



CLINICAL SCHOLARSHIP

## A Focused Ethnography of Baccalaureate Nursing Students Who Are Using Motivational Interviewing

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Focused ethnography, motivational interviewing, nursing students, undergraduate education

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### Abstract

**Purpose:** The purpose of this article is to describe how nursing students learned and used motivational interviewing (MI) in a community-based clinical context at a primary care vascular risk reduction clinic focused on health promotion.

**Design and Methods:** A focused ethnography was used to access a sample of 20 undergraduate nursing students, 16 patients, and 2 instructors. Data were generated from participant observations, field notes, student journals, and interviews (one-on-one and focus group).

**Findings:** Central to the students' experience was their transformation because of learning and using MI. Three sub themes describe the social processes that shaped the student experience: learning a relational skill, engaging patients, and collaborating as partners.

**Conclusions:** It is feasible for nursing students to learn MI and use this approach to enhance collaborative care in a primary care setting. The experience can be transformative for students.

**Clinical Relevance:** Supporting patients to adopt healthy lifestyles is a significant role for nurses in practice. The findings provide key insights and strategies for nurse educators teaching students a collaborative communication approach, such as MI, to engage patients in health behavior change.

Patient teaching is a large part of nurses' roles, and much of this education is about changing behaviors for improved health (Whitehead, 2007). Traditional lifestyle education includes giving information on healthy lifestyle behaviors, instructing patients on managing conditions, and targeting risk reduction. These approaches are typically didactic and intended to work through transferring illness knowledge to effect a change in patient behavior (Whitehead & Russell, 2004).

The literature provides a mixed impression of the effectiveness of health education, and authors posit this may be due in part to the preparation of undergraduate and practicing nurses as educators or the lack of time or priority given to health education activities (Holt & Warne, 2007; Miller & Beech, 2009; Wiley, Irwin, & Morrow, 2012). Some authors identified that traditional health teaching may not provide the collaborative problem

solving that patients need to make the complex adaptations accompanying the uptake of new behaviors (Miller & Rollnick, 2013; Montgomery-Dossey & Keegan, 2013). With a focus in health care on patient-centered approaches, nursing students would benefit from developing skills, such as motivational interviewing (MI), to work collaboratively with patients on health behavior change. This article reports on themes from a focused ethnography of how undergraduate nursing students learned and used MI as a collaborative approach to engage patients in behavior changes targeted at vascular risk reduction. We report on the patient experiences of MI by nursing students in another article.

MI is a patient-focused approach to behavior change that is distinct from health education because it explores and addresses values, beliefs, and worries about change (Miller & Rollnick, 2013). The clinician uses open-ended

questions, affirmative statements, reflective statements, and summary statements (OARS skills) to engage patients to talk through the ambivalence associated with adopting different lifestyle patterns. Despite considerable research activity, questions remain about how MI works from a patient's perspective as well as the best way to prepare practitioners and determine their competence (Rouleau et al., 2015; VanBuskirk, & Loebach Wetherell, 2014). Some scholars have suggested MI is a good complement to nursing practice because its key principles align with a collaborative and holistic view of patients (Maissi et al., 2011; Southard, Bark, & Hess, 2013). While nurses in primary care settings have successfully used MI to support patients with behavior change (Brobeck, Bergh, Odencrants, & Hildingh, 2011; Noordman et al., 2012), little is known about undergraduate nurses using MI in practice. Thus, the aim of this study was to describe how nursing students learned and used MI in a community-based, primary care clinical context with the intent that our account can help nurse educators better prepare students to work with patients on changing health behaviors.

