit of it is actually how you feel about it and not what you do.'*

Jo is clear in the behaviours she perceives to be part of caring; empathy, listening and compassion, or moreover the feeling linked to them

'*We are all capable of listening, but whether we actually listen and hear and respond is the bit that actually is about the caring. Do you listen because you have to and you do what you need to do as a process from it? So I think to me caring is the feeling that goes with it. Caring as a behaviour is about demonstrating empathy, it's demonstrating understanding, it's demonstrating compassion, it's those things… they are the things that you are showing by doing it, but actually the care is the way that you feel about it when you are doing it*.'

Caring for Jo, involves an awareness that a particular need is there, without being asked. Picking up on and being perceptive to the non-verbal cues from patients and students alike.

'C*aring isn't necessarily them telling you they need help about something and you either doing something about it or not, it's about having an awareness that someone might need it and might not be saying and therefore giving the opportunity for them to access that or allow you to care without them needing to say.*'

Regarding caring in individuals, Jo speaks about the importance of role models to help the development of caring behaviours. However, she believes making someone care is not possible, but that learnt behaviours can be refined.

'*I think those qualities in somebody as to whether they actually care or not, probably not; but I think you can … you can help to develop people's ability to allow themselves to care and I think sometimes that might be significant ….if you feel it, you know what it feels like to be cared for or not cared for and then you do that yourself to support somebody else to be the same, so I don't think you can necessarily teach someone care, but I would say in an academic setting, I would give examples of occasions and how that impacted on me.'*

In demonstrating care towards students, Jo explains how it is important to create an openness so students can approach you with concerns, to talk them through. This Jo believes, is made possible by sharing one's own lived experiences with patients.

'…demonstrating it to the students is demonstrating what I would perceive as acceptable and what constitutes care so hopefully on the receiving end of it they feel that and they then will then demonstrate that; it's kind of learnt behaviours isn't it?'

Jo also explains the feelings and process aspects of caring as *'caring about'* and '*caring for'*. She describes '*caring about*' as going beyond demonstrating care, it is an emotion or feeling driving you. Caring impacts the individual and is of clear importance in Jo's life as a mother, clinical radiographer and as an educator.

I guess 'caring for', to me, indicates more of a practical side of it, it's the practical aspect of providing care; and 'caring about' is the emotional side of it that is actually beyond that demonstrating care, it's actually … it's the actual, yeah, the emotional bit of it that drives you doing it and also impacts on you as a result of it probably. You can provide care to somebody practically, you can go in and do dressings for somebody and that is

practical care, but whether you care about the impact that that has on them or the impact that it has on you is the 'caring about.

Linda – Textural – Structural Description

Linda splits her time between educational and clinical practice. She '*juggles'* her dual roles as an experienced clinical radiographer and relatively new educator. She retells how some have accused her of being *'too dedicated to the job'* but Linda feels strongly that our role needs investment of the self.

'..this isn't a job you do unless you are willing to invest and give something of yourself'

Linda goes onto share her real concern for the profession and the risk of the high technical and imaging focus of radiotherapy being at the expense of the softer skills such as caring.

'I think we are in danger of radiotherapy becoming highly technology-based, imaging-based and I see both sides in that students that are coming through are very technically focused and perhaps struggle more with the softer skills, but to me that's always been the key role of a radiographer, is that blend of technical ability, but also people skills and everything'

For Linda, the therapeutic radiographer is different to diagnostic colleagues as *'we are building that relationship, building that rapport'*. This aspect of the clinical role is clearly important to Linda, and she explains how she manages the emotional aspects of caring by compartmentalising them from her personal life whilst remaining empathetic. The impact of caring for a close family member who passed away from cancer *'does influence your practice'* in Linda's view.

'I am quite good at compartmentalising, so I think I always managed to keep the kind of emotional aspect of the work, whilst being empathetic, but still kind of being able to section that quite well from my own life and my own experience'

For Linda, she can clearly explain what caring means to her in the clinical setting. *'Well, it's a daily occurrence really … where you tried to go the extra mile.*' Linda talks of two aspects to caring, it being multifaceted, with a more practical aspect alongside a more emotional aspect.

'Caring can be a multi-faceted thing, is it having those conversations, or is it organising someone's appointments and taking a logistical… sometimes that is the role – it's sort of just fixing a small logistical problem that actually makes that patient feel you really understood and cared about my situation.'

Linda explains how she feels there are many ways of showing caring, not all of them emotional. Some small actions can positively improve the cancer journey for patients.

'It doesn't always have to be a deep and meaningful conversation, for me it can just be appreciating and alleviating an expect of that cancer journey that radiotherapy brings …. if you can do something in that pathway, it doesn't always have to be an emotional component I guess – there are lots of ways of showing you care.'

Although problems can be '*fixed'* for patients, Linda feels caring also includes times when problem-solving may not be possible. In this case, making time to listen is essential*, ' …sometimes it is just about letting someone express how they are feeling on that day and vent to you and that can be caring as well.'* She acknowledges that time may be difficult on busy treatment units in comparison to the slower pace of brachytherapy but feels there is still time to care.

'It's perhaps the unending time to sort of have those deeper discussions with people. But personally, I am a big advocate for thinking you can do a lot in that 10-minute slot, it doesn't have to be a totally robotic process'

To Linda, demonstrating caring includes an interest in people as individuals, their feelings, and experiences so that she would ' …*try and hang on to some things with a certain patient, so when you see them again you can pick up that thread or ... so that's a kind of a trick I guess I have always employed – again, I think making people feel like you do remember them, you do care, you are interested in what they did at the weekend or how something went that they told you about*.' Linda views caring as an essential part of the therapeutic radiographer role, which can be better developed as radiographers become more experienced, especially with reading signals and nonverbal communication.

'I think those skills definitely develop as you get further into your career, just being more comfortable to… And knowing when to push and when to kind of step back a little bit, and if someone really is giving you the signals they don't want to open up, they don't want to talk to you, also respecting that, because patients sometimes get so many people that want to know, you know, friends and family…'

Linda explains how she has witnessed episodes of non-caring or the absence of caring in the clinical setting. She describes a lack of warmth, a very non-personalised robotic, task-focussed process-driven encounter.

'I have come across radiotherapy treatments … that are very automatic and it is very much 'What are the practicalities? We need to get date of birth, we need to get I.D., we need the patient to get on the bed. We need to align our tattoos, we needed to leave the room and it feels quite limited sometimes. I don't feel the warmth, so I sort of think the patient isn't probably going to feel the warmth.'

'… it's creating that environment isn't it as well? It's something we always say to students is, welcoming a patient, 'how was your day, how was your travel?' It doesn't have to be anything particularly… you might not always have that deep understanding with a patient but I think it's just being interested in people as well. I think you wouldn't do this job unless you actually were interested in people and how they felt and what was going on for them…….it is very much just that 'Hello Mrs Smith, come in, can we have your date of birth, can we have your address? OK, do you want to get on the bed?' and that really is kind of it. There is no sort of building … sort of building up to that event if you know what I mean.'

Linda feels a sadness for our profession and the lack of caring which she believes is essential to practice. *'I feel sad for the profession because I feel that's not … our role shouldn't be… but it's a special thing about our role, as I say, that ability to blend communication and technical skill.'*

Some of this poor caring Linda feels may be a result of a lack of suitable role models in the department, as promotion is gained quickly and a focus on careers progression takes precedence.

'I think there is a lack of modelling as well of good communication style and good rapport building, ... because we are pursuing the advanced practice that whilst practice is important and it's something we should strive for, but are we perhaps losing the skill of what the treatment floor should be?'

Linda feels competency in imaging and fast progression may be eroding caring from the therapeutic radiographer role *' …also leaving our 5's and our 6's at a bit of a loss as to what the caring element perhaps of the profession looks like, because they see progression as gaining competency to get your band 6. Gain more competency technically to get your band 7, whereas I think there's a lot more to being a band 7 than being a band 6, but just can you perform a sort of tissue match here on a prostate?'* Alongside the technical aspects, Linda feels high service needs compound issues with departments working over capacity, resulting in a less personalised caring experience for patients and a risk of burnout for staff.

'*As radiotherapy, as it becomes more technical, you are naturally driving people to work more in that way, you know, appointment times are cut down,*

machines are working at capacity or in my experience we work at over capacity…..'I think it does definitely grind people emotionally sometimes to a point where you don't have that to give.'

Moving onto her educator role, Linda acknowledges the complexities students experience today *' ..they all seem to be coping with multiple issues and demands on their time.'* She describes the impact on universities as being vast in terms of student support and wellbeing, so that often these cannot be met, and additional support is being provided by educators.

'I very much want to be empathetic but I think … our role is becoming quite blurred in terms of what students are looking for from us, but then I think universities are struggling with wellbeing, so it is kind of falling back on lecturers as well to sort of provide that support.'

However, Linda explains that as educators and caring clinical practitioners, we naturally want to help our students *'I think because we are all therapy radiographers, we are kind of … it's our inbuilt nature to want to help and to want to try and solve problems where we can……. my only ability as a lecturer is to draw on my clinical experience.'*

Linda again links caring in the educational context, to providing an individualised approach, enabled by getting *'….to know our students quite well.'* Listening is key, offering support *'…through whatever they are struggling with.'*

'I can't fix that problem for them, I can't provide a practical solution to that but yeah, I guess again it's just that listening role, being someone they can just come and just share that with and yeah, help where you can really.'

Linda speaks passionately about supporting students who struggle academically but have excellent caring abilities in the clinical department.

'I love teaching on this course because it'd not at all about that. He is going to be a great radiographer because he has got those caring abilities in abundance; he just needed that help with (as I say) getting over those academic hurdles.'

Student success bring joy to Linda, *'I think I am starting to see that there is really that gratification in seeing students achieve.'* But she constantly strives to be comfortable in finding ways to support all of her students.

'You know, I found that much easier and again that is part of sort of learning as a lecturer how to cater for everyone I guess. But also it's pushing myself out of that comfort zone as well and trying to actually get more comfortable

and finding ways to help students who perhaps don't see things as clearly or as straightforward as a lot of other students perhaps do.'

The educator role of caring is more than just solving a problem *'…you are there to empathise and you are there to help'.* However Linda explains that providing high levels of caring and support to students can take a toll on her and her colleagues, *'..we are realising that perhaps we have engaged very emotionally with our students.'* Yet she feels strongly that emotional support is an integral part of the educator role.

'It is part of our role, absolutely, it is part of our role to be that emotional support so we can't blur that line too much in that part of that emotional support is acknowledging and understanding their situation so we can help them move forward, because we are here to support them to become radiographers.'

Linda explains how a fine balance is needed to maintain certain boundaries whilst also being '*a friend'* to students. This mirrors the relationship with patients in the clinical setting.

'It's always managing that line and the same as with a patient – it is that professional boundary that yes, we care, and I think we all care deeply about the students, you know, it's not a job you stay in if you don't care, but also for their own benefit as well, there's got to be clear kind of boundaries of what is expected in this relationship.'

