

BEING AND BECOMING AN EXEMPLARY  
NURSE -  
AN AUTHENTIC JOURNEY

By

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## **ABSTRACT**

### **BEING AND BECOMING AN EXEMPLARY NURSE – AN AUTHENTIC JOURNEY**

The aims of this study were to illuminate the joint constructions of exemplary nurses and their lived experiences of being and becoming one. Inherent in being ‘exemplary’ was the notion of ‘becoming’, which involved the integration of knowledge and experiences through reflecting on the day-to-day of ‘being a nurse’. Being exemplary was not about perfection but learning from every experience and integrating these into becoming.

To elucidate these phenomena, I developed a creative qualitative and participatory method informed by Guba and Lincoln’s Constructivist, and van Manen’s Human Science Approaches, underpinned by Glaser’s Emergent Philosophy.

Ten exemplary nurses were recruited and interviewed three times. They also provided supplementary data such as photos, poetry and writings. This interview data was transcribed and imported into the computer programme QSR NVivo. This programme allowed for management of the raw data and facilitated coding and categorising, while remaining grounded in the whole text and its meanings. Analysis occurred through first and second level categorising and the use of writing as method. Writing became a way of knowing – assisting discovery and allowing reflection on the data in order to connect the categories and themes together in a coherent and workable whole.

The above method led to the following emergent findings. The pivotal construct was Authentic Being, through living a reflective life, surrounded by the major constructs of Love of Nursing, Making a Difference, Critical Friends, Walking the Talk and Backpack patients.

These constructs directed a specific and comprehensive review of both the philosophical and nursing literature. This review was not used to expand or enlarge the findings but to enlighten, illuminate and clarify. Significant philosophical ideas were extended, developed and synthesised with the findings. Noteworthy was the expansion of Heidegger’s notion of B/being: where capitalisation denotes essence and lower case symbolises the verb – to be. The use of B/being represents the merging of a person’s essence and being into one. The notion of B/being and B/becoming through time – specifically human-lived-time was also important. B/being and B/becoming exemplary was an authentic embodiment of being self with being with others – a true holistic B/being-in-the-world.

The purposeful review of significant nursing theorists and the general nursing literature demonstrated that this study's participants had attributes and skills comparable to those described and 'called' for. In addition, this study's participants often went further than these descriptions, and demonstrated and exemplified a true holistic B/being – where they were more than the sum of their parts and integrated all aspects of themselves through critical reflection in order to B/be and B/become.

Through synthesis of this knowledge a definition of B/being and B/being an Exemplary Nurse was developed - *Exemplary nurses authentically embody being themselves – with being with others – they are B/being-in-the-world. Situated in human-lived-time they use experiences carried in their backpacks to actively 'Be' who they want to 'Become'. At the spiralling intersection between past and future they use their love of nursing and critical friends to make a difference for those they care for and to walk the talk with their colleagues.*

The new knowledge that emerged from this research has profound implications for everyday nursing practice, undergraduate and post graduate nursing education, and for Charge Nurses and Senior Nurses, who are of vital importance as role models, mentors and critical friends. The results are significant and are important for nurses and the nursing profession and contribute to, and, advance nursing knowledge.

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## **PROLOGUE**

In this prologue I introduce the use of the Fern/Koru metaphor and describe its appropriateness for this study. I then give an overview of the thesis and explain what to expect when reading it. Finally I describe how the reader should navigate through the thesis - explicating the different fonts used to designate different voices and giving an overview of each thesis chapter.

### **THE KORU/FERN METAPHOR**

Throughout this project I have used metaphor to connect and link the thesis together. The word metaphor comes from the Greek word “*metaphora*”, which is derived from “*meta*” which means ‘over’ and “*pherein*” which means ‘to carry’ (Hawkes, 1972, p. 1). It denotes a linguistic process where aspects of one object are carried over to another, so that the second object is articulated as it were the first - this being a type of figurative language (Hawkes, 1972). The use of metaphor calls forth a comparison of two objects which provides a tangible way of seeing something that was less clear by linking it to something that is more familiar (Cooper, 1986). In this way, metaphor can provide new meaning, understandings and insight about a phenomenon (Hartrick & Schreiber, 1998). Hawkes described the use of metaphor throughout the ages and said:

*The effect of metaphor ‘properly’ used is that by combining the familiar with the unfamiliar, it adds charm, and distinction, to clarity. Clarity comes from familiar ‘everyday words’, the ‘proper or regular class’ of terms used by everybody in conversation. Charm comes from the intellectual pleasure afforded by the new resemblances noted in the metaphor, distinction from the surprising nature of some of the resemblances discerned.* (Hawkes, 1972, p. 9).

In this thesis I have used metaphor from the New Zealand (NZ) bush. In particular, I use the NZ Native Silver Fern (see Figure 1) and its visual symbol - the Koru (see Figure 2), to weave the chapters and the concepts I present throughout this thesis into a cohesive whole.

The choice of this metaphor has come from multiple sources. Primarily, the Koru/Fern represents the background and culture of this study – nursing in Aotearoa<sup>1</sup> NZ. The Silver Tree Fern, or ponga (punga) in Maori language, is endemic to NZ and grows in

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<sup>1</sup> Aotearoa is the Maori name for New Zealand. Translated from the Maori it means ‘Land of the Long White Cloud’ and refers to the first Maori seeing cloud above a landmass which would be subsequently called (by later Europeans) New Zealand.

many areas of native bush throughout the country (Baggins & Large, 2004). The Fern is of vital symbolic importance, as both a cultural icon and symbol to the NZ Maori<sup>2</sup>. For Maori, the spiralled scroll shaped Koru is the name given to the unfurling fern frond and symbolises unfolding new life, growth, renewal, strength and peace. It is an integral symbol in Maori carving and tattoos. The Silver Fern is widely representative of New Zealand and is the emblem for many of its cultural and sporting activities. The Fern is widely incorporated in most NZ Army Unit badges and insignia; the Koru shape is the symbol of the national airline carrier - Air New Zealand and it has been suggested as the most appropriate replacement as the emblem for the NZ Flag if we become a republic. In sports, the Fern is the logo embroidered on the rugby jerseys of the All Blacks – New Zealand's Rugby Union Team and the Silver Ferns is the name of the NZ Netball Team.



**FIGURE 1: NZ Native Silver Fern**



**FIGURE 2: Symbol of Koru**

It was the unexpected and surprising recurrence of the spiralling shape of the Koru that kept entering my consciousness throughout this research journey. It made me want to utilise it to clarify and illuminate the different parts that made up both the research process and the thesis as a whole. The Koru is reflective of the following aspects of this study:

- Before the thesis began the ‘unknowing’ of my research journey reminded me of a furled Fern with multiple, yet to be identified, concepts (fronds) curled up inside waiting to emerge and explicate themselves to the world.
- A Fern with multiple curled fronds (pinnae) could be compared to the one metaphorical journey the ten participants are taking in Being and Becoming an Exemplary Nurse. Ten multiple smaller sub-fronds curled inside are the different

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<sup>2</sup> Maori are the indigenous people of NZ. Maori means ‘normal’ or ‘ordinary’ in Maori language and denotes mortal being as distinct from the Gods. Maori often refer themselves as ‘tangata whenua’ (people of the land) to emphasise their indigenous status.

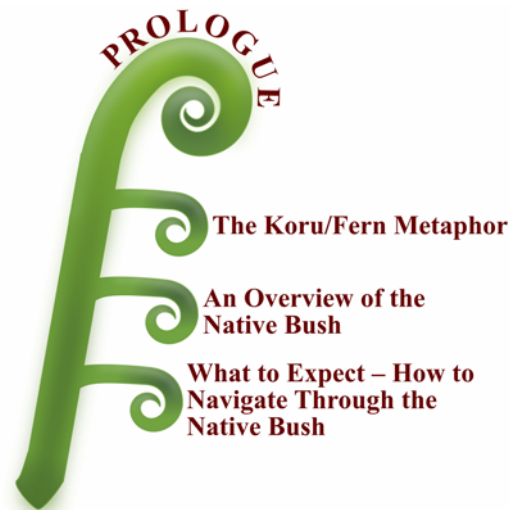
participants - curled up inside and ready to unfurl and share their different stories of Being and Becoming.