The research on undergraduate students using MI primarily focused on skill acquisition and involved research participants from dental hygiene (Croffoot, Krust Bray, Black, & Koerber, 2010) medicine (Martino, Haeseler, Belitsky, Pantaloni, & Fortin, 2007; White, Gazewood, & Mounsey, 2007), nursing (Carpenter, Watson, Rafferty, & Chabal, 2003; Czart, 2014) and pharmacy programs (Goggin et al., 2010). The studies identified that students should learn theoretical material on MI principles, then develop skills using a variety of modalities, including role play, standardized patients, or high-fidelity simulation (Carpenter et al., 2003; Croffoot et al., 2010; Czart, 2014; Goggin et al., 2010; Martino et al., 2007; White et al., 2007). These recommendations are consistent with synthesis research on MI training for clinicians in practice (Schwalbe, Oh, & Zweben, 2014; Soderlund, Madson, Rubak & Nilsen, 2011). There is some evidence that high-fidelity simulation is a feasible strategy to teach nursing students MI and that they achieve proficiency with basic principles and techniques (Carpenter et al., 2003; Czart, 2014). However, in these studies, the aim of the encounter was smoking cessation, and this neither reflects a collaborative approach to care (Gottlieb & Feeley, 2006) nor is consistent with the spirit of MI where the patient should identify the focus of discussion (Miller & Rollnick, 2013).

## Methods

A focused ethnography is an adaptation of traditional ethnography that addresses a phenomenon as it is

experienced by a particular group in a specific context (Erickson, 2011; Knoblauch, 2005). Since the aim of this research was to understand how undergraduate nursing students learned and used MI in their clinical work, a focused ethnographic approach was selected for its emphasis on social context, participant interactions, and subjective experiences. Focused ethnography is distinct from traditional ethnography by specific attention to a selected phenomenon, and therefore the researcher should be familiar with the area of investigation (Knoblauch, 2005). In our research, the primary author had extensive knowledge of MI, undergraduate clinical teaching, and patient education for health promotion and secondary prevention. The ability to both converse with and observe the students as well as those with whom they interacted, such as instructors and patients, provided a multidimensional view of how students learn and apply this relational skill. Both authors had professional backgrounds in nursing education. The primary author had training at the graduate level in field observation techniques and consulted with peers who were experienced in ethnographic research.

Throughout the course of the research study, the investigators adhered to the procedures outlined in the Tri-council Policy Statement: Ethical Conduct for Research Involving Humans. The study protocol, accompanied by interview guides, received ethical approval from two research ethics boards at universities in western Canada. Recruitment occurred through third parties not affiliated with the nursing students' activities or the patients' health care. The primary author collected the data and was not associated with the students' academic progression or patients' care.

## Context and Participants

The study occurred at a postsecondary institution in western Canada and took in activities as part of a 13-week community-based clinical experience in a primary care setting where students used MI to support patients with health promotion and vascular risk reduction. The students worked in pairs during the patient encounters and had direct supervision by an instructor. Debrief sessions for student feedback on skill development took place following the patient visits. The community experience occurred in year 3 or 4 of an undergraduate nursing program.

In a focused ethnography, the sample is drawn from the setting and informed by the participants' relationship to the phenomenon of interest (Roper & Shapira, 2000); therefore, we sampled to obtain diverse views of how learning MI unfolds for students in the setting. The sample included nursing students who learned MI, instructors

who taught students MI in the clinical setting, and patients who received MI from nursing students. All student participants were in the third year of a 4-year nursing program. There were 38 participants (20 students, 16 patients, 2 instructors); 9 identified as male and 29 female, and they ranged in age from 23 to 55 years.

### Data Collection

The authors had no association with the students prior to their being contacted to participate in the study. Eligible students ( $n = 48$ ) and instructors ( $n = 3$ ) each received an information letter describing the study sent by e-mail from an administrative support person. Students and instructors received an email invitation sent by an administrative professional not connected with academic or clinical activities. Potential patient participants ( $n = 100$ ) received a letter describing the study from administrative personnel (not affiliated with care delivery) in the location where they accessed health promotion services. Potential participants notified the primary author of their interest using an email address in the invitation letter. The primary author contacted potential participants, answered questions about the study, reviewed the consent form, and discussed the range of activities involved in the research. The consent form was reviewed and signed prior to the first observation, and participants were aware they could withdraw or modify participation. In the case of one patient where an observation did not occur, the consent form was reviewed and signed prior to the one-on-one interview. Data collection occurred over two 13-week academic terms.

Ethnographic approaches are grounded in a constructivist philosophy that perceives the nature of reality as something socially constructed by human beings rather than naturally given (Roper & Shapira, 2000). To support coherence between method and question, we used data collection strategies that included field observations and notes, student journals, one-on-one interviews with patients and instructors, and focus group interviews with students.