An area Linda feels may impact educators' caring towards students is when a cohort can be '*challenging'*.

'I think perhaps there are instances where behaviour suggests that the students are a certain way and perhaps staff sometimes then are less inclined to want to offer support in that scenario, but I have never come across an uncaring attitude.'

Some staff may be '*ground down'* by poor behaviour but she suggests such student behaviours may be masking something else, that educators should try to reveal and to not judge.

Another aspect of caring to Linda is that educators listen and make time for their students, being open and responsive.

'I think just your presence and openness to have that conversation as well, so students know they can come and have a chat with you if they are feeling like they can't cope, they don't have to just sit at home and not hand in assignments and not complete work because they don't want to bother anyone.'

Caring is also having the skill of noticing when students need to talk but might be evading the real issue. Linda feels a good relationship will help these situations.

'When you are talking to someone what is being evaded perhaps and then making that judgment of whether it's important. Do you need to know as well really? If they are not telling you about it, perhaps that tells you more than … perhaps that tells you that you are not quite at that point in that relationship for them to give you that insight.'

Linda believes not all educators can demonstrate care, as their personality may mean they find the emotional conversations difficult.

'There are some members of staff who I think just maybe that's not their personality type, and again perhaps they are just not comfortable enough to have those conversations, and you know, they are, in all social interactions, perhaps not the most kind of open in that respect, so I can see why that would be difficult for them.'

To Linda, the concept of caring means that educators are available and have flexibility as essential attributes, being proactive in reaching out to students and making students their priority.

'Students knowing that we are available, so we try and have an open-door policy in the office so that students can just pass by and drop in and see if someone is available….I always send an email about how things are going, let me know if you are having any problems. It's just keeping those lines of discussion open, particularly when students are on placement, sometimes for an academic it's also being flexible as when you can meet and how you can meet; so just I think having various levels of contact and them knowing that contact is available.'

In contrast, Linda feels that avoiding students is uncaring.

'I think that avoidance of …. you know, if students want to come and talk about an assignment, people sort of saying 'Well look at the assignment guidance on the portal or read these papers', you know… perhaps someone doesn't really need that… It might seem more of a conversation and apparently, it's not what they need. But I haven't seen anyone reluctant to engage in my experience.'

Finally, Linda explains her view that caring is an intrinsic part of an individuals' personality. She believes skills can be modelled and developed but ultimately caring is part of us as people.

'I think you can model good behaviour, good examples of caring, and give people the practical skills…. but I think caring has to be something that intrinsically comes quite naturally to you or is quite a key component of your personality. You can give people skills to help them develop and to help

them with difficult situations or conflict situations, but if someone isn't comfortable with those sorts of interactions, then they are going to find it very, very difficult. It doesn't mean they don't care, but in a profession where it has to be conveyed, I think that has to be something that is a fairly natural skill for you.'

Lucy – Textural – Structural Description

Lucy is a senior lecturer with a particular remit for clinical education. Caring has been a strong focus in Lucy's life, caring for her parents and as a volunteer for many years. Lucy talks about a '*two-pronged approach*' to caring which includes '*psychological support*' and '*providing care directly, hands-on'*. Lucy found her volunteering a '*very meaningful thing to be doing, to help people out.*'

Lucy feels our profession naturally embodies caring.

'it's very obvious within therapeutic radiography that people are of a caring nature generally and I think you can learn a huge amount about the different ways to care for somebody and the way that you want to be cared for as well, and other people.'

She describes how her experiences of caring for patients includes

'Knowing how to speak with patients, knowing how to try and put them at ease, I think I started on a good footing because of my previous experience doing work with the disabled for so long, but obviously cancer is something a little bit different and you have got the patient and all the patient's concerns about their own families I think at the back of your mind as well when you are talking with them.'

Lucy is proud but humbled when she explains how she won an award for caring when she noticed a patient in distress. Lucy helped her in the moment but to the patient what was most meaningful was when Lucy approached her the following day to see how she was.

'I actually won an award in my first few weeks in clinical practice which was quite a surprise because I had a patient who was really quite distressed, she was quite distressed, she was quite emotional, she was crying and I kind of mopped her up and did what I could for her on the day, but the next day I saw her in the waiting room again and I popped over just to see how she was and she was so surprised that I had done that.'

Lucy highlights how small actions can mean much to people.

'It was quite a surprise, that something that I would have thought was quite a normal thing to do, actually resulted in an accolade. It just goes to show how something very trivial, what you think might be very trivial, just a little action, how much that actually means to other people, and I think that was highlighted by that event.'

Lucy felt embarrassed by her award but also pleased to have caring recognised by the Trust and to confirm she was doing the right thing. For Lucy, caring involves a balance to avoid being 'over-cloying with your patients'.

'You don't want to smother them because they are independent people but at the same time you need to make them realise that you have a relationship with them for that period, where they are in your care, and you want that to be as comfortable as possible. So I suppose it gave me the confidence as well that I was pitching it right, that I was doing the right thing'

Lucy also recalls an experience involving a patient's relative, again noticing distress and using her own experiences of caring for family to support the relative.

'… a patient's daughter, she was waiting for her mother to have her treatment and she was … she was just sitting and crying quietly in the waiting area because she knew that her mum was really quite poorly and probably… well she was a palliative patient anyway but she probably didn't… you know, she wasn't going to recover and she probably didn't have that much time left and so she was really quite distressed.

And so I just noticed this in the waiting area and as I was passing I just sat with her and just said 'Look, is there anything I can do for you?' And I was able to talk to her and bring her to... I think bring her to a better understanding of what her position in relation to her mother now was, and the kind of support that she could… in the time that her mum had left, the kind of support that she could offer. And I think that came from my own experience actually.'

Lucy describes feeling comfortable to offer emotional support due to her experiences, that younger staff may find challenging: *'I think some of the younger radiographers, you know, to do that emotional kind of support, that comes with experience, and I have no doubt they will be able to do it, but I was in the better position at that time.'*

Lucy also feels that establishing commonality helps a caring encounter, reflecting on interacting with a patient with dementia *'I could talk to her on her own level, I think we had a successful patient interaction there… I think because I used her name, I hand-type all the time, I use facial expressions, I called her my friend, all of those kinds of things that I think you can do when you have got the confidence of being that bit older, being adult, that you can get those relationships going.'*

Another aspect of caring to Lucy is the importance of touch, not a '*professional touch*' for treatment but '*sometimes if somebody is just having a rough day or, you know, it's just getting all a bit much or they are frightened or something like that, I think sometimes just a touch on the arm or just holding their hand for a minute is really, really important.'*

Similarly, for Lucy caring means careful questioning techniques: *'..change the language and suggest that there might be something else, there is something else, so just using some of those skills to let the person have the space I think to open up, that's really… to me that's really important.*' Which she acknowledges, takes time

'Sometimes it's rushed, it's hard to find the time to do that, but that's what's needed, they just need space because if you ask somebody a question, they can't always give you their answer immediately, so you need to allow them the space and that's part of caring, I think. So use the techniques that you know and allow them the space to kind of open up'

When a connection is made Lucy, heavy with emotion, describes how it feels to her, like walking '*on cushions of air….because you have made….that connection.'*

'You have made that connection with them and you have made a change to their immediate experience which is a positive one, and probably made her more confident about what she was going through as well, which is the best thing.'

In terms of reduced or lack of caring, Lucy describes some experiences she finds challenging but endeavours to overcome. She explains sometimes it feels harder to push past the difficult or rude patient and still deliver care, but it is likely due to their fear and anxiety. Lucy acknowledges caring can be very personal, meaning different things to different people.

'…it comes down to the personality of the patient sometimes and if you get an obstreperous or difficult or rude patient, it's sometimes hard to see past that and the fact that that is coming from fear and anxiety and all of those things because you are just dealing with what is happening on the surface which might be that they are yelling in your face or they have made a complaint about you every single day that they come for treatment, or it's very difficult to get past the sort of immediate expression of their fear and anxiety, down to what is going on underneath.'

In her educational role, Lucy describes how she feels caring for her students involves giving them time and helping them prepare for the clinical environment.

'…making sure that my students who are just about to go into clinical, so I am speaking as clinical lead now, kind of have things pointed out to them I suppose. They have the opportunity to hear about some of the things that they are going to experience because I like them to feel prepared.'

She also considers students' anxieties and helps build their confidence *'So there's all their anxieties about that and just making sure that… I think you need to look*

after their confidence levels more than anything else in that first term.' This is enabled by spending time with students and showing her belief in them as individuals.

'You need to prepare them, and you need to remind them that they have actually achieved something simply by getting this far and getting onto the course and they mustn't lose that confidence and belief I suppose in their own abilities. So I like to spend a lot of time helping them to realise what their strengths actually are, yeah.'

Lucy describes her experience with one student with severe anxiety. Caring for this student meant investing time and effort, whilst offering practical support and a '*nourishment'* of her emotions.

'So I have put a lot of effort into talking with her on a regular basis, giving her lots of opportunities to tell me as much as she can, or feels that she wants to about her situation, …pointing out the practical support that is available in terms of things like counselling, because at the end of the day we want her to achieve, and no matter what level of degree she eventually comes out with, she needs to feel good about herself and realise that she can do this job.

I think her kind of emotional stability and her confidence levels for her future are the things that I would want to help her to nourish I suppose.'

For Lucy, she feels caring comes naturally to her as '*that's kind of the way that I am made I suppose*.' She goes on to describe caring as wanting students to have happiness, wellbeing and confidence:

'I suppose from a caring point of view you want people to be happy and I don't mean frolicky happy, I mean happy in terms of their day-to-date wellbeing, that state of happiness which is just to do with family, knowing your place in the world, having confidence in your abilities, all of that kind of thing.'

Lucy uses 'nurturing' to describe her view of caring for students.

'I think all of their intellectual, emotional, mental(ness), all of their thinking, all of their thoughts, their feelings and everything are just as valid as anyone else's in this world and it's nurturing their ability to be able to express them, not necessarily in words but in their actions as well.

She also acknowledges the importance of relationships and talking, with a benefit to her as a practitioner, as well as to her students.

'I am their first point of contact so you don't want to lose that relationship, you actually want to enhance it, even though they may have to engage with other people outside of… and have conversations that are… you know, I

will never be party to, as part of that. I suppose it makes me feel that I am having a positive effect on them with my actions, yes.'

Considering a lack of or absence of caring, Lucy believes not all students have the positive experiences she fosters. She explains the power relationship can be open to exploitation by lecturers, depending upon their personality.

'Again, it comes down to personality sometimes I think, because of the way that situations are handled on their behalf I suppose by the people with the power, and then I think that's something we have to, as educators we have to be very careful of, that we don't exploit our own power, our own control level, to the detriment of the students' experience.'