- Each participant can also be described as a separate Fern. Their stem, an 'integrated and Authentic Being' linking everything together, with each lateral spiraling frond symbolising their experiences and practices that informed and influenced their 'Becoming'. Each lateral frond or spiraling pinnae curves back by a continuous process of reflection, learning and action. This in turn is integrated into the Being of the participants – into their journey of Being and Becoming an Exemplary Nurse.
- The divided pinnae act as mirrors for all the participants, they are like fractals, symbolising their individual experiences, all slightly different yet the same. Each Fern leaf is distinctive and slightly different, having both furled and unfurled fronds. These symbolise each participant presenting a different life, a different story, a different journey. Yet they all have similarities that connect their experiences. At times, the fronds stretch out as the participants move along their journey quickly, reflecting and making sense of their experiences with ease. While at other times, the fronds spiral tightly as the participants grapple with complicated issues.
- On reviewing my research journals, I had scribbled Koru and spirals in the margins and pages during many interview sessions to acknowledge the participants rotating their hands while talking to me or the spiralling nature of their stories. I also had drawn a series of Koru in my research journal to illustrate the participants' abilities to reflect and learn from their experiences in a spiraling fashion as they moved forward in their journey of becoming.
- Later as my research progressed many of my mind maps and conceptual models followed a spiralling Koru shape.

Additionally, the Graduate School of Nursing and Midwifery at Victoria University has a stunning 'native garden' with mature Ferns surrounding it. At my first residential school I was captivated by them and took numerous photographs of them (which I use for the bookmark, Figure 1 and on the last page of this thesis). Astonishingly, I also found that two of my research journals had Koru, Ferns or spiralling shapes etched or illustrated on their covers.

I believe the Koru/Fern metaphor has charm, distinction and provides a congruent clarity to this thesis. Therefore it has been used throughout the thesis to illustrate the

thesis as a whole and to demarcate each chapter. As a curled Fern, each stratum unfurls into the separate fronds to illustrate the findings and the discussions emerged within. Each unfurling explicating more and more of the thesis – more of Being and Becoming an Exemplary Nurse. As an example, Figure 3 depicts the use of the Koru to denote the chapter heading and sub sections of this Prologue.



**FIGURE 3: Koru Depicting Prologue**

### **AN OVERVIEW OF THE NATIVE BUSH**

This thesis presents the joint constructions/lived experiences of ten women as they were, are and continue to be and become exemplary nurses. They are all individuals and their stories are different and yet they are all alike. Like the Fern, they have all emerged from a tightly furled Koru. This thesis is a story of their emerging lives and their emerging Being. It is their stories so far, yet it also remains alive with their future Being and Becomings. It is not a static story in time and place but a fluid interweaving of past, present and future Being and practice by nurses who are on a journey of Becoming.

It is also a story of you the reader and me as the storyteller. For those of you who are not nurses or are unfamiliar with nursing, it allows you to enter this amazing world. You will read stories that will make you laugh and make you cry and you will enter the privileged world of sharing patients' lives. For those of you that are nurses, this thesis is a celebration. I want you to feel hope and joy as you celebrate and acknowledge the stories and experiences of these exemplary nurses – and I want you to see yourselves in their stories and the potential of yourselves in their B/being and B/becoming.

## **WHAT TO EXPECT – HOW TO NAVIGATE THROUGH THE NATIVE BUSH**

My methodology and my own ‘Being’, led me to write this thesis in a particular way. While I have relied on the conventional thesis approach of argument, illustration, integration of theory and literature, conclusions, limitations and future work, I have also swayed from the more traditional ‘urban path’ – out into the ‘trails in the native bush’. A thesis, because it is in written form, is laid out to be read in a linear manner; therefore it is important for the reader to note the spiralling and circuitous nature of this research as a whole. Most importantly, this research followed an emergent design which meant that it was essential to limit the literature review at the beginning of the study. While a small literature review was carried out before the study commenced, restricting this stage allowed the findings to ‘emerge’ from the participants’ data and be ‘grounded’ in their stories. These findings were then used to direct a deeper literature review which is discussed and synthesised with the study findings. Therefore in this thesis the findings (Chapter 4) are presented before the literature review chapters (Chapters 5 & 6).

The use of capitalisation, **bold** text and ‘single quotation marks’ have been used throughout this thesis to highlight the use of significant words. In particular it is important to note the capitalisation of the word Being. This notion has been drawn from Heidegger’s work, *Being and Time* (1962) and in this thesis is used to denote a person’s essence – their Being. This is different from the simple verb ‘to be’ something, for example, to be or become an exemplary nurse, which is symbolised by using lower case. When I wish to represent both essence and existence I use both lower and upper case, for example, B/being.

There are eight chapters in this thesis. Each chapter and subsequent sub-section, addresses a different element of this research project. I have written it mainly in the past tense, although direct quotes from the participants are in the present tense as they were spoken during the interviews. These participant quotes have been minimally edited for grammar and punctuation and to aid clarity and ease of reading, with the use of an ellipsis (...) to denote text that has been omitted in order to facilitate meaning. To illustrate the different voices that make up this thesis, I have used different fonts<sup>3</sup>. The text of this thesis itself is in - Times New Roman 12pt. Quotes from other authors are

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<sup>3</sup> A Bookmark has been placed in the inside flap of this thesis - for assistance in identifying the different voices.

recognised by the use of - *Times New Roman 12pt, in italics*. I am identified in the thesis by the use of - *Bradley Hand ITC in 12 pt*. Study participants are recognised by using - *Tahoma 11pt, in italics*. The different participant's quotes are identified by recoding their name and a string of numbers, separated by commas in brackets after each quote. The first numbers are either – 1<sup>st</sup>, 2<sup>nd</sup> or 3<sup>rd</sup> and describe which interview sequence the quote came from. Other letters that are used to identify a participant's quote are – 'AD' which represents the 'Associated Documents' that the particular participants provided, or 'PTTC' which denotes the 'Participants Thoughts on Thesis Chapter/being in the study'. The second set of numbers is the section of transcript the quote is from and the third set depicts the sentence numbers from the original transcript. For e.g. (Ellen, 1<sup>st</sup>, 0, 274-284) represents Ellen's quote from her 1<sup>st</sup> interview, in the first section and encompassing sentence number 274 to 284. Selected poetry from the participants is recorded in *Arial 11pt, italics*.

In this Prologue I have given an introduction to the use of the Koru/Fern metaphor and outlined the layout of the thesis and how to navigate through it.

In Chapter 1, I provide an introduction to myself and this study. Background information is given on why I chose to do this particular research and what it means to me. I then explain how my research topic was chosen and how I reached a decision about the best way to research it. I also describe how my journey meandered before I found the correct path through the forest to the open clearing. In this chapter I introduce the qualitative methods that inform this study – that of the Constructivist and Human Science and their underpinning by an Emergent philosophy.

In Chapter 2, I further describe the methodological/paradigmatic underpinning of this study and the research design and processes undertaken. Initially, I describe the ontological, epistemological and methodological aspects of this study and the use of the qualitative methodology. Subsequently I discuss the research design including the application for ethical approval. I then introduce the participants and their selection methods followed by a description of the procedures used to collect the data.

In Chapter 3, I present the processes undertaken to analyse the several hundred pages of data from the study, including the use of NVivo a computer programme which assisted coding and the use of writing as a form of research. I also present a discussion on

negotiated outcomes and the reporting of the research findings, including issues of voice.

In Chapter 4 the Koru is unfurled and the findings of the study are presented. This chapter illustrates the journey that is Being and Becoming an Exemplary Nurse. The primary construct within this journey - is Being and Becoming 'Authentic' through living reflective lives. This concept is related to their love of nursing; making a difference; critical friends; walking the talk; and their use of backpack patients – in both a personal and social way.