Unstructured field observations, a distinguishing feature of the ethnographic approach (Germain, 2001; McCurdy, Spradley, & Shandy, 2005), provided direct exposure to participants' actions relative to MI. The observations took place in weeks 5 through 12 of the 13-week community-based clinical experience. Thirty-five clinical observations occurred. These included 15 student-patient encounters and 20 student-instructor debrief sessions. An observation did not occur with one patient due to a scheduling conflict; however, this individual participated in an interview. The cumulative time in the field was 46 hr, and each observation lasted between 45 and

180 min. Field notes were taken discretely during the observations and updated immediately following with descriptions of the context, unique events, typical routines, as well as the primary author's reflections.

Spontaneous, unstructured interviews occurred during field observations, and these clarified elements that surfaced during observations. We received 10 student journals that each contained a 3- to 6-page reflective summary on either community health nursing in general (six journals) or MI in particular (four journals). The primary author completed all participant interviews (one-on-one interviews with patients and instructors, focus group interviews with students) after field observations in order to expand on experiences that surfaced during fieldwork. Interview questions for the two instructors focused on their approaches to and experiences with teaching students MI. The one-on-one patient interviews ( $n = 16$ ) were 30 to 60 min in duration and covered what it was like to have motivational support from a student as well as how this compared to the typical experience with a health provider. The student focus group interviews explored the timing, techniques, experiences, and insights associated with their learning and using MI. We used a focus group format with the nursing students because they worked in pairs or threes during the clinical experience and were uniquely positioned to build on insights from their debrief sessions in a focus group setting. Students had the option of a one-on-one interview; however, all took part in the focus groups. There were four student focus group interviews: two groups had two participants each and eight students attended each of two other focus groups. The focus group interviews were 60 to 90 min in length, took place in a private but familiar area, and happened at the end of the school term.

With the concurrency of data collection and analysis, the interview questions evolved as the research progressed over two academic terms to gain a better understanding of how students used MI in clinical practice. The instructor and patient interviews took place in a private space, and all but one, where a patient participant declined for personal reasons, were audio-recorded. The primary author took notes during the nonrecorded interview.

### Data Analysis

The diverse data collection strategies (observations, field notes, interviews, student journals) provided material to alert us to the fit between the data and research question, triangulate developing themes, and recognize patterns. Consistent with an inductive approach to qualitative research, we concurrently collected and analyzed data (Germain, 2001; Knoblauch, 2005; Morse

**Table 1.** Undergraduate Nursing Students and Motivational Interviewing (MI)—Themes and Features

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Central theme: Transforming as Nursing Students
Through using MI, students experienced transformation in their nursing practice
Subthemes:
Learning a Relational Skill
Timing—students ready to integrate MI into practice at Year 3
Feedback—instructors use MI when supporting students' skill development
Engaging Patients
Releasing the "expert stance"—students resist giving advice on what patients "should" do
Meeting patients "where they are at"—students discern cues of what is important for patients
Collaborating as Partners
Patients as partners—students and patients collaborating on approaches to change
Doing critical thinking—students tailoring knowledge to patients' unique situations

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Richards, 2002). Through this verification process, we assessed accumulating data to ensure a comprehensive description of the students' experiences. Interviews were the primary source of data for this research. The field observations and student journals provided context and insights to support the understanding of what students "thought about" and how they "enacted" MI relative to verbal accounts of their experiences. The interviews were transcribed verbatim (over 200 pages of single-spaced text) as they were completed, assessed for accuracy, stripped of identifiers, and annotated with observations made from the interviews. There were 30 double-sided, single-spaced pages of handwritten field notes transcribed for analysis. Due to the flexible nature of the journal assignment where students self-selected topics for reflection, we used only 4 of 10 student journals because they addressed MI in particular. The student journals were submitted in electronic format; after removing identifiers, we had 12 double-sided, double-spaced pages of text that we managed similar to the interview data. We reviewed all data line by line; identified consistent words, phrases, and events; organized these into categories; and formatted them into tables according to data type. All categories were derived from the data and represented distinct symbols that shared common relationships or meanings (McCurdy et al., 2005). This approach also supported the comparison of developing patterns across the different types of data (interviews, field notes, observations, and student journals).