She goes on to explain how she believes all students should be treated gently and that educators can apply university policies in a caring way.

'*We can work within those protocols in a kind and caring way, but we all (educators and students) all need to operate within that framework and so I don't think that all students are necessarily angels, they are not, but that doesn't mean to say that we can't be gentle with them and explain to them the situations and help them to come to an understanding of what their choices are*.'

Lucy feels educators should be caring, compassionate and fair in our interactions with students '*there is a framework to guide us in delivering what we deliver, but it is down to us as individuals to do that in a caring and compassionate way with our students and to be fair, and to be seen to be fair as well with the opportunities that are being offered to the students*.'

In terms of assessments, Lucy describes lacking or negative feedback can be uncaring as it damages students' confidence and the student-educator relationship, which can sometimes be seen as aggression.

'When we are talking about things like marking and feedback, I would say that's one area that can easily go wrong in some circumstances. So if feedback is either lacking or negative, then I think that knocks the confidence of the student and that can manifest itself in aggression or something that is taken to be aggression from the student, and then once that happens of course it's one step, you know, it's one step of aggression but it takes ten steps to get back from that and to repair that relationship.'

Lucy also considers uncaring behaviours to be negative comments to students and that we should all realise the shared responsibility we have as educators.

' …suppose, slightly loose-tongued sometimes, so comments about, I don't know, the reasons why you might be doing something might be financial-

based for example; you know, in the hearing of the student it's not necessarily the right way to go about something, so I think we all have to be quite careful about those sorts of things.'

She feels uncaring educators reflect badly on the university '*it's our individual responsibility as well to uphold those values because we are the ambassadors…. but for the institution level as well and the reputation of all of that person's colleagues as well because it's very difficult not to all get tarred with the same brush, isn't it?'*

For Lucy, caring experiences in education include being able to pick up on the thoughts and feelings of others, in a similar way to her patient interactions. Non-verbal communication she believes is key.

'…something that is intangible. It's something ... it's almost like being able to read somebody's thoughts and feelings isn't it? So it's a perception I suppose; it's body language, it's tone of voice, it's eye contact from the other person, all of those things give you a perception of how that person has just received the communication, whatever that happens to be.'

Lucy again believes not everyone has the ability to detect these cues as *'we are all made differently, physically, emotionally, mentally, we all have different levels of acuity..'*

Considering caring as a concept, Lucy believes it cannot be explicitly taught but can develop through our experiences.

'… I don't think it can necessarily be taught. I don't think you can necessarily tell somebody why they should care; I think they have to know that for themselves from experiences that they have garnered along the way of growing up and experiencing all the things that we do in life.'

Lucy feels as individuals we need to '*want to care'*, less as a conscious thought more part of our '*make-up'*

'I don't necessarily think that you can teach a person, an individual to care, because they have to have… I think they have to want to do it and that's not even … the wanting to do it isn't even a conscious thought, it is just part of their make-up.'

Although the nurturing and caring is often attributed to females, and dependent on roles, Lucy does not believe that to be the case. She does describe how caring can be '*seen'*:

'I don't think that it's necessarily just a female trait because obviously I have seen amazing care come from both sectors at all different levels in the organisation actually….. it doesn't matter if you are a hospital porter or a

consultant, you know, the amount of caring that you do, it's very obvious that you are a person who… when it's genuine you can see it, you can absolutely see it.'

Lucy describes caring as '*genuine'* and visible, '*you can absolutely see it'. Lucy* believes *'genuine caring'* has moments of humanity at its' core, like an *'aura' or 'force-field'* an individual has as part of their demeanour.

'It's a generosity of spirit I think, you know, it is that extra bit of time that you take to tell a joke or to talk to somebody about their granddaughter or the beautiful coat that they are wearing or... it could be anything really, it's just those moments isn't it of humanity that you just…? It's not even that you take the time for it, you make the time for it because it's just part of who you are so it follows you around, it's like it's just kind of around you the whole time, it's your force-field, it's your kind of aura isn't it?'

Lucy is clear what caring means to her, and it is a person-centred interest with positive interactions. *'People, relationships. Taking an interest, because people have immediate problems that you need to take an interest in….. take that person and have an interaction with that person that leaves them with something positive, with something extra that they won't forget.'*

Open, honest caring to Lucy is genuine and memorable to the person giving and the person receiving that care. '*If it's good caring and it's honest and it's open and it's genuine, they are never going to forget that and hopefully you won't forget that either.'* Whereas uncaring or a lack of caring involves solving problems because you are paid to, lacking in a *'human level'* of '*connection'*.

'That's when you just are solving the problem…. because you are being paid to do it…. but it isn't done at the human level I suppose, at the humanity level. It's that one step removed…. but actually, you have got no connection at all with that person on any kind of personal level at all.'

Lucy describes caring as the '*hands-on bit*' and the emotional side of psychological support, humanity, and connection.

'But the kind of psychosocial support is the humanity bit… that comes while you are doing all of that other stuff, you have this other person I suppose, this other self, other-yourself, that is still kind of there at the same time, but it's just helping that patient to … you know, to make things more emotionally comfortable as well as physically comfortable for that person and just trying to connect with people on their own level.'

Retelling her stories felt emotional for Lucy, a realisation of her experiences as a person, clinical radiographer and as an educator.

‘That was quite emotional actually because actually putting it into words makes you kind of ‘Oh my God’ and actually realise things that you didn’t realise before.’

Neil – Textural – Structural Description

Neil is an experienced radiographer and educator, currently in the role of course leader for the undergraduate programme. He explains his experiences of caring as a child, and how it shaped him as a person. '*So, there was always caring…I think it's ingrained in me.'* He describes caring as feeling '*secure'* and a sense of belonging, with somebody looking out for you.

'…it's that idea of belonging isn't it, of being cared for? It was, and still is always there but it's just assurances that somebody has got your back the whole time, that you are being looked out for.'

Neil also explains how his family and upbringing have enabled him to be empathetic, another feeling he relates to caring.

'I mean it's that empathy thing; how can you truly empathise if you have not lived another experience? I mean I have worked with cancer patients, and I have always tried to show empathy, but I have never been there myself thank God, so I don't know if I have ever truly understood what people are going through.'

He goes on to say that patient care has always been a favourite part of Neil's professional practice '…*that's always been one of my favourite parts of the profession, is the caring side. I am less of a science and techy type, I am more into patient care*.' Patient encounters still remain memorable to Neil, and he misses them now he is in education.

'I have been talking to the students recently about this, about what that involves, and I was saying 'I can remember individual patients from… when I was training, I can actually remember conversations, so something was right and something stayed with me. I miss that rapport with patients…'

In his clinical role, Neil describes the rewarding feelings he had from helping patients, from caring.

'I used to find it really rewarding helping the patients with the day-to-day organisation, I mean as a radiographer, a therapy radiographer and I am sure this is different to diagnostic radiographers, we are charged with all that ancillary work aren't we, you know, helping people who finances family matters etc, etc, I used to really enjoy that aspect of my role and helping more generally.'

To Neil, caring is more than '*counselling'*, it is making '*an effort'* and he believes '…*care is not just as obvious as that is it? It's actually … how do I put this, giving a damn about a patient, you know, just making that effort*.' In caring for people, Neil

believes '*if you know what you would expect as a patient and you can discharge that, then you are right*.'

Caring is important to Neil as a person and a professional.

'I think a lot of care that I gave came from me though as an individual, I think I would be caring even if I wasn't in radiotherapy, I am sure of that.'

A clear memory to Neil is working to support a young patient, and their individual needs, anticipating those needs.

'I remember working on a breast treatment unit where we had younger patients with … sometimes they would arrive with a young family and that used to strike a chord with me. I remember doing quite a lot of work with support services and working with a patient just to try and support them with their family requirements because I know that was difficult. Even day-to-day stuff like 'What am I going to do with my kids when I am in the treatment room?' you know, and just thinking one step ahead and those little things really, I can remember that quite clearly.'

But also, for Neil that time to care extended to relatives as well as the patients themselves. '*I used to spend quite a lot of time with patients' relatives in the waiting area really as well*.' Neil found a sense of enjoyment and fulfilment from such interactions. '*I used to enjoy that, and I miss that actually….well just a chat with patients, but I remember doing quite a lot of that*.'

Another experience Neil describes as caring was for a patient with an advanced, fungating tumour. In putting the patients' perceptions first and the team working around their needs was a caring interaction. Neil explains how *'I always find those sorts of things rewarding. It's all about making a difference, isn't it*?'

'One patient in particular sticks with me because of the situation of their disease actually, that's the other reason it stays with me; she was more embarrassed about revealing herself, undressing than she was about her prognosis and stuff, she didn't like coming into the radiotherapy clinic because of that. I had seen her in the planning area… but then I was on the treatment unit for her treatment as well… and I just remember having a word with the team – is that caring? Yes, I think it is because it's thinking about the patient, isn't it? It was all about the perception that the patient might have about us and our relationship with them and making that work.'

Neil goes on to proudly retell an experience as an educator assessing a student in the clinical setting. Despite staff recoiling at a patient with poor hygiene and self-care, his student took the initiative, went the 'extra mile' to identify and address the

patient's individual needs. Neil explained how they made time and put the individual first.

'One of my tutees from last year said to the senior 'I need an hour off the unit with this patient' and what she did was, she spoke to the… just took the patient aside and went through all her individual needs, worked out that none of the support was in place, she phoned the GP, got hold of the patient's relatives, all of that caring stuff, and I thought to myself 'Now that is impressive, that is what I am proud of as an educator to see… that is proper care.''

Neil recounts how some students feedback on experiences in the clinical department where care was absent or reduced.

'But those testimonies from the students are the most valid, and I have said this to the managers at the xx, 'You need to listen to student feedback because… certainly from a naïve first year who has got no preconceptions and then they launch onto a treatment unit and then for them as a novice student, a novice radiographer to report back, they were a little bit shocked at what they had seen…It's exceptional, it is exceptional, I know that, but I ... in my experience it tends to be the caring side goes out of the role with time in service – I am sure of that.'

Often senior staff were lacking caring demonstrated through poor body language and being short with patients '*..they have got no patience with the patients, the rolling of the eyes, it's all that body language. Bad mouthing patients behind their back, that's what upsets the students a lot*.'

Neil explains how some patients need extra '*work'* and time due to their '*additional needs'*. He feels not meeting these needs is a lack of caring. This is often linked to a conflict with service delivery demands and being 'automated' radiographers in Neil's view.

'…difficult patients who you need to actually work a little bit with, whether that is, I don't know, additional needs etc. Because any patient with an additional need, whatever that might be, can disrupt the flow of work on the treatment unit and some of the senior radiographers get very angry with that and I think that's… there is a conflict there about the service getting … keeping to time and delivering the treatment and getting the care… it's that routine-automated part of us as radiographers, needs to get through the list and works protocol and work, and if that is not being done the caring stuff suffers I find.'