Chapter 5 presents a review of the relevant literature related to the philosophical concepts of Being and Becoming and the core finding Authenticity. I describe the dictionary definitions of these terms and discuss specific ideas that make up these concepts including; social consciousness versus personal consciousness; consciousness to action; self and story; self-reflection; and temporality – being and time.

In Chapter 6, I present an extensive review of the nursing literature, including description and discussion of several nurse theorists' views, related to exemplary nursing and Being and Becoming.

In Chapter 7, I discuss and synthesise the findings (Chapter 4) with knowledge that illuminated and clarified these findings from Chapters 5 and 6. In this chapter I present my theorising about B/being and B/becoming an Exemplary Nurse and its interrelationship with Authenticity.

In Chapter 8, I present my concluding comments. Here I offer some reflections on the research journey and reveal my beliefs, reservations and limitations of this study. I also note the implications of the findings for nurses and the nursing profession and offer ideas for further research.

Wanting to research and find out what makes nurses the way they are has always been an interest of mine. In Chapter 1, I explicate this in greater depth and share my personal journey of coming to this research project and how I navigated my way through the native bush to the path (method) that would eventually guide me to the Fern in the clearing.

## CHAPTER 1

### INTRODUCTION TO SELF AND STUDY



#### IN THE BEGINNING – WALKING IN THE NATIVE BUSH

I had multiple reasons for undertaking this PhD. I wanted to give something back to the nursing profession – the love of my working life; make nurses feel proud and happy to acknowledge their expertness and exemplariness;

explicate to the lay person the ‘specialness’ of these exemplary nurses; and keep my passion for nursing alive while I took time out to care for, and bring up my young family. Many researchers believe that the choice of research question is pivotal. Stating that to ‘live’, ‘become’, and ‘research’ something that comes from our hearts, is the only way we can truly question and reveal its essence (Gadamer, 1975). Binswanger (1963) has said that you can only understand something or someone for whom you care, stating that to know another human being *“one learns to know only what one loves, and the deeper and fuller the knowledge is to be, the more powerful and vivid must be the love, indeed the passion”* (p. 83). I love nursing and have done so from the first moment I stepped outside the classroom and into the wards. I went nursing for all the wrong reasons yet I took to it naturally - it was just meant to be. While my career was not without its challenges, I could always say to myself that the patients I cared for were always getting the best that I could give them. In addition, while I was caring for them, I was always happy, fulfilled and felt privileged to care. Nursing was both my passion and my love and until my family was born, it was the major part of my life. And indeed, it still is a large part – as can one ever stop being a nurse? I don’t think you can. My thesis explicates this idea in part but also illuminates much more.

#### **The Horticulturalist**

I am a major part of this thesis, as I am the instrument of data collection, analysis and presentation. I am like the ‘propagator’ – the ‘gardener’ and the ‘flower arranger’ -



choosing which fern to grow, then which pieces to prune or cut and which parts to exhibit - choosing how exactly they should be arranged and presented. This thesis undertaking has allowed me to pursue my passion for nursing and has illuminated my own Being and Becoming. It has been a journey of enlightenment, as many times I have seen my own reflections in the raindrops nestled between the fronds. It has allowed me to contemplate my own life story and see myself as I learnt and grew through both my life so far and also throughout the thesis journey itself.

## **Reflections in a Raindrop**

It is an interesting experience to look at oneself as a reflection. You see yourself as only you can see yourself – as a mirror image. You do not see yourself as others see you, but only a very good likeness. Working on this project has also been like looking at my reflection in a raindrop, as I have seen many similarities of myself in the different stories of the participants. As I became more involved with the thesis I found it more difficult to visualise what was the true image and what was the reflection. I have often asked the question of myself: Is my ‘Being’ reflective of the participants or is it their experiences that are similar to mine? As the reflections in the ‘raindrops’ became stronger I looked deeper into my own ‘Being’. I took several wonderful months ‘out’ to just think about myself and my life. I quickly realised that my whole existence so far has been one of a journey of ‘becoming’. I have continually striven to become a better person, wife, mother, sister, daughter, friend ... and nurse. It is what drives me. I continually reflect on my interactions with others, review them, examine them and either feel satisfied with the outcome or make amends to ratify them. And that practice of reflecting on myself in that metaphorical mirror is the core to my own ‘Being’ and therefore my own ‘becoming’. However, I have not used my own data for the study as I parallel van Manens’ (1990) thoughts when he stated, *“My own life experiences are immediately accessible to me in a way that no one else’s are. However the phenomenologist does not want to trouble the reader with purely autobiographical facticities of one’s life”* (p. 54). Instead this personal knowledge was used to enhance my understanding of the participants’ own feelings and stories and was particularly useful in discovering patterns and meanings in their data.

I also revisited my past written and artistic works to determine whether they could be relevant to this journey of self-discovery. I reviewed several relevant papers, poems and artworks that I had done previous to this project. These included my ‘Personal

Philosophy of Nursing Practice’ and its associated poem and painting (refer Appendix 1.0) written during my Post Graduate Certificate in Arts (Applied) in 1999; a piece called ‘Exemplary’ Nurses – an exploration of the phenomenon’, that I later re-wrote to be published in the nursing journal - Nursing Praxis in New Zealand (Noble-Adams, 2001) and ‘My Story’, a piece of biographical work written as my PhD commenced. On reading my philosophy of nursing paper, it is interesting to note that my beliefs are still similar. I have had the privilege of being invited for the past five years to present this work and its associated poem and painting to a group of students on their Palliative Care Course (Victoria University/Whitireia Polytechnic). Each year that I have presented it, I have reaffirmed what is important to me and my practice. The only concern that reviewing it has raised, is that of my initial non-concurrence with Watson’s Theory of Nursing (Watson, 1988). This changed having read her later treatise (Watson, 1999). I now understood her stance much better and realised that she was not excluding the physical at all but going beyond it, towards a more metaphysical, postmodern position that indeed works as a mirror itself for the participants in our study in many ways. This change in perspective and understanding occurred by having the privilege of attending one of Jean’s postmodern workshops in November 2000. I remember talking to her about my thesis ideas, (having not interviewed my participants at that time), and stating that I wondered if my participants could be her ‘ontological architects’ that she believed nursing needed to strive for to take ourselves into the postmodern era. This notion will be discussed further in Chapter 6.

As mentioned, before I started my interviews, I wrote ‘My Story’. I did this to get out ‘my’ life story so that I could listen to others without wanting to interrupt them and talk about my own similar experiences. This was an interesting process and brought up a number of issues. While it was in one way cathartic to write my life story it did cause me some un-ease. Primarily this dealt with working with other nurses. I was often very quick in my judgment and expected colleagues to work with the same amount of commitment and expertness that I placed on caring for my patients. I was also very honest and assertive which did not always bode well when working with more senior staff. However, the other major factor was that I always had amazing relationships with my patients and despite conflicts that may have occurred with colleagues, this never stopped me from bouncing back and giving my all to caring for the patients. And what amazing patient stories I remembered! I had been very privileged to work with and care for so many remarkable people throughout my career. I realised that caring for them

was the reason I continued nursing and the reason why I loved it. Each story had taught me so much and I carried them with me, in what I called my ‘patient backpack’<sup>4</sup> – a mental library of the influential encounters and interactions I had experienced with patients.

It is a difficult moment when one must stop and look deeply at your reflection and say to the self - “*I am one too - I am Being and Becoming an Exemplary Nurse*”. However, I didn’t like to use the term ‘exemplary’ nurse to describe myself, as it conjured up an image of being better than other nurses. It was a term that invoked descriptions of being excellent, and setting a good example (Sykes, 1982) but also of being “*match-less, peer-less, saintly*”, and even “*godlike*” (Roget, 1972, p. 216). I believe nobody can be perfect and that nobody would want to be perfect - for to be perfect one would have learnt everything, there would be no challenges and no rewards, as one would ‘have’ and ‘know’ everything. If being exemplary was a trait that could possibly be achieved it would take a very long time. For myself - ‘being exemplary’ is an aspiration. I have been exemplary in specific situations in the past, and will be exemplary in time to come. But these are moments in time, reflections of self, situated in a life that is evolving and fluid. By continuing to reflect on my ‘B/being’ and my relationships with others, and learning from these experiences to improve myself, I too will continue the journey of ‘B/becoming’ an exemplary nurse.