Categories were reevaluated (discussed, reviewed, refined) as the data collection progressed to assess the data fit within the categories, the comprehensiveness of the categories overall, and the developing themes. We continued the process of concurrent data collection and analyses until we identified that the categories were rich in detail, replicated in several cases, and uncovered no new information. The instructor themes aligned with the themes in the student data providing credibility to our

analysis. From the data-generated categories, we noted salient features from which we identified themes (Morse, 2008). The themes represent contextual features that influenced students' use of MI in their clinical practice and distinguished the substantive elements that constituted the overall experience. Two student participants reviewed the analysis and reported that our account resonated with their experience.

## Findings

We identified a central theme of transformation that was supported by three subthemes to describe how students learn and use MI in clinical practice: learning a relational skill, engaging patients, and collaborating as partners (Table 1).

The findings describe the shared understandings and social actions organized around how nursing students use MI in clinical practice. A central finding was that the students identified that the experience of learning and applying MI transformed them as health professionals. Subthemes of learning a relational skill, engaging patients, and collaborating as partners describe the social processes that influenced student transformation. Specifically, learning a relational skill like MI was shaped by introducing the skills at the right time in their academic program and providing ongoing feedback on skill development. The application of MI skills pushed the students to focus on engaging patients, and this entailed letting go of an expert stance and meeting patients "where they are at." As students became experienced using MI to discern what was important for patients, the students collaborated with patients as partners to understand the context of patients' lives and used critical thinking to tailor health messages. Altogether, the growth that occurred through learning MI—using the skills to engage with patients and subsequently collaborate as partners—created a transformation in the nursing students.

## Transforming as Nursing Students

With learning MI, students adopted a way of being that enhanced patient connection, collaboration, and ultimately the students' personal transformation. Through using MI, students experienced a transformation in their nursing practice and it became "how I nurse." Transformation is a deep, structural shift in thinking, feeling, and acting (O'Sullivan, Morrell, & O'Connor, 2002). We identified diverse accounts of transformation. Students talked about the impact of using MI, such as how they behave with patients: "it is part of my nursing practice; it is the way I am with people—respectful and collaborative" and "I use these skills all the time because they show what professional caring looks like." The students' transformation included changed thinking about knowledge: "there is a feeling of confidence that patients will still trust us and see us as professionals even if we don't have all the answers" and "it's not just about reading articles to know things, we 'read' patients and put those together."

A significant transformation was in attitude: "[we] had to take a hard look inwards so now there is more softness in our approach" and "we stopped fighting with patients to make them do what we want and learned to guide them along." Indeed, using MI influenced students' confidence in their patients: "for many of us who were skeptical about people changing it happened that using these skills brought out huge potential in patients and we became a lot less cynical." Overall, learning and using MI in a clinical setting was both educational and formational for undergraduate nursing students.

### Learning a Relational Skill

Both instructor and student participants identified that the timing of learning MI as well as the approach to feedback were significant determinants of skill acquisition. The students indicated they would not have been interested in using MI in years 1 and 2 because they were preoccupied with "doing things to patients," such as developing their skill with nursing procedures. Students described feedback sessions with their instructors as "motivating experiences that inspired [us] to build on what worked and strategize to build up what didn't work."

**Timing.** From the students' perspective, the best time to learn MI was in year 3 because the students' focus was expanding beyond hands-on clinical skills towards relational skills: "in those first 2 years it was a challenge to even talk with the patient while doing nursing tasks; in year 3 came the ability to focus on both skills and communication." The field observations confirmed that students started the clinical experience with only basic

interpersonal skills and it was noted how "students talked at rather than spoke with patients." The students linked the timing of teaching MI to their professional formation: "third year is when a lot comes together and the 'light bulb' moment was that communication is as significant to the patient care as doing the tasks." The clinical instructors recognized MI was an advanced helping skill, yet believed in teaching MI early and "nurturing concurrently throughout their program alongside psychomotor skills so students develop relational techniques to enhance hands-on care." Instructors who teach MI should be sensitive to when they introduce the skill and establish clear linkages for students to the role MI has in accentuating nursing care.