With some frustration Neil describes how technically competent radiographers can lack caring, and he has '*a duty to report this stuff*.'

'*I know of radiographers who have lost it and I just don't think they have got that caring side at the moment. Technically competent and can run the treatment unit effortlessly and efficiently but you do worry about the patient care.'*

Some radiographers he feels are technically focussed whilst others are patient focussed.

'Some of them… are absolutely patient-focused and guided by the patient in front of them, whereas some are more technically focused I think, are more interested in themselves sometimes.'

As an educator, Neil explains how he has experienced many students with '*troubled backgrounds*' needing caring. One particular student stays within his thoughts.

'She has got mental health problems including self-harm etc and has been having conversations with me about this and she said to me last week, because she was talking about an injury that she has got, a self-harm injury and she said 'it's the only way I could get my parents to care for me and I thought that's incredible.'

Neil feels the pastoral care role he has as an educator is difficult but also a strength: '*..it's difficult, really difficult the responsibility we have as educators because we are not just educators. It's all pastoral care and stuff. That is a strength isn't it, to have that responsibility in your work?*'

Neil has a great desire to be seen as caring by his students '*I hope it works now with the students; I hope they find me caring…'.* He has caring conversations, going beyond duty, the extra mile rather than just through the motions, even though it can be demanding. '*I do have conversations about academic work and clinical practice, I don't just let them go through the motions.'*

As an educator Neil sees caring as prioritising students' wellbeing and treating them as individuals. '*I have always prioritised the wellbeing of the students that I work with. I think caring is caring about them as individuals. I like to see happy students*.' He admits it can be stressful to staff especially as more students need greater pastoral care, linked in part to a lack of socialisation.

'I mean it's stressful, I mean therapeutic radiography is so demanding, I mean it's all that pressure of clinical practice, some of the... I mean we get a lot of younger kids now who the demographic has changed, some of them are not particularly well socialised, they do need that pastoral care, they need that additional responsibility.'

He also feels caring could be influenced by gender and culture. '*I mean there's work to be done I think really with looking at the caring aspect with certain ethnic groups and gender differences as well*.'

Neil admits '*sometimes I go too far I think, I am taking on too much for the students*.' and acknowledges the need to '*signpost and refer',* yet Neil enjoys student interactions to the routine administration as an educator.

'I enjoy that aspect of my job whereas I don't enjoy admin, I don't enjoy … (sorry, put your fingers in your ears) quality assurance, monitoring and all the report writing. Conversations with students have been the best thing through lockdown actually, and making sure of their health and wellbeing - it's really stressful for them.'

To Neil, caring for students means keeping them on track, something he shares with his team and he feels may be due to previous clinical roles

'I think caring is making sure they are staying on trajectory. I worry about their wellbeing more generally and just being charged with that responsibility as well. I think as a team, certainly myself and my colleagues, yeah, I think as a team it's great because I think we all think the same way, I think we are all wired up the same way in radiotherapy.'

Neil has not experienced this caring so much in other faculties where '*students are just treated like a number*'. In radiotherapy Neil explains:

'I think we have a duty of care to students, as educators. I wonder if that's because we are health educators and we are all from a health background? I am sure that's what it is. I am pretty sure that is what it is. As I have said, I think we have got a different approach from colleagues from non-health backgrounds.'

Neil does not see students as 'customers' and takes great joy in sharing their successes at graduation, especially for those with difficult journeys.

'I think hopefully they are grateful. They say they are grateful at the end of it, I get a lot of thank you cards at the end of every year which is testimony and to me, the greatest reward is graduation day when you see them and if you know their study journey, some of them have been at breaking point and to pull them back and get them back on track – now that's caring isn't it?'

Neil admits the '*easier'* route would be to let students '*flounder'* but he could not allow that to happen. *'If I didn't give a shit then that would be easier I think actually, just let them flounder but I don't have that in me, I just don't have that. I couldn't live with myself if I knew there was a student who failed because we hadn't done*

our bit.' His view is as '*healthcare educators'* there is a particular '*duty of care*' towards students.

Neil talks about caring as having faith in students, going the extra mile and giving support, he recalls one student in particular, excellent in placement and '*…deserving of this chance, so we went through all sorts of machinations to give her additional opportunities etc to get her studies back on track and then all of a sudden it just kind of clicked and she was coming up to qualification and she was working at the competencies of a band 5 and then she said to me 'I can't thank you enough Neil just having faith in me.' So I wonder if it is .. having faith is…? I don't think that's caring is it?'*

Going beyond the norm, putting in extra effort and work to support students demonstrates caring to Neil.

> *'All the additional extra work, arguing the toss to give her extra opportunities, she had to have a discretionary sit so in all sorts, and exceptional circumstances which were turned down, and I sort of thought have I got the energy to argue with the appeals people, which I did! But lots of in-depth conversations with the student about their responsibilities and guidance in terms of what's needed to sort these problems out and get back on track.'*

He is not driven by reducing attrition or NSS scores, more being bothered by what he sees as important on a personal and individual level.

> *'I have been doing this job long enough to know when a student is capable and that was nothing to do with university pressures to reduce attrition, that was nothing to do with improving our scores, that's on an individual level, I wanted that individual student to be successful and take the opportunity that she had in front of her.'*

For Neil, who describes himself as an '*emotional person*,' his job as an educator is more than just going through the motions, it gives him satisfaction and self-worth to '*make a difference'*.

> *'That makes me happy. I mean I am quite a practical person but I am also quite an emotional person I think. I don't want to have a job that is a job just to pay the mortgage, I have never wanted that. I know I have a very stressful role at times, most of the time, but there is always that sense of satisfaction and self-worth because you do make a difference as an educator, and the support and actually the teaching you get as a student will stay with you and be the benchmark for the rest of your professional career.'*

Neil describes the importance of relationships with students which he feels can contrast with other university colleagues who '*depersonalise'* education.

'…are there tutors who literally just teach and manage the programme? I mean you could be a robot couldn't you, working on an assembly line? It's that depersonalisation of education is what…? Oh God, I wouldn't do it, I wouldn't work as a tutor. If we couldn't work closely and get to know our students properly… I mean we are friends with our students, I mean they are a small group and we are well staffed fortunately so we are friends with our students.'

He talks about caring as taking time to talk with students as individuals, which helps them '*share experiences'*.

'…for us to sit down in the café with them and have a chat about clinical practice or a debrief when they come back into practice, some of them are a little bit … 'Oh OK' and they learn to [share]… I think that's a learnt skill for the students.'

Knowing the students well, supporting them and building a relationship acts as a '*triage'* so crises are usually averted.

'I think because of our student support mechanisms, we kind of triage that process, we are already … we know our students so well that they don't have to be getting so upset or in a crisis or desperate situation… but they do, we do get students like that, but… so I find that rewarding, that relationship we have got.'

Neil explains how '*demonstrating'* compassion and care is important when recruiting students. He relates this to caring behaviours where he would always go to help a student in need, never walking by.

'So, I guess it's behaviours, isn't it? I mean if I … for example if you asked me if I wanted to go and help somebody in distress, what my immediate reaction would be is to never walk on by, is to always go and help and that's caring, that's wanting to help. But for some people, they don't work like that, I know they would rather turn and run, wouldn't they?'

For Neil, caring means '…*going beyond the call of duty*' and giving of himself *'I always extend my responsibilities, I always go that extra mile and we all do as a team, so it's making sacrifices of one's own time, isn't it? I mean potentially doing something where you have to give something of your own – not financially but time or mental effort*.' Caring involves giving time, listening even if unable to directly help *'I don't ignore students, do you know what I mean? It's saying don't worry, here is my diary time, you can have an hour, come and see me and I will make that effort,*

and it's the stuff I don't need to be doing isn't it? It's all that added value I think, that's caring.'

The innate need to care, can sometimes be at the cost of Neil's own free time and his health and wellbeing.

> *'Sometimes I think I can't let this go, I can't let this student sit and worry, I have got to help in some way, so I think there has been times when I have worried. I do worry sometimes about my own health and wellbeing, sometimes I know I have let stuff dwell on my mind and whether I should have done something extra… I have stayed late at work and fired emails at weekends at, because I am letting stuff worry about... I am worrying about stuff.'*

But Neil believes this is because he genuinely cares, '..*doesn't that mean that I am caring about the situation? you have got to give a bit more in the caring professions, you have got to give a bit more of yourself.'* Neil goes on to explain '*care is complicated, I think there are gender differences. Some of the demographic groups of our students don't like talking about the care aspects with the male students because I think they might feel that's a sign of weakness….some of the male students seem less… I don't think they are less engaged, they don't want to contribute as much as the girls.'*

Neil talks about his experiences with students who '*really get on top of their duties, the care and communication with patients'* developing those skills during the course. He explains how experience enables students to identify behaviours and pick up on cues as '…*quite high-level emotional intelligence isn't it, working out what somebody is thinking or feeling. And you do see that in students, I think they can develop that and that comes from practice, we don't teach this stuff, that develops through experience, that's experiential learning and that's great.'* Being perceptive and using careful questioning is caring to Neil. Such skills can be best learnt through experience and patient interactions, linked to reflection and experiential learning.

> *'There is so much I can't teach in front of a class of students and you have to take each interaction with the patient on its own merit as well don't you? You can't have a generic approach towards patient care, it comes from remembering back to how I reacted… it's that reflective learning isn't it?'*

As Neil describes caring at a conceptual level, he considers two aspects come into play. '*Facilitating care,…its not just an attitude, it's about actions as well so that's*

why I say discharge care.' Caring can involve an attitudinal internalised opinion to Neil, but also an action part too.

> *'I mean we can all have an opinion or an attitude about something but that's internalised isn't it…it could be the way you communicate an action, organising something for a patient, making something happen for the patient, offering support etc that's an actual physical part of the domain as well I would say.'*

As Neil concludes, '*Caring for' is demonstrable, it's offering care, providing care. 'Caring about' is your internalised approach, it's actually giving a damn about your patient or caring about a situation.*'

Philippa – Textural – Structural Description

Philippa is an experienced radiographer and educator, being in the profession for over 25 years. Part of her current role includes being a link tutor for students on placement.

Philippa talks about organising her life around caring for others, including her parents when they became ill in later life, and her children when young. Both caring responsibilities were clearly divided to Philippa, into the practical and the emotional aspects.

'You are obviously caring for them in terms of the physical caring, that they are fed, they are clothed, they are clean and that sort of thing, but you are also caring for them … for their mental health and I suppose it's … you are caring for the future if you see what I mean, you are caring for them for what they will be or what they will become in future life,'

The professional role of caring crosses into the personal caring role for Philippa creating mixed emotions.

'And it's hard because in a way I suppose as well, I think when you have been in a care industry if you like, you do tend to switch a bit into professional mode as well, which sometimes makes it easier and sometimes makes it harder. I think you are at risk of detaching yourself a bit too much sometimes - yeah, it was weird, a weird mix of emotions I think and feelings.'