## **WHICH FERN TO CHOOSE**

The idea for my thesis topic is distilled from many years of nursing. I wanted to do something concerned with nurses themselves because I had an interest in wanting to know what made nurses the way they were - how they got to where they were and what kept them going.

Initially I wanted to look at something to do with cancer/palliative care nurses as this was ‘my’ field of expertise. It had been my major clinical focus for most of the years since I had graduated from nursing school in 1986. I had also spent three years working in two of the world’s most foremost cancer hospitals in England and at the same time completed a BSc (Hons) majoring in Oncology Nursing from The Royal Marsden Hospital/Manchester University. I loved this area of nursing and I believed these nurses

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<sup>4</sup> The ‘Backpack’ was a metaphorical device I had used all of my practice life to describe the patients I remembered and ‘carried’ with me.

were in a group of their own and had special skills and attributes. This, I ‘knew’ from both my own extensive clinical experience and my knowledge of the cancer/palliative care nursing literature. I believed that these nurses had chosen their specialty because they knew they could talk about cancer and the issues of death and dying with their patients/families - they felt comfortable working in this area and their care of these people came naturally. At this stage my thesis topic would be something about cancer/palliative care nurses and being special.

However after I returned from England to New Zealand, my clinical focus changed to that of being a Clinical Nurse Specialist in a Gynaecology Unit. It was here that I saw other nurses with just as much passion for their job as my cancer nurse colleagues. I vividly remember coming to work one day and while on my ‘rounds’, visiting patients and catching up on the last 16 hours of their hospitalisation, I observed a colleague interacting with a young woman who had just miscarried her 19 week old ‘baby’ during the night. While I sat there putting across a brave face, nodding and gesturing in a supportive way, inside I was struck with grief and sadness. I felt uncomfortable and ill at ease in the situation. My colleague on the other hand, naturally talked to this woman about her loss. On reflection of this episode I realised that my colleagues in the Gynaecology Unit had ‘special’ attributes related to their own specialty. For this nurse it wasn’t a burden or a challenge to talk and care for women who had miscarried. She had an affinity for her specialty just like I had an affinity to cancer nursing. I then started to think about other specialties and what special attributes these nurses might have with their patients. Did nurses working in the Burns Unit feel as comfortable working with horrifically scarred individuals as the nurse in the Spinal Unit supporting those who would never walk again, or as the ophthalmic nurses dealing with patients who became blind? I now realised that all nurses had the potential to be special. So my focus shifted to ‘special nurses’. As I thought about the title, I realised that ‘special’ did not encompass all the attributes that the nurse may have. I spent time pondering other labels including ‘passion’ and ‘energy’. In the end I came up with the word ‘exemplary’, meaning the best example. But what did I want to find out? Was it their lived experiences I wanted to know about? or the narratives of their life stories? Did their childhoods, their families or their nursing training have any impact? In the end I decided I wanted to know as much as possible - so my first working title was; ‘The X Factors – Being and Becoming an Exemplary Nurse’.

## **HOW BEST TO PROPAGATE THE FERN?**

My choice of research paradigm was always qualitative as I believed this was the only way I could truly get to understand, in the exemplary nurses' own words, what the X Factors and Being and Becoming was all about. However the question I chose needed to suit the methodology. As van Manen says there are many research methods available to choose and each method is a way of investigating a certain kind of question. What is important is "*the questions themselves and the way one understands the questions...not the method as such...so there exists a certain dialectic between question and method*". (van Manen, 1990, p. 2).

### **Lost in the Bush**

During the preparatory phase of this research I gave serious consideration to five different research methods.

As previously stated, before I commenced my PhD proper I completed a Certificate in Arts (Applied). During this time I wrote an assignment based on three methodologies that may suit a research project (at that time) built around the experiences of cancer nurses. In this assignment I described and discussed the approaches of Ethnography, Hermeneutic Phenomenology and Grounded Theory. I quickly discarded Ethnography as a suitable method for my PhD project, as I did not want to observe the participants in their practice areas - rather I wanted to talk with them.

I liked van Manen's (1990) Phenomenological Human Science Approach, described as a study of the lifeworld as it is immediately experienced, rather than it being conceptualised and categorised. It aims at getting a better understanding of the nature and meaning of everyday experiences. Human Science was derived from Wilhelm Dilthey's contention that human (mental or social) phenomena differed from natural (physical or chemical), phenomena and therefore required interpretation rather than external observation or explanation (Dilthey, 1987). Using van Manen's Phenomenology to undertake this research would describe the way exemplary nurses experienced the world. It would not present a theory, but could communicate conceivable insights into the participants' way of Being, or as van Manen paraphrased it - "*a certain way of being in the world*" (van Manen, 1990, p. 39). However, as I entered my PhD journey (and where my study idea changed to the X Factors of Exemplary

Nurses) I became unsure of its suitability. At that time in my journey I didn't believe the 'lived experiences' of the participants would reveal the X Factors that I wanted to know about.

Grounded Theory had many attractive features which I believed could help me explicate a substantive theory and isolate a core category or basic social process of Being and Becoming an Exemplary Nurse (Glaser & Strauss, 1967). I read extensively around the subject and submitted my initial research proposal stating that I would use Glaser's Emergent Grounded Theory approach (Glaser, 1994). I really liked Glaser's approach as I could enter the study, ask the right questions and let the findings emerge from the ground up. I liked that there was structure to the method and this made me feel more comfortable and safe stepping out on such a big journey. I also believed that a study of exemplary nurses would illuminate a substantive theory that in time could be used to explicate a grand theory on exemplariness itself. However, as I read more about the methodology and discussed my ideas with critical friends, I came to the realisation that this method didn't quite match as neatly as I first thought. Could I really break down 'exemplary nurses' into one or more basic social processes? Was a Grounded Theory of this phenomenon possible? And was it able to illuminate all of the X factors? In the finish I decided that this method would narrow the findings too much as I wanted to find out the bigger picture. I wanted to know their life stories and their X Factors - I wanted to know about their Being **and** their Becoming.

Following participation at my first resident PhD school, it was suggested that Narrative Inquiry into their life stories could be a possible path to elucidate the X Factors of exemplary nurses. I went back to the books and read widely on the topic of Narrative Inquiry. Many aspects of these approaches felt right but I was uncertain about its 'looseness', as I couldn't find the structure in its method that I required at that time in my journey. One approach was better than the others and had been described by Barbara Pamphilon as the "*Zoom Model: a dynamic framework for the analysis of life histories*" (Pamphilon 1999, p. 393). At this stage I felt it had a better fit for my study. I could look at the life story narratives of the participants, illuminating how their lives had impinged on their 'becoming' exemplary from a very micro level through to a meso and macro level, to reveal the X Factors I was looking for. Despite this, I was unsure if it could answer all the 'Being' aspects. As a compromise, I decided to undertake the study being 'informed' by both Glaser's Emergent Grounded Theory (Glaser, 1992) and the

Zoom Model (Pamphilon, 1999). Accordingly, my first ethics application had these approaches as my methodological framework.