**Feedback.** Feedback sessions, or "debriefings," were instructor-facilitated, student-centered conversations where students reflected back on the patient encounter and described how MI skills unfolded, discussed what aspects worked well, and self-identified areas to strengthen. During field observations, it was noted that instructor participants used MI to draw out students' self-assessment of how things went and provide feedback. Indeed, the student participants appeared enthusiastic to participate in the feedback sessions and did most of the talking. When the influence of the instructors demonstrating MI during debrief was raised in the focus group interviews, the student participants shared "the instructor using MI during debrief made the feedback on what I was doing sink in because I saw how it could be done." The interviews, journals, and field observations confirmed the value of feedback. There were examples of how the students' self-awareness of their skill performance progressed to self-correction in subsequent patient encounters: "as I got better at it, I found myself thinking 'how could I be doing this differently' so the debrief was about that moment when I realized that and modified the approach."

Some students, however, struggled with incorporating MI into a natural conversation. In these cases, the instructors would demonstrate MI skills with the student role-playing a patient. The role reversal was a turning point because it gave students a "personal experience" of MI with a skilled professional and "first-hand feedback" of how to integrate MI into the conversational flow. A frequent student comment on the role of feedback was "getting beyond the initial clumsiness of communicating differently, recognizing what I'm doing with a patient and adapting to take those skills further." The findings in this theme provide guidance to the timing of introducing MI to nursing students and the importance of feedback on skill development. Instructor-guided, student-centered feedback on MI use with real patients prepared the

students to be self-reflexive as they incorporated this advanced relational skill into their communication repertoire.

### Engaging Patients

When using MI to engage patients in conversations about modifying health behaviors, nursing students unlearned the “expert stance” and created an opening to “meet the patient where they are at.” Miller and Rollnick (2013) identified that when clinicians transition from being the expert, they have embodied both the spirit and style of MI. In this research, the turning away from an expert stance changed the conversation’s direction from students telling patients standardized information and towards students using MI skills to discern patients’ needs.

**Releasing the “expert stance.”** The students described how using MI changed their communication, specifically using the OARS skills to have patients discuss their preferences for health behavior changes rather than providing unsolicited, expert advice on what “should” be on the change agenda. Field observations, journal reflections, and focus group interviews consistently identified that “students acting like the expert and giving advice” resulted in the patient “disengaging” and “zoning out” of the conversation. Students learned to recognize patients’ physical and verbal cues: “you see their eyes glaze over and you notice their answers get more abrupt” or “it became like ‘talk to the hand,’ they just weren’t with you anymore.” The students described how releasing an expert stance ameliorated the expectations of them “having all the answers” and got them to trust patients’ personal knowing. The MI skills enabled students to tune in to what was important for a patient, reflect these observations in the conversation, and sustain patient interest: “it was about using OARS to get at what the patient wanted rather than me proving how smart I was by telling them what I thought they needed to know.” Students described how MI repaired instances of “patient zone out” that came about from defaulting into an expert role: “the patient just faded out until I stopped talking and started listening—well they just perked right up.”

**Meeting patients “where they are at.”** The students discussed the importance of MI for patient engagement because it also helped them “connect with what was meaningful to the patient.” Meeting the patients “where they are at” included using MI skills to discern the covert cues of what was important for the patient and build an agenda around the patient’s needs. Students enacted engagement as “moving from telling to probing to show the patient I was there for and with them.” This feature of

engagement reflects field observations of student–patient encounters where using MI made the student attend to the person, rather than the chart with patient results, in front of them. The process of engaging with patients presented as a turning point in the student’s ability to appreciate both the wholeness and uniqueness of the patient: “learning MI made us pay attention to the person and not just the numbers and it gave us skills to talk with patients about anything—including numbers.” As students used their motivational skills to attune to the patient, they moved beyond a detached, expert stance and created an opening for a collaborative partnership.

### Collaborating as Partners

During their clinical experience of learning and applying MI to support patients with vascular risk reduction, students realized their potential to collaborate with patients as partners in health. With the patient as a partner, the application of MI made critical thinking tangible for students. The synergy between MI and critical thinking was evident in students’ ability to draw out the patient’s perspective, deliberate with patients about potential change, tailor information to unique situations, and develop goals within a collaborative partnership.