As a clinical radiographer, Philippa retells her experiences of treating children with radiotherapy. She explained how to her, caring included both parents and the children themselves. In caring for the parents, this was more of a supportive role, '*So you were sort of reassuring them and talking to them as equals in your knowledge and it was that sort of … I suppose mental support as much as anything and the fact that obviously you weren't harming their children'*. Whilst for the children being treated, the caring Philippa adopted was centred more on physical and psychological aspects.

'You were doing your best for them, and for the children themselves it was physically, you know, if they were old enough to understand, it was getting them to hopefully be able to have the treatment without having to have a general anaesthetic, which obviously if they were 6 weeks old there was no way that [wasn't] going to happen, but for the children of 7, 8, 9….it was trying to sort of do the job I suppose in the initial stages of a play specialist, to try and get the children to be able to compliant with the treatment so you could give them the best treatment they could and make it as less scary as it could be for them, so it was quite a psychological thing.'

Philippa talks with pride and pleasure when retelling how she could enable a young child to have their radiotherapy without the need for a general anaesthetic.

'The triumph really was trying to get a child that was old enough to understand, to get them to be compliant for the treatment and not be scared, or as less scared as they could be so they didn't need a GA.'

This was caring for children in Philippa's view, reassuring, motivating and rewarding them during radiotherapy, with '*sticker charts and lollipops and crisps and all that sort of stuff ….. it was that as much as the technical aspect of giving them the treatment'*. This caring meant making time to talk to the young children, normalising the difficult and strange environment of radiotherapy.

'… it was just being able to try and talk to them and try and, if you like, normalise the situation because I think the thing with children is, because they are young and they have got no life experience, you know, I think if you do something like that in the correct way, they just take it onboard'

Turning to her experiences of treating adults, Philippa speaks about caring as making time, developing trust and breaking down barriers.

'By talking to them and calming them down and being rational, you know, being as honest as you can with them, you can befriend them and then they feel like they have got an ally and then you can break down those barriers and it's better for everybody and mostly the patient – even if it's just one person that they think they can trust and relate to.'

Philippa explains how she feels now, reflecting on her experiences. That psychology was such an important aspect of the radiographer role caring for patients *'it's that sort of aspect of care which is quite a… I don't know, I am not quite sure how to describe it, but I think there's more psychology looking back than I ever thought there was when I was doing it.'* Caring meant taking time to talk to her patients, making them feel valued as individuals, remembering discussions about the person's life, being more than just a statistic.

'I think just chatting to her and answering her questions patiently and then slowly, slowly that breaks down the barriers and remember things about, you know, if she told you a story about something the day before, remembering it the next day so you can carry it on, so that makes them feel like a person not just a patient or a statistic'

Philippa stresses the importance of, and need to make a conscious effort to remember events and activities within patients' lives *'..always try and remember… you know, if a patient tells you something like 'Oh my it's my daughter's birthday*

tomorrow' or … saying to them the next day 'Oh what are you doing today?' because then it does make them… it makes it more personal to them and I think that helps them a lot.'

Being able to build meaningful relationships, offering care and support gave Philippa the feeling *'as though you have done your job well'*, making *'a difference because you have broken down that barrier and it's not only for the patient, although they are the number one priority, but actually for the rest of the team.'*

With great sadness, Philippa recounts her experiences with a child where she could not make that meaningful relationship or connection she described as caring. She could not break down the barriers to care for her patient,

'..he just didn't speak…. we were all… it just upset us so much…So we would try and have a conversation directly with the child to try and talk to him and help him through but we never really, we never managed to break that down. I always think … I used to think I will never ever forget him, I thought how sad'

Philippa explained how she and the team tried to forge a relationship, to show care but the child did not respond. She was still very emotional about this experience.

We felt quite helpless really…to try and build some sort of relationship with him..and it just failed. He just didn't respond to anything, he sort of, you know… get him into a room on your own and we would try and chat to him about things that we knew he was interested in, hobbies that he had and things like that, and he just wouldn't… wouldn't engage at all, it was quite frightening.'

A lack of caring was witnessed by Philippa when a patient's fears and worries about fertility were dismissed by a colleague,

'she hadn't realised that the treatment, the radiotherapy would make her sterile until he mentioned it. She was sort of like 'Oh I don't really know, I don't know whether to have this or not now' and he went 'Oh I have not got time to wait for you, go and have a think about it for 15 minutes and come back and tell me what you want.'

The lack of caring impacted their working relationship as Philippa found the attitude unacceptable, *'…that was just horrific and afterwards he and I didn't have the best of relationships because I couldn't hack his attitude at all, couldn't hack it.'*

Philippa would clearly define caring to be making time and not rushing the patient, whilst ensuring they are seen as an individual person, not just a treatment area:

'you don't want the staff to feel like they are unduly rushing you, so sort of like 'Yes, yes, get a gown, get on the bed' and I think you want to be felt as though... you want to feel as though you are individual and not just the breast patient, the cervix patient or whatever it is you are and that they remember you as a person.'

Caring is treating each patient as you would want family treated '*And as I always say to the students, just remember that could be… You always have to think if that was my mother, sister, father, brother on the bed, would I want them treated like that? And if the answer is no, then there is something wrong.'*

To Philippa, caring in the clinical setting involves a humanistic approach, building a relationship where patients feel comfortable and can open-up or '*relate'* to you as a person.

'I think you have got to have that human element and I think the patients want to know that there is someone human because they are… certainly when they have got cancer, my God, they are so stressed and worried….to know that there is somebody there that they can relate to and feel comfortable telling of their concerns and that's how they offload and that's how you can help them and make them feel better.'

Caring is at a *'…. basic human level so that the patient doesn't become a number, they are a person and they have got families and they have got other worries and things like that'.*

Within her educational role, Philippa similarly views caring as offering emotional support to students. However, she feels that sometimes cultural differences can make this challenging.

'Sometimes it's been very difficult to support them both on an emotional level but also because sometimes if they are from a different culture, it's a very difficult line because everything you say with the best intentions and the best will in the world are coming from where I am and, in my culture, and it's very difficult to know whether you are making things better or worse.'

Caring for students to Philippa involves regular contact *'I think keeping in regular contact with them has been really important. I think seeking out and trying to find appropriate help for them'* and appropriate signposting. She takes her caring role very seriously offering her own contact number to a student without any other support.

'I was so concerned about one student, I gave her my mobile number and I said 'If you need me any time night or day call me and I will come and find you' because at that time she was the same age as my daughter was then

and she didn't appear to have anybody to give her support and I thought that was fairly untenable.'

Philippa feels a personal responsibility and accountability for her care of students, wanting to do the right thing, such that she checked with counselling to confirm she was acting appropriately.

'I actually queued up at the drop-in counselling service at the university and went it and said 'Look, I just need to talk to somebody who knows about counselling, am I doing….?' You know, I told them the circumstances, 'Am I doing the right thing because I am not sure whether I am making things better or worse because I am totally out of my comfort zone here.' … fortunately, they thought I was doing the right thing.'

Philippa relates caring for students as demonstrating *'mum-like'* behaviours, from both herself and the clinical staff when a student had a particularly difficult time. This maternal caring Philippa describes as *'…in loco parentis but we're not and we shouldn't be because they are 18'*, involved making time to talk, showing overt concern and being proactive, as well as a physical *'scooping-up'* of the student.

'They were just concerned about her, they were supporting her all the time, they were engaging more in day-to-day chat, you know, 'How are you? Alright. What are you doing, are you going to be alright today', …so they were overtly showing her every day that they were concerned about her, they were supporting her, they had her back and I think to her that made a huge difference that she wasn't on her own.'

Philippa describes this as '*nurturing'* and instinct from both her and the clinical radiographers *'…certainly that's how the radiographers reacted once when I told them the story, they literally… all their nurturing came out.'* It is knowing the students as individuals that Philippa says enables her to offer appropriate levels of support *'..it's getting to know them well enough so that you understand what their own particular situation is so that therefore you can act appropriately with them.'* Philippa believes the personal tutor system helps develop the close individualised relationship that is caring for students.

'..a good personal tutor system is so important because if they have the same personal tutor throughout their 3 years and they do get to know them well, then they can offer appropriate care and support to them depending on their own circumstances because it can never be one size fits all because they are all different with different experiences of how they have been brought up and life experiences.'

For Philippa, a lack of caring is shown by a 'them and us' mindset whilst small cohorts help develop less defined lines between students and staff.

'I have seen in the past lecturers come and they have a very fixed idea of what the university lecturer is, maybe based on, in some cases, on their own experiences, when it was very much 'us and them' and your lecturer was a professor and he came in and you just sat and listened to him, he taught and walked out; whereas I think now the lines vary, well certainly on our courses, the lines are very much more blurred than that, I think partly because our courses are so small and our cohort numbers are very small so that means you get to know them far better as individuals.'

Philippa is very clear in explaining what enables or demonstrates caring in education, and this is like her experiences and description of caring in the clinical setting. Students seeing staff as a human, rather than just a lecturer. This involves sharing of the self, and one's personal life experiences to foster caring relationships, *'you have got to be approachable for them to even want to come to see you.'*

'I think students will respond to you more and be more likely to come to you for help if they see you as a human being, as something other than a lecturer. So I think I certainly have no problem having a laugh and joke with them and sharing personal experiences about either myself or my kids or something like that, and that draws them to you, you know, they will come and talk to you, whereas I know in years gone by I have seen other staff who are very much like 'I will never tell them anything about myself' and the students never go to those… They are never the people students will go to because they don't see them as an approachable person and I think you have got to have, you have got to be approachable for them to even want to come to see you I think. If a student in dire need wants help they are not going to go to someone they see as a sort of 'closed' … and I think if you are open and friendly and whatever to them, you can still do that and be a lecturer at the same time.'

Philippa describes how a tutorial can offer time to talk with students, build personal bonds and break down barriers, all key aspects of caring for her:

'We have a tutorial…that lasts about 10 minutes and the rest of the time we just chat, but it gives them chance to be with each other as a group, to get to know you and just to get anything off their chests, ….it breaks down the barriers and it does develop a very, very strong relationship with the students, and I think yeah, it's a whole different level of support.'

Caring is a concept that Philippa clearly relates to the humanistic and psychological aspects in both clinical and educational settings.

'I mean 'caring', the word 'care' encompasses sort of a huge range of things doesn't it because depending on the circumstances it's a combination of any

of or all of things like physical, mental, sort of physical health, mental health, financial is all those things, it's a combination of everything and actually even just talking to you now, I think if somebody ever said to me what's the biggest role of the therapy radiographer, I would have said technical, but actually talking to you now, I think no it's not, it's psychological, or it's at least 50:50.'

A good radiographer, she believes, not only delivers safe, accurate treatment but also cares for the patient *'in the psychological basis as well as the technical basis, so you are not just treating a tumour, you are supporting a whole person.*' Whilst in the educational setting caring is equally clear to Philippa, she explains it as knowing students, offering individualised support and breaking down barriers.