However, during my second PhD school I was introduced by another student to the Constructivist Approach (Lincoln & Guba, 1985). As I listened to my colleague briefly outline the method, as a prerequisite to the presentation of her completed PhD project, I felt it related closely to many of the aspects I liked in both Grounded Theory and Narrative. Back to the books I went and after reading about Naturalistic Inquiry, later re-coined the Constructivist Approach (Guba & Lincoln, 1989; Lincoln & Guba, 1985), I discovered that this approach was a better match with my study question than the previous methods (from both a paradigmatic and a methodological point of view). I believed as a basic framework to start my thesis it would work well as it used the ‘constant comparative method’ as espoused by Glaser and Strauss (1967) and utilised many tenants of the Narrative Approach I also liked, such as utilising story (Clandinin & Connelly, 2000; Pamphilon, 1999). Story, while not stated as a component in a Constructivist Inquiry, is congruent with the beliefs inherent in the approach and was a comfortable way for the participants to tell me about Being and Becoming an Exemplary Nurse.

### **Settling on One Species**

Guba and Lincoln (1989) describe the Constructivist Approach as one which takes the position that the findings are not descriptions of the way things really are or really work but instead represent the meaningful constructions that the participants have formed – in this case - on Being and Becoming Exemplary Nurses. The findings are created through an interactive process that includes me as the researcher and what emerges from this process are our joint constructions. This is achieved through “*negotiation*” where the participants and I “*make sense*” of the data together (Guba & Lincoln, 1989, p. 8). It supports the use of the participants’ voices. It is an approach that recognises that people make sense of their situations through constructions that are shaped by their values. These values are linked to their particular physical, psychological, social and cultural contexts. Since the participants share part of the same contexts, for example nursing training and work experiences - shared constructions may emerge over time. These joint construction consenses do not imply a greater degree of reality or truth, only that the participants (in agreement) have come to share a construction that has a reality for them.

Truth becomes the best-informed construction on which there is consensus at a given time.

## **The Bush Opens Up to a Clearing**

These Constructivist ideas all made sense to me and therefore I changed my Research Proposal and Participant Information sheets to include the Constructivist Approach and returned these to the Victoria University Ethics Committee where they were accepted with the new changes. At this stage, I was ready to undertake my PhD currently titled: 'Being and Becoming an Exemplary Nurse' - as I had decided that the X Factors were not a necessary element in the PhD title as these would emerge through the research process. I also had a methodology and method with a good structure and framework to support me on my way. However, what was to occur through the research process was not exactly as I planned. As the thesis journey progressed I was supported by my critical friends to let more of my intuition guide me and to 'trust the process'. While the Constructivist Approach seemed to be the way to go initially – I found as I progressed through the study, that I started to diverge from the plan. What occurred was that I followed my own instincts - doing the things that felt right and natural to me. That's not to say that the words and readings of all the theorists and researchers that I had read so far on my journey were not an unconscious part of my thinking, nor that I was haphazard and without rigor, only that I let the process guide **me**.

Like many authors, including Janesick (1994), Schwandt (1994) and van Manen (1990), I believe there are times when there is no one best system for analysis and ultimately the decision lies with the researcher who must find both a coherent method that suits the purpose of the study and the most successful way to tell the story to the reader. Janesick states the best way to do this is to stay close to the data. She believes the purpose of qualitative research is to produce findings and the methods and strategies to do this should not become means in themselves. She thinks that there is often danger in becoming so preoccupied with the methods that the findings are hidden. She calls this *"methodolatry, a combination of method and idolatry ...a preoccupation with selecting and defending methods to the exclusion of the actual substance of the story being told"* (Janesick, 1994, p. 215).



For me, the most important feature was to construct findings that were grounded in the participants' data. Therefore in this study I have taken the tenets of three very similar methods that were applicable to my research question, expanded and used them to inform this study. I have used the 'emergence' ideas philosophised by Glaser (1992) throughout the study, based the coding of the data on Guba and Lincoln's (1989) Constructive Approach which mirror Glaser's (1978) 'open and selective coding'. I have also used many of the strategies suggested by van Manen (1990) in his Human Science Approach - such as using writing as the method of analysis and letting the participants speak to the reader to present the findings. This use of writing is congruent with Guba and Lincoln (1989) 'creative writing' and Glaser's (1978) writing of theoretical memos. There were numerous other paradigmatic and methodological congruencies shared by these three approaches (see Table 1).

I have expanded and developed these three Approaches into a cohesive design and method in order to answer this particular study's question in an emergent way. Furthermore, I explicitly describe this study's data collection and analysis procedures without succumbing to either methodolatry (Janesick, 1994) or "*method slurring*" (Baker, Wuest & Stern, 1992, pg 1359) in Chapters 3 and 4 of this thesis.

CONGRUENCIES	CONSTRUCTIVIST APPROACH (Guba & Lincoln, 1989)	HUMAN SCIENCE APPROACH (van Manen, 1990)	EMERGENT PHILOSOPHY (Glaser, 1978)
<b>Naturalistic Paradigm</b>	These approaches share the goal of understanding the multifaceted world of lived experience, from the perspective of those living it		
<b>Ontology (Nature of reality)</b>	Realities are different for each participant but joint constructions are possible	Each persons experience and meaning is distinctive – interested in the ontological question of what is being?	Social/psychological realities of the processes at work in the situation being researched
<b>Epistemology (Relationship between participants and researcher)</b>	An interaction between the two – findings are created through negotiation	Research is a caring act – researcher is orientated to the participants and meaningful research requires full understanding and co-operation of the participants	Relationship with participants is to be open to emerging ideas
<b>Methodology (How the knowledge is found)</b>	Knowledge is elicited through dialogue and refined hermeneutically until substantial consensus occurred	Hermeneutic significance is placed on the participant's experiences and meaning is established	Emergent and grounded with the participants
<b>Setting</b>	Realities are wholes that cannot be fragmented for separate study – natural setting	Where the participants are naturally engaged in their world – natural setting	In the 'field' under study – natural setting
<b>Open and Emergent Research Question</b>	Research question left open as tentative ideas	Discovery orientated approach that does not have a pre-determined set of questions	Data emerges from the ground up without any preconceived questioning
<b>Participant Selection</b>	Initial selection – anyone that can illuminate knowledge – snowball selection	Those living the experience under study	Participants experiencing the social processes under investigation
	Selection stops with saturation of data	No single interpretation will ever exhaust the possibilities of another person's interpretation	Selection stops with saturation of data
<b>Role of the Researcher</b>	Not 'bracketed' – researcher is an intrinsic part of study - use of memos		
<b>Data Collection</b>	Qualitative data collection such as Interviews and any other method (such as associated documents from participants) that can illuminate knowledge		
<b>Analysis</b>	Inductive data analysis - unitising and categorising – Constant Comparative Method	Thematic analysis of 'seeing' meaning.	Substantive and theoretical coding - Constant Comparative Method
	Use of computer assisted coding (QSR NVivo)		
	Use of 'creative' writing	Writing as a 'method of inquiry'	Findings 'emerge' through the writing up of memos. Writing is part of the method
<b>Core Construct/ Category/ Universal Theme</b>	Themes emerge from the data One core category or basic social process	A universal theme is that which makes the phenomenon what it is and without which the phenomenon could not be what it is	Themes emerge from the data One core category or basic social process
<b>Reporting the Findings</b>	Use of participants' vignettes, exemplars, excerpts from interview transcripts – to present thick description and illustrate multiple realities		
<b>Rigor</b>	Trustworthiness Criteria - Credibility, Transferability, Dependability, Conformability	Rigor is defined through a courage and resolve to stand up for the findings uniqueness and significance	Usefulness of the findings – 'fit' and 'work'
	Validated by participants – member checking		

TABLE 1: Congruencies of Three Approaches That Inform This Study

In the following chapter, I describe the research process and design. Initially I discuss the metaphysical axioms of ontology, epistemology and methodology that underpin this research, including issues of qualitative design, natural setting, and the utilisation of tacit and intuitive knowledge. I then describe the ethical approval processes undertaken, before introducing the research participants and their selection methods. Finally, I describe the collection of participant data by the use of myself as the primary instrument of data collection, as I undertook three rounds of participant interviews and acquired associated written and photographic documents from the participants.