**Patients as partners.** During field observations of student–patient encounters, a visit routine evolved where students asked patients about potential topics to discuss, supported patients to prioritize areas, invited them to share personal knowledge, and validated past experiences to guide future goals. The instructors interpreted this routine as “becoming a partner by helping the patient get in the driver’s seat.” Instructors described partnership to their students in feedback sessions as “demonstrating an interest to be an affiliate in the relationship.” In focus group interviews, students perceived partnership as a change in the relationship dynamic: “it’s less one-sided because when patients see we want to get to know them they are interested to work with us.” Students believed partnership was distinct from engagement because “it means we trust each other and that comes from going past connecting to sharing ideas and getting out of our boxes to do things differently.” As partners, students and patients collaborated on customized approaches to behavior change.

**Doing critical thinking.** The students described how MI engaged their critical thinking as they identified and considered multiple approaches to respond to an array of patient situations. MI made critical thinking visible as students discerned relevant health issues, tailored information to the patient’s unique situation, and

supported patients to begin to navigate the complex processes of planning change. As one student summarized,

MI is me doing critical thinking. I'm putting together what I've learned in school with what I'm hearing from patients and together we make sense of their big picture and the little steps they can work on for their health.

The patient encounters involved a review of laboratory results, and, without exception, patients wanted to know if their lab values were "normal." A student's poignant account resonated across many patient encounters: "normal is not the same for everyone and we owe people more than telling them they are normal." In making sense of the laboratory results, the students used MI and critical thinking to move beyond a situational focus on "normal" and towards individual capacity building. MI facilitated a back-and-forth exchange between student and patient about health based on personal relevance and ability to engage in change: "we're using MI to move 'blocks' of ideas around, to help patients 'build' their version of health." Students described this as "probing beyond the normal to get patients thinking about what is important to them and how they might act on that." In many cases it was identified that "patients wanted to change everything at once," and the students seized the opportunity to use their MI skills to "work together to understand patients' hopes and refine those lofty aspirations to something that works for them and fits for their health." Assessment of the importance a patient places on making a change, and clarification of an ability to change, constitutes proficient MI practice (Miller & Rollnick, 2013) and reflects a collaborative approach to care (Gottlieb & Feeley, 2006).

In this research, the application of MI skill and spirit enabled students to engage patients in conversations about what is important about health, tailor information to the patient's needs, and engage in collaborative patient partnerships to explore health behavior change. The experience of learning MI, engaging patients, and collaborating as partners enabled students to demonstrate critical thinking skills, and this had a transformative effect on students.

## Discussion

MI presents as a promising approach to prepare nursing students to work collaboratively with patients. Using MI in a collaborative partnership has the potential to change how nursing students go about their work and shift from a habitual practice of "doing to" patients toward a different way of "working with" patients. This research answers important questions about whether, how, and why

MI has a place in undergraduate nursing education. Indeed, nursing students can become proficient with MI provided they can practice with real patients and have ongoing, personalized feedback from a skilled instructor.

This research described both how nursing students learned MI and the transformative influence the experience had for their practice. It is an original finding to both identify learning MI as transformative and describe how transformation took place through reorienting to a new way of being as a professional, connecting with patients as people, and collaborating with patients on problem solving. Our findings are consistent with current recommendations on MI teaching that performance assessment by a skilled provider after the initial training is necessary for clinician skill development (Rouleau et al., 2015; VanBuskirk & Loebach Wetherell, 2014). MI unfolds in two distinct phases where the clinician uses OARS skills to help patients explore areas for change and then establishes goals consistent with patients' beliefs and capacity (Miller & Rollnick, 2013). The themes of engaging with patients and collaborating on change parallel these phases and show how students initially used OARS skills to "meet patients where they are at" and then worked collaboratively to tailor goals to the patients' unique context and ability. Authors highlight the relevance of MI "spirit," especially for clinicians who are more accustomed to adopting an expert stance when supporting patients with lifestyle change (Everett, Davidson, Sheerin, Salamonson, & DiGiacomo, 2008; Miller & Rollnick, 2013). Similarly, the students recognized an expert attitude disengaged patients and found when they used OARS skills to draw patients out there was opportunity for sharing mutual expertise. Addressing the complex interplay between patients' values, beliefs, and social practices involves a high degree of collaboration to tailor support to the patient's needs (Miller & Rollnick, 2013). Our research demonstrated that MI supports a student-patient collaborative partnership for exploring health behavior change and makes critical thinking visible. In addition, the experiences of learning MI transform students in their practice. We provide some recommendations for instructors interested in teaching MI and decision makers interested to incorporate MI in undergraduate nursing education.