'I think for the students it's being able to know them well enough to be able to support them because they all have slightly different needs and it's not just the obvious ones like dyslexia or dyspraxia or things like that; it's to do with often their family situation, their background, what their parental expectations are and all those sorts of things I think makes them the people they are. And sometimes it's helping them to get through those barriers that makes them a success on the programme or not, and a good radiographer at the end of the day.'

Rob – Textural – Structural Description

Rob describes himself as a caring person and a caring practitioner. During his time as a clinical radiographer, it was clear Rob found caring to be an integral part of his role.

'I really needed to be able to kind of really care and show that I was caring as well.'

But Rob acknowledged service demands often limited the ability to care in a 'patient-focussed' way, '*we were kind of highlighting to our, the managers at the time, that they needed more time and more kind of patient-focused care to the patients'*. Rob perceived some staff were '*very technically orientated and kind of forgot about the patient care a lot',* describing them as '*novices to this kind of caring kind of role'*. In contrast, Rob explained that for him, caring was ingrained within his personality.

'For me it's ingrained in me since a young age, since I started training, and I wouldn't have gone into this profession if I didn't feel an ounce of care for my patients or even my students, I wouldn't know how I would have survived 20 years without caring, if I hadn't already had that ingrained in me,'

Rob's experience was that in working for more than twenty years as a radiographer, it would be impossible to do so without the inherent attribute of caring, that he possessed.

An experience with a young patient was particularly memorable to Rob. He repeatedly described that demonstration of caring was to go '*above and beyond'*. This was fostered through building a relationship and rapport with his patient. The connectedness enabled Rob to adapt his care towards the individual needs of the patient.

'trying to develop this kind of rapport, this relationship with them and the fact that we do that for all our patients (and go over, above and beyond), but we adapt it to their particular needs'

However, if there was a less trusting relationship, or this trust had not yet been built, Rob felt that caring suffered. The connection and rapport were essential in Rob's view, to what he called the '*caring process'*.

'the way that you develop the rapport and the relationship that starts off that kind of caring process, because it makes it a really good opportunity

then for you to be able to show support, reassurance, discuss, be honest, be frank, have an opportunity for them to talk as well'

When the trusted relationship and rapport existed, Rob described a connection to his patients such that *'I could really sense what he was going through very much'*. But if this was negative or lacking, caring suffered.

'If the initial rapport starts off negatively and quite absent, you are going to have to work really hard to gain their trust and it's not a case of 'We can start caring for them straight away', it's about 'OK we can care for them but it's going to be a bit of a tricky situation because there may be some patients who are not as open and honest,'

Another important aspect of caring in the clinical setting for Rob was communication with patients and information giving. Large amounts of high stakes information are given to patients around side effects and treatment. Rob felt this often-lacked adequate time for patients to ask questions, and for patients to develop, process and understand that information. Caring for Rob involved giving time, including the patient in the process, and thus shifting the power imbalance.

'we just give so much information, but we don't give enough time for our patients to be able to ask us questions, and we sometimes forget that they also need to ask some of the questions, and it has to be a two-way process'

A further thread throughout the caring relationship and communication for Rob, was an understanding of the individual and empathy for their situation.

'I think in terms of the caring kind of nature of it, it's about yeah… the communication, the reassurance, thinking about the patient, putting yourself in the patient's shoes, you know, what information would they want if I was in that position?'

When describing his role as an educator, caring for students, Rob identified many similarities with caring for patients. In fact, Rob would inadvertently refer to students as patients when retelling their experiences.

'then once I have gauged it by seeing the patients… I say patients instead of students!'

He was keen to link caring in education to caring in clinical practice, and how there is a natural translation from one to the other.

'as practitioners in a clinical department the skills that we have gained from that I think have been so useful particularly for me, and I am sure it must be for all my colleagues and staff, to be able to then speak to our

students about sensitive natures, about topics where it can be quite tricky,'

Rob describes how the clinical experience could fully equip radiotherapy educators in caring for their students,

'to show the same care and support within the clinical environment as we do for our students in an education setting as well, so I think we are fully equipped in that respect, and I think we need to show the same kind of caring nature for our students in an education setting as well'

For Rob, the importance of relationships, rapport, trust, and empowerment of students exists as a mirror image of caring in the clinical environment. Similarly, when this rapport and trust are lacking there is a negative impact on caring for the student.

'very much with the examples about patients; we won't know how the relationship and the rapport begins until the patient, or the student in this case, opens up to us some information they want to tell us'

Rob describes how students will be open and share their concerns and experiences only if the relationship exists in a supportive manner. With that relationship and rapport working well, Rob described how he could individualise his support for a student who felt safe and trusting.

'So with the caring of the individual need, it was very much about bringing her in, it was about again, you had to really talk about the situation, making her feel she was safe, so asking her about what other family members has she got, who is she living with, does she have a partner, does she have anyone else, does she have other siblings as well?'

Retelling one experience with a bereaved student, Rob explained how being aware of her circumstances enabled him to better support and care for the student. Support as a theme runs powerfully through Rob's narrative of experiences in both his personal and professional life.

Rob described his educator role as 'two-pronged' when caring for students. One aspect relating to a holistic or personalised support from a connected relationship, the other an academic support role.

'So for me I had two kind of hats on; my first hat was how can we support her in terms of her personal circumstances, what can we do, what can I do as a personal tutor in that respect to help as much as I can?'

'The other hat I had on was the impact that was going to have on her studies, so I had two kind of key areas I had to think about; caring for her

personally, her mental wellbeing and health, and the scenario that she is currently facing but also caring for her in terms of what educational support I could give her in view of the current scenario'

Rob described feeling that in caring for students as individuals, signposting them to support for well-being, counselling and bereavement, empowered them to take a more pragmatic view regarding their studies, enabling a positive outcome despite their setbacks.

'I have given them an opportunity to not worry about their placement, not to worry about assignments, we have got the support mechanisms there, we have got different kind of avenues that we can take to make sure that you are supported educationally, but always be mindful that it's quite a delicate and really critical time for them in view of a death in the family'

These caring discussions were identified as sometimes being a worry to Rob, but also a great sense of fulfilment, accomplishment and pride.

'for me, at first, initially I feel really kind of anxious about how it's going to play'

'I sometimes feel that I have done something good for them, I kind of get that sense of wow, I have managed to support them as much as I can'.

'I do feel sometimes like I have managed to help them and give them a bit of support where I can in view of the information that I could help them with and with the kind of questions they ask me.'

A sense of wanting and needing to care for students was evident from Rob's experiences in a similar way to how he felt a 'need' to care for patients.

Regarding the development of caring during education, Rob described the multiple relationships that he believed influenced students' caring. Clinical and academic radiographers were considered as role models by Rob. He went on to explain how he experienced students learning from each other as well as staff. To help them develop what Rob described as '*the caring skills'*.

'I think working with their peers is another opportunity for them to develop their caring skills, hearing about it from themselves in their groups, I think that is always a good learning tool for them. Peer-to-peer learning in all forms, whether it be in a more formal way or whether it be them talking amongst themselves, break time, out of uni, out on placement, they start to hear things are happening amongst their group and I think that is also another driver for their caring kind of skills'

Another relationship described by Rob as influencing caring, was that with patients. He described every patient interaction providing a caring opportunity, and that

students should be encouraged to see every task or episode as an occasion to care.

'I would argue the fact is that every patient they see that interact, they engage, they talk to, they are supportive in one way or another and they are caring in a… you know, something simple like, getting them changed into a gown to explain to them about particular side effects, to asking about how their day was, they are all forms of caring one way or another. It's about how they engage that, how they approach that.'

As well as relationships, Rob described how both placement opportunities and the academic sessions within the curriculum help in developing caring in students. Some learning episodes were overt, '*us, as educators, you know. We have specific modules for, as I say, holistic care, where we talk about care of the patients, we also have caring as a thread throughout their degree,*' Whilst other aspects were more covert or hidden, building throughout training and only revealing themselves to students within their final year. At this latter stage of training, Rob felt students could acknowledge the caring and support they might offer patients.

'I think they can never run away from that kind of caring development and progress, they think it's something that they are always a part of, embracing, and sometimes students don't realise it, you know'

'actually don't realise it until very much towards the latter end of their training where they think actually do you know what? I am doing a good job, I am showing good skills, I am demonstrating care and support.'

Rob described placement as

'a beautiful opportunity for them to develop their caring skills and I think that kind of emphasis from the clinical staff and from link lecturers when we visit them is about getting them to kind of think about patients, and they are always told the patients are number one, the patients are number one, we have to support them and care for them.'

The need for all practitioners, in clinical and education roles, to be patient-centric was a key aspect of practice for Rob. Within the curriculum, Rob described how caring skills were identified and then demonstrated by students through competencies and assessments. He acknowledged these might initially appear perfunctory, but they did assist in moving students' perception and understanding of caring from the covert to the overt.

'a paper exercise where you get them to sign off and things like that, but actually to them it's about a realisation they are actually involved in some

sort of patient care and the clinical assessments they have to demonstrate patient care'

When considering the concept of caring and what it means to Rob, he described it as holism and individualisation. The person-centred construct of holistic care translates from the clinical to the educational setting. Considering student-care, as Rob explains

'we need to always think about the student and they need to be our number one in view of the emotional, the psychological, the physical, the spiritual – those kinds of particular multifaceted considerations.'

Rob embraces caring for students through psychological, emotional, physical and spiritual aspects in a similar way to patient-centred holistic care. Offering guidance, support and coaching.

'I have always said to my staff, you know, whatever you do think about it from the perspective of your student because they are the ones that you need to think about, and we have a duty and obligation that we have to care for them and support them and look after them and mentor them and coach them'

Rob's views again mirror his experiences and perceptions of caring in clinical practice, through concepts of holistic person-centred care, targeted towards the individual in question.

A strong theme describing authentic caring for Rob is that of going 'above and beyond' or as he says, '*it's about going further'*. Rob explains how it is easy to say "yes, I am caring", but he does not believe that alone makes for a caring person.

'you can say I am caring, I am confident, I am compassionate about my patients but actually it's about how do you demonstrate that consistently to warrant you saying that you are a caring person?'

'We can all care, it's about how far we push that care and demonstrate that care as individuals which is the more value in my eyes'

In displaying what Rob describes as *'care characteristics*' or '*attributes'*, he suggests personality is of influence.

'I'd come prepared; that to me is going above and beyond in terms of how much care characteristics or attributes that I would show my particular student'

Rob's altruistic personality he relates far back to his time at school, describing how the healthcare degree formalised his caring attributes and personality. Rob explains

the capacity to care is in everyone, but that essence of care, to demonstrate true caring as he sees it, may manifest differently amongst individuals.