## **CHAPTER 2**

### **METHODOLOGY, STUDY DESIGN AND RESEARCH PROCESS**



In this chapter, I explicate the methodological and paradigmatic underpinning of this study and the research design and processes undertaken. To start, I describe the ontological, epistemological and methodological aspects of this study and the use of a qualitative methodology. Subsequently I discuss the research design including the application for ethical approval. I then introduce the participants and their selection methods followed by a description of the procedures used to collect the data.

### **METHODOLOGICAL UNDERPINNINGS**

This study has been informed by the Qualitative Methodologies of the Constructivist (Guba & Lincoln, 1989; Lincoln & Guba, 1985), and Human Science Approaches (van Manen, 1990). These approaches share the goal of understanding the multifaceted world of lived experience from the point of view of those who are living or who have lived it (Schwandt, 1994). Of primary concern are matters of Knowing and Being rather than method per se. Underpinning these two approaches I have used the ‘Emergence’ philosophy espoused by Glaser (1992) who believed data should emerge from the ground up without any preconceived questioning. This was echoed by van Manen (1990) who believed that Human Science is “*discovery orientated*” and a methodology “*that tries to ward off any tendency toward constructing a predetermined set of fixed procedures, techniques and concepts that would rule-govern the research project*” (p. 29). These three approaches are congruent and fit under the qualitative umbrella of the

Naturalist/Constructivist Paradigm (Guba & Lincoln, 1989). A paradigm may be perceived as a set of basic beliefs or metaphysics that defines the way people view the world, the individuals place in it and the relationships that co-exist within it (Lincoln & Guba, 1985). Paradigms are based on a set of assumptions that help shape the form and purpose of the study and provide the means through which the study is interpreted.

## **Questions on Metaphysics**

Metaphysical beliefs are part of a paradigm of what we think about the world, including the actions we take as researchers. These metaphysical ideas give us some judgment about the nature of reality along with a method for finding out what can be found and include the axioms of ontology, epistemology and methodology (Reece, 1980). Axioms may be defined as the set of ‘basic beliefs’ that have been accepted by some convention or established as building blocks of some conceptual or theoretical structure or system (Lincoln & Guba, 1985).

### **Axiom 1: The Nature of Reality (Ontology)**

Humans have long been interested in their own reality and existence in the world and consequently their relationship with other people and things that exist in it. The quest to find answers related to how people live in the world and make sense of their existence as beings is the realm of ontology. In regard to this study, it is a core principle that each of the participants has their own reality about B/being and B/becoming an Exemplary Nurse. Each of these realities has been constructed by various influences over time and these *“realities exist in the form of multiple, mental constructions, socially and experientially based, local and specific, dependent for their form and content on the persons who hold them”* (Guba, 1990, p. 27). The participants piece together and build constructions of what they have experienced and no particular participant’s construction is ‘better’ or ‘more true’ than another’s. Constructions are meaningful to the participant who holds them and there is never one ‘correct’ construction of reality. These realities may be different for each participant but similarities and joint constructions may be possible.

Time becomes a context to these constructions as it can affect remembering, recalling and the telling of stories and new experiences are continually occurring which may affect the memory. van Manen (1990) also believed that:

*Experiential accounts or lived-experience descriptions – whether caught in oral or in written discourse – are never identical to lived experience itself. All recollections of experiences, reflections on experiences, descriptions of experiences, taped interviews about experiences, or transcribed conversations about experiences are already **transformations** of those experiences.* (p. 54).

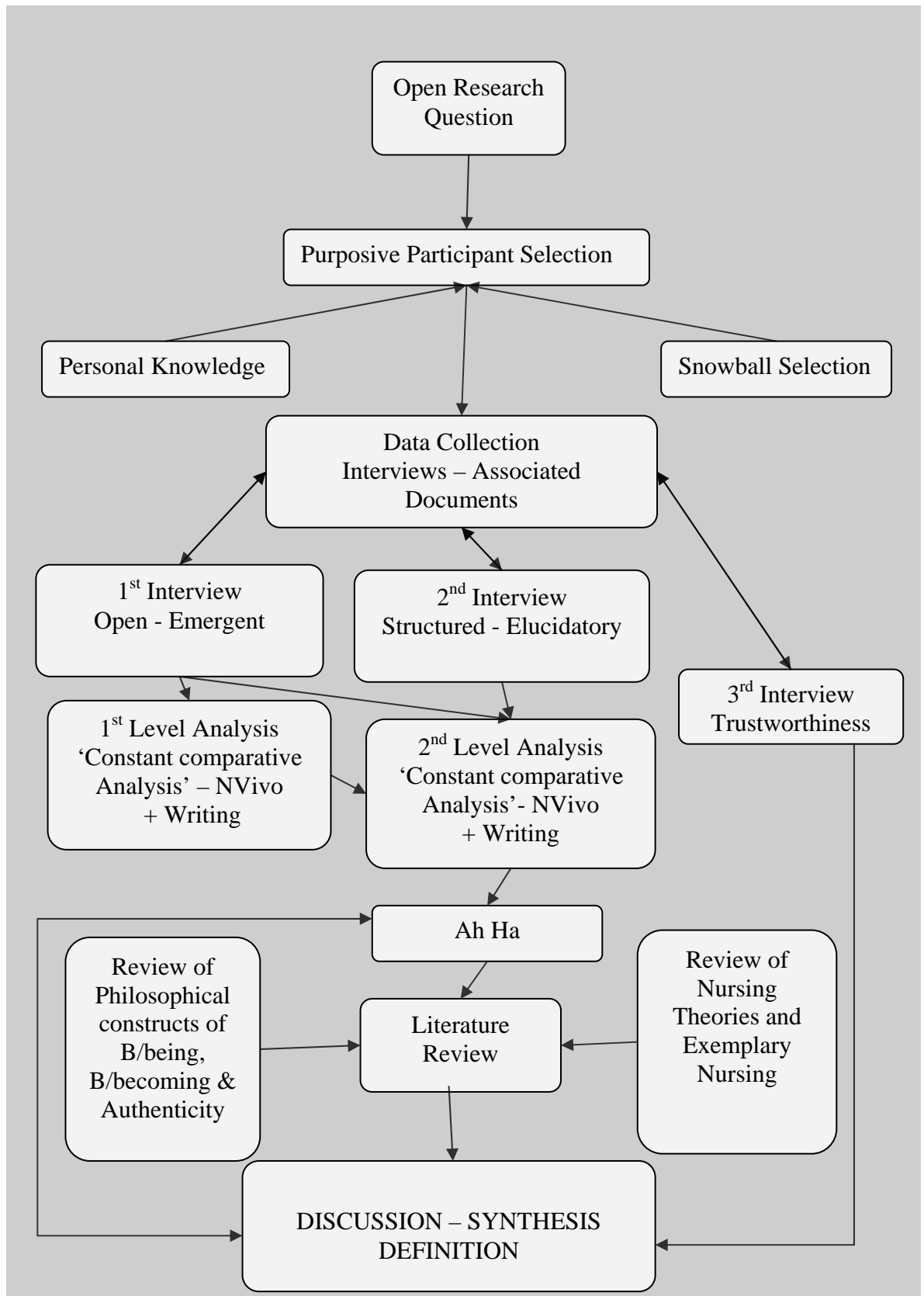
These encounters can only be grasped through reflecting on them as past presence and recognised in retrospect. The ‘Constructivist’ view also allows for these constructions to change as new ideas and thoughts are incorporated into the existing constructions (Guba, 1990). In being informed by these two views, this research recognises that the participants may not hold the same construction forever and therefore that this research will remain ‘true’ only for a ‘time’.

## **Axiom 2: The Relationship of the Knower to the Known (Epistemology)**

Humans want to know and understand what truth is and therefore what constitutes knowledge about themselves and the world around them. The answers to these questions are found in the study of epistemology. In this study, the research questioned the way exemplary nurses experience their world and their Being and Becoming within it. I interviewed the participants about their experiences of being and becoming exemplary and therefore we became interactively linked. Consequently, the findings were “*literally the creation of the process of interaction between the two*” (Guba, 1990, p. 27).