## Recommendations

In this research, students identified feedback as instrumental in their formation as proficient nurses in MI, and feedback had a significant role in helping students to adapt the skills to fit their unique style. Verbal feedback should occur immediately after the patient encounter; an instructor who interrupts to give correction potentially

creates disruption (Beukes & Nolte, 2013). Both instructors in this research study accompanied students as they used MI and provided feedback immediately following unless the student invited feedback concurrent to patient care. Instructors should provide feedback that is relevant to the student, linked to behavior, and associated with the student–patient collaborative process because this is easiest for students to assimilate (Plank, Dixon, & Ward, 2014). A feedback session is an opportunity to engage the student in self-reflection and target specific areas for reinforcement and modification.

In this research, there appeared to be something reinforcing the students' view of themselves as "experts," and this served neither the aims of conversations about health behavior change nor the purposes of a collaborative nurse–patient relationship. Our observation may be isolated to the present research context; however, we advise instructors to be alert to practices embedded in nursing education programs that reinforce an expert stance because this could undermine the collaborative spirit of MI.

Based on our research, it is feasible for nursing students to learn MI, and the best timing for learning MI is when students are proficient with basic communication skills, comfortable in their clinical knowledge to support patient problem solving, and in a clinical course that gives them opportunity to practice techniques with real patients. The clinical setting is an ideal place to develop MI proficiency (Miller & Rollnick, 2013) and critical thinking skills because direct patient care supports application and transfer of knowledge from an abstract theoretical level to a unique situation (Brunt, 2005). MI involves a high degree of interaction and an ability to tailor support to the patient's needs. These conditions are best suited to a clinical placement at a time in the student's program when he or she has sufficient knowledge, skill, and experience to exercise critical thinking. We recommend that MI be part of nursing education and that instructors introduce MI to support integration of critical thinking into patient communication.

## Limitations

The findings are unique to the research context because of the synergies among participants and setting such that the account may vary when different instructors teach MI or apply it in alternate clinical placements. The addition of another setting and a different group of nursing students at a similar point in their studies could strengthen the research findings. In our study, nursing students used MI with a population of patients who agreed to receive support from nursing students on health-promoting behaviors that would reduce vascular

risk. The interest on the part of our patient participants to help students with learning MI or the nature of behavior change associated with risk reduction and health promotion may have positively influenced the students' experiences with learning a complex relational skill. Using MI for chronic illness management, for example, requires supporting a patient to address multiple behaviors over the course of a lifetime; some behaviors are pleasurable and not perceived as problematic (Everett et al., 2008; VanBuskirk & Loebach Wetherell, 2014). Therefore, further research is needed on how undergraduate students use MI in more complex clinical situations.

## Conclusions

This study identified that students can learn and apply MI to evoke problem solving around health-promoting behaviors and support patients to explore change. The spirit of MI is a process of formation where students require targeted feedback on their ability to connect meaningfully with the patient and work collaboratively as partners. The exposure to MI as part of a collaborative partnership in undergraduate education is an opportunity to embed this relational style into routine nursing care. Because of learning MI, students experienced a deep transformation in themselves and their nursing practice. Furthermore, MI, as part of a collaborative partnership, contributes to meaningful nurse–patient encounters that enhance patient capacity for problem solving.

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### Clinical Resources

- California Healthcare Foundation. Video with techniques: <http://www.chcf.org/publications/2006/08/video-with-techniques-for-effective-patient-selfmanagement>
- Heart and Stroke Foundation (Ontario). Counselling tips for motivational interviewing: <http://www.heartands.on.ca/atf/cf/%7B33C6FA68-B56B-4760-ABC6-D85B2D02EE71%7D/HSFBLP%20counselling%20tips%20for%20web.pdf>



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