'we are always having to care and support everyone and anyone, whether it be at work, whether it be at home, care for ourselves so it's really important I think'

'I struggle about no one having 'no care'; they must have some essence to care but it's how they approach that care, for me is important.'

In Rob's personal life he describes caring for a relative using similar constructs to those depicting caring in his professional role. The need for information, communication and reciprocal relationships, in addition to building trust and rapport are a common thread throughout all of Rob's experiences and perceptions retold during his interview.

A final overwhelming view of Rob around caring is the belief that a caring personality draws individuals to the caring professions. His experiences and descriptions identified strong and clear views around what caring means to him as an individual and professional, and whether caring can be 'learnt'.

'I think we wouldn't have come into this profession if we hadn't an ounce of caring skills or personality in ourselves, and I would really argue with anyone saying to me that ultimately we have had to learn to care; well no not really, it's something that has happened in our personalities, it's been triggered off coming onto the course, it's something that we have always had, it's been inherent and we are now just utilising it and formalising it and demonstrating it so I think that's a niche kind of a key message really, it's always been part and parcel of us really, it's just being… we are now showing and demonstrating in this kind of educational forum really.'

Sam – Textural – Structural Description

Sam is an experienced radiographer and educator, currently with a role of clinical education lead. In her personal life, Sam speaks about experiences of caring for her parents, her children and as a volunteer.

Experiences of care provided to her mother lacked personalisation in Sam's view. Sam explains how individualised care is better provided when a personal connection exists.

'They were all very professional but … it lacked the personalisation that I think I wanted to see in dealing with somebody who was so uncomfortable, and also who was my loved one…. we could also recognise her nuances of when she was uncomfortable because mum was somebody who wouldn't necessarily say that she was uncomfortable – very stoic. So in having that personal connection we were able to do this and support her a bit more than perhaps an external body could.'

Sam describes a lack of time and a focus on tasks that felt the encounters lacked care, '*attention to detail'* and was '*perfunctory'*.

'I think they were busy with the task, rather than the attention to how mum was feeling; they had to do it in that time so they went in, it was like 30 minutes or half an hour that they had and there was no sort of sit back and have a conversation with her to say, you know, I think they actually limit it to 'how are you today?' and then it was 'Oh come on xx, let's do this, come on xx, let's move you this way' and it was very perfunctory,'

In her clinical role, Sam describes how she would always try to personalise care and connect with patients, '…*personalisation and be able to connect with somebody via something that you can talk with them about and to take their mind off the function of what we were doing, so distract them a little bit so that they felt more at ease*…'. Sam retold fondly, an experience of caring for an elderly widower. She describes caring being practical actions as well as careful questioning about his homelife, subsequently organising social care.

'We went and found him another pair of trousers to go home in, they were in need of a good wash anyway and so we just followed the … we made sure that he had got some support at home, so he didn't have anybody living with him, he was a widower and in questioning when we asked him about the washing, he was like 'Well, I have never been able to get used to that washing machine, that was always the missus that did that.' So we were able to arrange social care for him to go out and do some stuff for him, and to be sure that those sorts of things were happening. And to stop him coming in his yellow pants.'

Sam describes making '*heartfelt'* connections with patients particularly when they are socially isolated. She shares the importance of this with her students.

'I think whenever you get involved and you find out about people's personal lives you feel that greater connection with them and it is heartfelt, and when you think of people being lonely and on their own, how … then they come into the department, that is their social connection. So I think recognising that people are alone in their home lives and that sometimes something like showing the students that it is often that interaction with you as a radiographer, it's the only contact they get in a day.'

With great emotion and sadness, Sam explains an experience she had when a patient died just after radiotherapy. She retells making time for the patient's family and the caring interactions with them, and the compassionate needed.

'This is more about the interaction with the family as opposed to the patient, but in terms of being there for the patient and just sitting with him next to us, sitting next to me and just having him lean on me and yeah, his final few breaths.'

She explains how the relaxed relationship, the rapport she had built enabled the family to ask questions. Sam felt it was important to make time.

'The family asking to sit and talk with us afterwards and just asking about those final moments, just being considerate of their needs. They had not been there, and they wanted to know what had happened… Yeah, that compassion that you need to sit with somebody and just let them have their moments and try to come to terms with it, with the change in circumstances…. Just giving them the time to ask any questions and thinking … just letting them explore their understanding of what had happened…..I think they felt that as a radiographer they could talk to us, they talked to me a little bit more. So they felt a little bit more relaxed ….'

As a radiographer Sam described feeling 'privileged' to share these last moments with the patient and care for the family: *'the fact that I was able to sit there and hold him at that time – it felt important.*'

'I felt … it's not quite the right word I am looking for, but 'special' in that I was very privileged to be with that person at the end, and that it almost felt that I wasn't the right person to be there, but equally there was that … yeah, sort of privileged.'

Sam has experienced or witnessed a lack of caring which she describes as a lack of compassion, dignity, and respect, especially for people in embarrassing situations.

'A female patient was having pelvic radiotherapy and they saw the scans saying that she had gas, yeah, so they'd gone back in and the whole team had gone back in at this point and they said 'Oh, you have got too much gas in your bowels, can you try and release some of that gas please?' and the poor lady looked absolutely mortified, that she was asked to let rip!'

Sam used this experience as a discussion point with students. The staff, she felt, valued their convenience above the needs and feelings of the patient, for Sam this was a lack of caring.

'I mean as it was, the lady couldn't have emptied the gas so they did eventually get her up and walk her around and said 'Come back in half an hour', not inconvenienced by it, rather than showing some understanding that it could be difficult for the patient.'

Sam describes caring as '*Making somebody else feel valued, that they are your priority at that time, that you know them and their needs and that … yeah, that you listen to what it is they have got to say, give them the time to say what they need to say.*' She also explains how giving orders, commands, not using someone's name, and viewing them as an inconvenience if uncaring.

'Talking … talking about patients when they are in your presence, like 'Oh she has moved.' 'Oh we are going to have to prep her up again' as if it's a piece of meat. I think that makes people feel uncomfortable and that they have … they are an inconvenience. So always … so if people don't talk to the patient or don't address them by name, and just give them orders rather than say 'Would you be able to?' and phrasing a question in a way that isn't a command.'

In her educational role, Sam also views caring as making time and having conversations: *'Sitting with them, like they have alerted us/me to the fact that they are really not coping with the demands of the course and something that … it would be comments like 'I don't anybody would notice if I wasn't here anymore…… Being responsive to the call for help, making myself available. Again, giving somebody some time, face-to-face time or over the phone – sitting and listening to them.'*

Sam talks about '*coaching conversations'* to elicit feelings of students and then signposting to meet their needs: *'Just picking up the phone to them saying 'Look, let's get together, come and sit and have a conversation, let's have a chat' and just go through that risk assessment of what are you going to do if you leave here now, and what makes…? You know, having a bit of a coaching conversation with them.'*

'… in terms of just trying to elicit some information from them and figure out their feelings and see if there is any option to be able to turn their

thinking around a little bit, to think about it in a different way. But often it's more about signposting I think at that point, you know, not a qualified counsellor, not a … it needs medical intervention at that point, making sure that they've engaged, their wellbeing…'

She goes on to say how 'hearing' concerns, exploring needs and offering individualised support is caring as an educator.

'Hearing what it is that is their concern, so for a student point of view we make assumptions I think that everybody feels the same or everybody understood the same, but taking it as an individual … each individual has a view so say 'Right, what is it you understand from the situation?' or 'What are your needs right now?' and trying to address those individually.'

Some aspects of students' behaviours can impact the caring relationship in Sam's view. Negative behaviours may be due to hidden reasons but the students' needs may not be readily picked up if they are seen as 'touble-makers'.

'We lose it a little bit when you have a student who may be a bit mouthy in class, they get themselves a reputation for not turning up regularly and when they are there, they are being inconsiderate of others and then you don't necessarily pay attention to the detail as to why they might be behaving like that. So make that follow-up call to say they have been a pain in the backside and they are being a bit of a nuisance, so you sort of gravitate more towards the ones that you feel want to be there and so yeah, so they might… they may have needs but you don't necessarily pick them up.'

Lack of caring as an educator is described by Sam as not being available to help students with queries and assumptions of feelings rather than individualised knowledge. She also acknowledges that non-white students' situations may also be more negative, with failing support so students do not reach their potential.

'You know, never being around so you are picking up on their queries, and probably making those assumptions that everybody is feeling the same or having the same experience – like the BAME students and some of the issues that we know cause … so they are not reaching their potential and getting their value-added.'

Finally, Sam explains how she feels many other aspects of an educator role can take you away from the 'caring aspect'.

'A lot of those students are the ones that perhaps don't attend all the time, that have got issues behind, you know, they are caring for a family and you don't yet know about it, you try and support them and so more than anything I think it's the pressures of the role, you know, reporting on this,

that and the other and having to do the job that you lose that caring aspect, you are less able to respond in a timely manner.'

Sam considers the concept of caring to embody listening, using body language such as eye contact to actively engage, and not having one's own '*agenda'*.

'Body language, listening very much, looking… eye contact, making sure you smile at people, turning towards them, all of those little body language aspects, actively listening. So not speaking …with your own agenda in mind and without intent, so actually listening to understand the issues.'

She also considers caring to include picking up non-verbal clues, with communication being essential. '*I think that when we speak about the spoken word and contributing such a small element to the understanding that it's better when you can see somebody because you can pick up ideas*.'

Sam also thinks it is a lack of caring if individual's needs are not considered *'I mean for me it's all about the communication, caring and communication go hand-in-hand, so anywhere where there is poor communication is a lack of care. Yeah, not considering that individual's needs, it lacks care.'*

Sam believes that self-awareness can enable a more intuitive understanding of others, which helps caring behaviours to be developed.

'I think when people have a better understanding of themselves and why they act in certain ways, well, then they are more intuitive about other people and understand other people's needs because they can compare with themselves and how they might be.'

When discussing how caring develops, Sam believes it is naturally within individuals, but those altruistic personalities can better hone their caring skills.

'I think you see it naturally in people, but I think you can develop it further. So, I think there is a natural instinct, there are some people who are more nurturing and naturally take on that role in terms of looking out for others and putting other people's interests before theirs, so I do believe that there are personalities that are altruistic, but that they can be… that through extra work you can really hone those skills.'