As a nurse and researcher, I am passionate about nurses and nursing. Janesick (1994) believed this is important, stating that to become immersed in a study requires “*passion for people, passion for communication and passion for understanding people*” (p. 217). van Manen (1990) used Heidegger’s word “*thoughtfulness*” to describe this notion and described it as the heedful minding and caring attunement to another (p. 12). He held that:

*Research is a caring act: we want to know that which is most essential to being. To care is to serve and to share our being with the one we love. We truly desire to know our loved one’s very nature. And if our love is strong enough, we not only will learn much about life, we will also come face to face with its mystery.* (van Manen 1990, p. 5).



**FIGURE 4: Study Design**

I love nursing but this love is not in-itself a method for knowing but only foundational for understanding the other nurses in this study. As previously noted and will be further explicated as I discuss the issues of tacit and intuitive knowing, my intense interest in nurses and nursing is only a device used for appreciating and uncovering meaning from the participants' data.

### **Axiom 3: How Should the Inquirer go about Finding Knowledge (Methodology)**

There are various ways humans have found out the truths of knowledge. In this study, I researched nurses and the method used needed to be congruent with working with people. For that reason, a qualitative framework was used where the findings were a result of interaction between the participants and myself. The project design was emergent rather than constructed preordinately (a priori) because it was impossible to know ahead of time about the many multiple realities that may have emerged. The methodology was:

*Hermeneutic, dialectic – individual constructions are elicited and refined hermeneutically, and compared and contrasted dialectically with the aim of generation of one (or a few) constructions on which there is substantial consensus. (Guba 1990, p. 27).*

The experiences of Being and Becoming an Exemplary Nurse were given hermeneutic significance as the participants reflectively collected them. They did this by giving memory to them - and then as they wrote about them in poetry or other writings and talked about them during the study interviews - they were assigned meaning (van Manen, 1990).

### **STUDY DESIGN**

One of the underpinnings of this study and which shaped its design was an emergent philosophy. This was based on Glaser's descriptions of emergence stated in his books; Theoretical Sensitivity (1978) and Basics of Grounded Theory Analysis (1992). This philosophy informed my use of initial open questioning, comparing all units of data with others using 'constant comparative analysis' and presenting the research as a theory supported by examples from the data which had 'fit' and 'work' for the participants who described them. Importantly, it supported the employment of a specific and purposeful literature review until after the findings had emerged. In being informed



by this philosophy and incorporating it into the study design, the findings were able to be ‘grounded’ in the data. Therefore while this study is presented in a linear way, it was, at the same time, both spiralling and emergent. Figure 4 is a diagrammatic representation of this study’s design.

The study design and research process rested on several additional conditions: a natural setting; the utilisation of tacit and intuitive knowledge, ethical conduct with the research participants and the use of a human instrument for data collection.

### **Natural Setting**

This study was concerned with the human world and where human beings, in this case exemplary nurses, were naturally engaged in their worlds (van Manen, 1990). This is congruent with Guba and Lincoln (1989) who believed context plays an important part in any study. They maintained that realities were wholes which could not be understood in isolation from their contexts, nor could they be fragmented for separate study of the parts (the whole being more than the sum of the parts).

The participant interviews were carried out in a setting of their choice. This was, in the majority of cases, the natural setting of the participant’s own home. Other settings included a comfortable room in the participant’s place of work, in my own home or a local café. The physical context of the interviews was a place where the participants were relaxed and felt comfortable to talk. Other than being a place where they were in the ‘right’ space to talk, the physical context played little role in regard to the stories they told. This did not mean however, that context played no part in this study as the participants often related stories about the impact of specific environments on their journey of Being and Becoming Exemplary Nurses.

### **Tacit and Intuitive Knowledge**

The use of tacit or intuitive knowledge was a legitimate part of this study and was an important feature of appreciating the nuances of the participants’ multiple realities (Guba & Lincoln, 1989; van Manen, 1990). Polanyi (1958, 1969) understood that all knowledge consisted of or was embedded in processes that could be made possible through tacit knowing, and stated: “*we know more than we can tell*” (1969, p. 159). Polanyi described two types of tacit knowledge; subsidiary and focal. Subsidiary knowledge was essential to knowing and occurred when personal experiences were

examined - where perceptions entered the conscious awareness. They were visible and could be described and included such skill elements as having a sense of space, timing, coordination or reading a person's mood – such as noting their voice, the shape of their eyes, brows, mouth etc. This knowledge, combined with focal (unseen and invisible) aspects of an experience, made it possible to have a sense of wholeness or essence of a phenomenon. This focal knowledge was an essential element and included implicit and subliminal knowing, self-esteem, confidence, optimism, readiness and a sense of stress. The integration of both subsidiary and focal knowledge created a whole experience (Polanyi, 1969).

Moustakas (1990) believed this tacit dimension underlay and preceded intuition and could guide a researcher into undiscovered directions and sources of meaning. He alleged that from the tacit dimension a bridge could be formed between implicit knowledge inherent in the tacit and the explicit knowledge that was observable and describable. He described the bridge in between, as the territory of the intuitive - where the subsidiary or observable elements could be utilised internally in order to make inferences and immediate knowledge accessible without the intervening steps of logic and reasoning. He believed intuition was an essential characteristic in research and could assist the researcher when asking questions about phenomena. He stated: *“intuition guides the researcher in discovering patterns and meanings that will lead to enhanced meanings, and deepened and extended knowledge”* (Moustakas, 1990, p. 24).

The tacit and intuitive ‘feelings’ that occurred to me while undertaking interviews with the participants were written down in my Interview Journal<sup>5</sup> during the interviews as reminders to ask questions at the end of that interview or noted to discuss at a later interview. Other tacit or intuitive ‘feelings’ that occurred during the study process were written down in my Research Process Journal<sup>6</sup>; ‘Ah Ha’ Journal<sup>7</sup>, or written up as a memo and placed in the computer program QSR NUD\*IST Vivo (QSR NVivo) and subsequently used in the analysis and writing process. These personal writings and memos that were written throughout the research were in accord with the three

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<sup>5</sup> This Interview Journal was used to record any information I thought was important. It was used throughout all rounds of interviews and whenever I communicated with the participants.

<sup>6</sup> The Research Process Journal recorded any information related to process.

<sup>7</sup> Ah Ha is a word I used to describe an epiphany or revelation about an idea. Ah Ha's – although reflective moments - were revelations that arose after much conscious and unconscious thinking about these ideas. The ‘Ah Ha’ journal was a diary I used to write these ideas or thoughts that occurred at any time during the research process. These notes were used to direct further inquiry or to be used during analysis and writing up.

approaches that were used to inform this study. The use of tacit and intuitive knowledge will be further explicated in the subsequent section on Data Collection and the use of myself as the research instrument.

## **ETHICS APPROVAL**

In November 2000, I applied to the Human Ethics Committee (HEC) of Victoria University of Wellington (VUW) for ethical approval to undertake this research. In December 2000, I received approval subject to grammatical and clarification errors being corrected and adding further definition of the term exemplary (refer Appendix 2.0).

The HEC, while acknowledging that definitions may pre-empt the research findings, believed it was important for the participants to know why they were chosen to take part in the research and the type of nurse to recommend as further interviewees. They also asked a question regarding what I would do if I did not agree with the basis on which others used to select the participants, stating that although this was not an ethical issue per se, it did have relevance to informed consent. They concluded with an acknowledgment of the apparent circularity of the fundamental premises of my project.

I wrote back to the HEC with the required changes in January 2001 (refer Appendix 2.1). In regard to the first issue I added the following definitions of exemplary – being a caring nurse in the most holistic way possible, being altruistic, committed and dedicated to the nursing profession, valuing the nurse-patient relationship and instilling others with vitality and enthusiasm. I thanked them for their perception and understanding of the revolving nature of my project and explained that the constant comparative method of analysis would minimise any disagreement by myself of any participant's suitability to be depicted as exemplary. I received confirmation of these changes and full approval to proceed to data collection in February 2001, for the period 22 February 2001 to 28 February 2003 (refer Appendix 2.2).