Appendix 13 Clustered Themes by Participant

Participant	Being Caring	Caring For	Caring About	Teaching Caring
Alan	A Desire to Help Responsibility 'doing the right thing' Professional Distance Impact of Clinical Role Responsibility Sense of Pride Caring for Carers	Technology Information Technology Barrier	Connections, Individualisation and Relationships Holistic Support Building Relationships Making Time for the Individual Demonstrating Concern Empathy Individualisation, the 'Small Things' Respect and Empowerment	Reflection
Jo	Selflessness and Altruism Shared Emotional Experiences (with Patient and Team) Practitioner Benefit from Caring	Communication Process Driven Practical Caring For	Relationships, Rapport & Support Knowing the Person / Individualised Belonging & Motivation Emotional Caring About Making Time Above and Beyond Empathy Prioritising & Availability Listening Lack of Caring	Role Models - Developing & Enhancing Caring

Linda	Practice Influenced by Experiences Compartmentalising Personality & Investment of Self Emotional Labour & Burnout Practitioner Benefit Boundaries Personality & Previous Clinical Role Emotional Burden	Process and Task Focus Technology and Service Focus Practical Caring for Communication	Building Relationships, Rapport & Individualisation Connections & Conversations Emotional Aspects Caring About Listening Making time & Listening Prioritising Students, & Making Time Empathetic Student Support	Leadership, Role Models & Experience Skills & Modelling Disruptive Students
Lucy	Practice Influenced by Personal Experiences Practitioner Benefit Personality Personality & Power Picking Up on Ques	Practical Caring for Practical Support	Emotional Aspects Caring About Building Student-Staff Relationships Relationships, Rapport & Individualisation Humanity & Connections Importance of Touch Making Time and Employing Skills Culture Challenges Conversations & Listening Empathy & Compassion Nourishing Emotions and Confidence	Experiential Development of Caring Anyone Can Care – Authentic Caring
Neil	Childhood Experiences/Fostering	Service Demands Impact Caring	Individual Needs Personalised Care AUTHENTIC	Modelling Care Innate Desire to Help

	Desensitisation Own Understanding and Experiences of Caring Impact on Practitioner - Personal Detriment – Personal Reward Previous Clinical Role Making a Difference to Students Demographic and Gender Influences on Caring Detriment to Self Influence of Family / Emotional Intelligence and Being Perceptive Societal / Gender Influences	Technical Focus Caring For	Relationships Caring About Important and Memorable Someone Looking Out for You, Secure and Belonging Helping Beyond Technical and Professional 'giving a damn' Respecting and Prioritising Pastoral Care Role Above and Beyond, Students the Priority Making Time Empathy Compassion Going the Extra Mile Giving of Self and Giving Time	Role Models
Philippa	Impact of Professional Role Emotionality	Physical caring Practical Caring Signposting Caring For	Emotional Caring Building Equal & Individualised Relationships Emotional/Psychological Humanism	

	Impact and Awareness of Previous Experiences Practitioner Roles & Practitioner Benefit		Knowing Students as Individuals Caring About Small Cohorts, Closer Relationships Taking Time and Building Trust Cultural Awareness & Differences Above & Beyond Overt Concern & Nurturing	
Rob	Impact of Caring in Previous Clinical Role Fulfilment and Concern Inherent Attribute	Communication and Information Service and Technical Demands Information and Communication	Connectedness, Relationships & Rapport Individualisation Multiple Educator Roles – Holistic & Academic Every Interaction Caring Individualisation and Holism Authenticity Empowerment Being There Empathy and Understanding Trust Above and Beyond,	Role Models and Peer Learning Covert and Overt Learning
Sam	Practitioner Benefit Caring Self-Aware Personality	Time Pressures & Task Focussed Service & Tasks Prioritised Communication	Personalised and Individualised Connectedness Individualised Support Being There & Involved Active Listening & Making Time	Case Studies and service users

			Compassion, Dignity & Respect Complex Student Lives & Pastoral Role Academic Pressures Prioritising Students as Individuals	

Appendix 14 – Personal Reflections & Dissemination Plans

Personal Reflections

Completing a doctorate has been an ambition of mine for many years. I am firmly settled within teaching, so an education focus was most appropriate. The topic for my doctorate was clear from the outset. I saw varying levels of caring in my clinical work and hoped that as an educator I could help instil the value of caring, so important to me, in my students' practice. I discovered much uncertainty about caring in the curriculum, and a paucity of any meaningful research into the construct from a patient's viewpoint. After the Francis Report was published in 2013, I felt sure our professional body would suggest how caring should feature in therapeutic radiography clinical and educational practice. This did not happen, and I then felt demoralised which almost created a quest for me to ensure our profession was caring. At times this became quite overwhelming, and I needed reminding I was not on a mission, more a reveal. Then my experience as an educator grew and I became more questioning of our curriculum, so naturally the topic settled as caring. I was excited to begin this journey.

The journey has been long, much longer than I anticipated. As a person I felt much doubt in my ability to complete such substantial research. I always felt inadequate during our taught component of the EdD as others seemed to know so much more and appear to be so widely read in philosophy and pedagogy. But I wanted this to succeed for me and for our patients, students and profession. I have since begun to acknowledge how substantial changes in my career, starting with becoming Course Lead meant I had little time to spare. We are a small team and staff movement also had an impact. I expect my procrastination did too. I probably took my altruistic behaviour too far and did not prioritise me sufficiently. However, I successfully gained my SFHEA, promotion and an additional Associate Dean role at St George's that I love. I always want to be moving forward and despite two interruptions as a student I have kept going. In this research phase it has been with constant support and encouragement from Marcus and John that has helped my self-esteem and belief. They truly kept me going and believed in me. Now I believe in me too, so my thanks to them.

I have changed as a person, due to this journey of enlightenment. It sounds cliché but it is true. I look at things differently, thinking outside the box in more aspects of life than just the professional. Being a student and supporting both my sons in their career journeys has given me a new experience upon which to draw. Living the complexities of life as a mother, daughter and student whilst working and existing in life is hard. Not just the time to work and 'neglect' other aspects of life, but also the feeling of guilt and that I was never doing anything well enough. I need to remember to care for me too. But I truly believe research into caring has made me more caring, and I know I was caring at the start of this journey. Sometimes being an empath and caring so much is hard as the world is a challenging place at present, not just due to Covid-19 which impacted me as a person, being separated from those I love.

As an educator and researcher my knowledge has increased beyond belief. I have explored areas of research and philosophy that have ignited a passion in me to learn even more, and to further research into caring, from a student, patient and clinical practitioner viewpoint. In terms of supporting my students I have a greater empathy and understanding having managed time to care for family, work and study. But also, a realisation that you are not a caring or non-caring individual through choice entirely. There are experiences, behaviours and antecedents at play in addition to the culture and environmental pressures or facilitators. Caring is an individualised concept, but my study has revealed new knowledge around aspects of caring in TR education. I am proud and excited about this.

At the proposal stage of this journey, I took some time to refine my research questions. I tussled with the setting and scope of the study, intending to interview students, staff, educators and patients. With the support of the EdD course team and my supervisors I was able to refine the questions to be more appropriate and within my sphere of influence. I had previously conducted qualitative research using focus groups for my Masters study with people having radiotherapy, using a thematic method of analysis. I knew a qualitative phenomenological approach sat well with my questions and exploration of caring, but within that paradigm I had limited knowledge of the different types of phenomenology for example. So, my explorations began, and I feel I have learnt much about the topic. Initially I was unaware of the Husserlian or Heidegger approaches and the background behind them. With further reading, considering exactly what I wanted to explore and the

importance of me as a researcher and my influence on the study, I concluded that Husserl's approach was most appropriate. With little if any specific research in my specialist setting, the Heidegger approach could have meant I overshadowed the findings. The acknowledgement and bracketing of my views from the Husserlian methodology would limit my impact but also enable the 'essences' of caring to be revealed. A structured data analysis method, the modified van Kaam would further enable this revelation of the essences of caring. Once my direction was known, after much back-and-forth exploration, I was able to move forward but with some trepidation having not used this methodology or process of data analysis previously. I had felt much frustration wanting to progress and perceiving that the details would fall into place. Now I realise that clarity regarding fundamental aspects of the research were essential from the outset.

Covid-19 impacted my data collection in addition to a participant withdrawing after transcribing had taken place, both of which were frustrating. I realised when analysing the first interviews, the method was lengthy and time consuming with much richness being revealed so the loss of one participant was not too problematic. With structured stages, the modified van Kaam enabled thorough data exploration and revelation of the true essences of caring. I became more skilled at the process as each interview completed, feeling a sense of accomplishment and excitement as patterns became evident. In deciding to complete the data analysis before drafting the whole literature chapter, I reduced the risk of subconsciously selecting areas based on the literature. This meant the essences revealed were from the participants, not my personal views or based on literature selected.

As an educator my practice has developed, I feel I have a different approach to many aspects of my role. I have more confidence in my abilities and knowledge, but also look at dilemmas and problems with a different lens. I feel more able to critique and question, opening my mind and excited to debate views and practices in pedagogy. This research study has given me the opportunity to refine and add to my knowledge base which can be shared with students and staff. It genuinely has changed me in a variety of ways, some of which are hard to quantify and articulate. As someone who has doubted themselves constantly, completing my study brings me pride and fulfilment as I genuinely feel this study is meaningful and could begin an exciting journey into further exploration of caring in my professional setting. I hope that sharing findings will prompt other educators to consider their practice and

how we might all interact with each other, building relationships and humanity into our practice with students. Having shone the light of caring and what it means we might explore our curricula, our student support and relationships to make what is arguably good, even better.

Dissemination and Future Research

To disseminate my findings and look at areas of future research I have considered where opportunities may lie. I would want to summarise outcomes of this study in articles for the professional journals, Radiography or Journal of Radiotherapy in Practice, but also spark some debate in terms of pedagogy. This could build on my 2019 publication around compassionate care.

The idea of student-centred care mirroring person-centred care is a concept I would want to share within my profession and beyond. Presenting at an Advance HE conference would bring the discussion of caring to a wider audience, maybe beyond healthcare programmes specifically. I feel student-centred caring links to the developing area of compassionate assessment and compassionate curriculum, something I discovered as part of this study, and an area I would like to explore further. Creating a learning resource for student-centred caring and beginning professional discussions of the topic through the Society and College of Radiographers CoRIPs funding is a further area of interest. I have already reached out to a diagnostic colleague who has worked on patient-centred care in radiography. She developed a MOOC exploring patient-centred care so a collaboration would be natural, she is very keen too.

At my own institution and within my own programme, I can and have begun to instil study findings and outcomes within my teaching. Caring in radiotherapy will now be delivered through the *caring for* and *about* concepts within my teaching. I hope colleagues will embrace the ideas within their teaching too. My study does not aim to be transferable to other settings due to the unique experiences and perceptions of TR educators, but it may have elements that could be transdisciplinary. Sharing my study findings with my HEI colleagues would be interesting and fulfilling, maybe sparking debate and discussion from a student experience and practice lens.

I intend to continue exploring this fascinating topic in TR but through the lens of our students, clinical colleagues and of course our patients. I recall the advice of a colleague at the start of my doctoral journey, choose something that excites you and interests you because it is with you for a long time, and you do not want to be bored with it! I have found the contrary, I feel more passionate and excited for this topic than ever before, caring is part of me as a person and a practitioner. I am proud of that and want to reveal and unravel more and more of the construct. This feels very much like it is just the beginning.