In August 2001, I changed my method to that informed by the Constructivist Approach and wrote to the convener of the HEC with the proposed changes to the participants information sheet (refer Appendix 2.3). Later that month, I received approval of the revisions (refer Appendix 2.4). Following this, I commenced the selection of participants for this study.

Due to taking leave of candidacy of PhD for 9 months in 2001, I requested an extension to my ethics approval in August 2003 (refer Appendix 2.5). I received confirmation and approval to extend ethics approval, from the convener of the HEC, until the end of 2005 (refer Appendix 2.6).

## **THE RESEARCH PARTICIPANTS**

### **Purposive Sampling**

All participant sampling in this study was done with a specific purpose in mind and that purpose was to elicit stories of B/being and B/becoming an Exemplary Nurse. To do this ‘exemplary nurses’ needed to be sampled. van Manen (1990) would concur as he believed the only people that can explicate the meaning of phenomena are those who are living it. Guba and Lincoln (1985) and Glaser (1978, 1992) in contrast, direct the researcher to undertake an emergent sampling design, where there can be no a priori specification of the sample. They believe that no participants can be “*drawn in advance*” because the “*very term ‘drawn’ reflects a bias towards generalisation-orientated random sampling*” (Lincoln & Guba 1985, p. 201). Whilst it is true to say that at the beginning of my study I didn’t know the identification of the participants (or the numbers) that would be interviewed for the study, I did know that they would all be exemplary nurses. I believed that nurses who were ‘Exemplary’ would be the only ones that could most fully describe their Being and how they became such.

In the prescribed Constructivist Approach maximum variation sampling is the usual mode of choice. The object in this case is not to focus on similarities to be developed into generalisations but to detail the many specifics that give context its unique flavour. This allows for the generation of information upon which the emergent design and grounded theory can be based (Lincoln & Guba, 1985). They reference ‘Grounded Theorists’ Glaser and Strauss (1967) in relation to sampling, and state that ‘theoretical’ sampling is a term synonymous with their own ‘purposive’ sampling. They believe that the purpose of maximum variation is achieved by selecting each participant only after the previous participant has been interviewed and analysed. In congruence with this study the Constructivists do agree that the first participant would have been an exemplary nurse, however each successive participant would be chosen to extend the data already obtained, to obtain other details that may contrast with it or to fill gaps in the information gathered so far.

For this study, the prescribed Constructivist Approach would also not have enabled each of the participants in the study to ‘tell’ their own story. To interview other stakeholders<sup>8</sup> such as patients, families, associated staff and colleagues, would give another view of ‘exemplary nurses’ but not the view of B/being and B/becoming one. Another way congruent with the formal approach would have been to interview divergent cases. This would have entailed interviewing ‘non-exemplary nurses’ and while I am sure many aspects prudent to this study would have been elucidated, the ethical dilemmas inherent in this approach would have been enormous. Even if these obstructions were to be overcome and nurses were invited to participate who had ‘self-identified’ themselves as being ‘non-exemplary’ or who had ‘left the field of nursing’ – this would have entailed the participant to have reflected on their mode of Being and have made a decision about it, i.e., to continue in the profession or to leave. As I believed self-reflection could be one of the very pivotal elements of this study, these nurses may not have been ‘non-exemplary’ at all. Instead they may have been nurses who had reflected on their nursing practice/work lives and its relation to their own Being – and made an informed decision to leave nursing. This, in my opinion, would be an ‘exemplary’ behaviour rather than one that was not.

## **Participant Selection**

In my application for ethical approval I suggested that I would need to interview up to twelve participants. Sample size in a Constructivist study is usually based upon information rather than statistical considerations and the numbers of participants is not decided a priori but dependent on the particular ebb and flow of information. Stopping sampling is based on informational redundancy (saturation), rather than a statistical confidence level (Lincoln & Guba, 1985). In this study, the number of participants required to ‘saturate’ the categories, was not known until primary analysis was carried out. I stipulated that the initial participants would be selected through my personal knowledge of them, where they had revealed exemplary attributes relating to the literature concerning ‘work excitement’ (Simms, Erbin-Roesmann, Darga, & Coeling, 1990), ‘positive energy’ (Mabbett, 1987) and/or ‘star quality’ (Kendall, 1999). Subsequently these participants would be asked to nominate another exemplary nurse that was known to them. This procedure called the ‘snowball’ sample is one in which members of a group identify other possible members and in-turn identify other members

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<sup>8</sup> Stakeholders are people who have may have a ‘stake’ in the outcome of the research (Lincoln & Guba, 1985).

– thus the sample grows like a snowball (Faugier, 1997; Roberts & Taylor 1998; van Manen, 1990). This technique has utility in much the same way as the *"each one reach one"* (Lincoln & Guba, 1985 p. 202), or *"nomination technique"* (Guba & Lincoln 1989, p.182) espoused by proponents of the Constructivist Approach. I also stipulated in my proposal and ethics application, that if further participants were required, notices calling for exemplary nurses to join the study would be posted in appropriate areas (following permission from relevant gatekeepers<sup>9</sup>). These selection methods were in accord with the Constructivist Approach, where Guba and Lincoln suggest obtaining successive participants by nomination, stating that using reputation or personal means to identify participants or *"any means that brings the investigator's attention to bear on heuristic new units can be employed"* (1989, p. 202). They were also required to be registered nurses working in a South Island of NZ nursing related area, such as a hospital, community based organisation, private establishment, or institution of higher learning.

In this study, three initial participants were chosen by me. I knew these nurses through various types of professional associations and recognised them as exemplary nurses. Four further participants were referred to me. Of this four, one person who knew of the axioms of my study, volunteered to participate. She was well known to me through professional circles and I knew her to be an exceptional nurse. The three others were suggested by several nurse educators from a large tertiary teaching institution, where a notice of my study had been posted on the notice board. These nurses were also known to me as being exemplary nurses.

This first group of seven potential participants were contacted by letter and invited to participate (refer Appendix 2.1.3), given a study information sheet (refer Appendix 2.1.4), biographical data sheet (refer Appendix 2.1.6) and consent form (refer Appendix 2.1.7). Six of these replied and appointments were made for the first interviews. Following these initial interviews, each of the participants was asked to introduce one or two other exemplary nurses to be part of the study. From this method eight other nurses were nominated and contacted by a similar letter or email to join the study. Interestingly several nominations were the same and one nomination was already in the study. A couple of 'snowball participants' also stated that their nominator would have been their

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<sup>9</sup> Gatekeepers are those people that have formal or informal authority, influence and power over access to a study population, Ibid.

recommendation had the roles been reversed. Therefore, from a pool of five potential participants, four replied and subsequently joined the study - giving a total of ten participants.

## **Meeting the participants**

I believed it was important that the potential participants could make an informed choice and be able to read the study information sheet at their leisure - without having to speak with the investigator in the first instance. Therefore, the first communications between myself and the participants occurred by letter or an e-mail with an attached letter. If they decided to go further, it was their decision to make the first personal (phone) contact with me and if they chose not to, this would be understood by me as their decision not to proceed. This letter described how they had been chosen, i.e., by me or as a suggestion from another participant. In the 'snowball' letters all the nominators shared their names with the nominees. While this particular point had not been highlighted in my ethics approval, all participants were asked their opinion on this matter and all felt happy to share their own participation with their nominated colleague.

Once the participants called me to commence participation, we discussed any issues of concern and I answered any questions about method and process and negotiated a time and place for the first interview. At the beginning of this first round interview, we also discussed issues relating to the time involved in being a participant, my role in the study and the possible risks of being a study participant. The participant and I then signed both their informed consent to participate in the study form and my copy.

An important feature of informed consent was the use of pseudonyms or the use of their own name in the thesis. While the aspects of confidentiality were fully explained to the participants, I felt it was also important to discuss identifiability and that it was their choice to use a pseudonym or their own name during the research process and in the subsequent thesis publication. This decision, of course, could be changed at any time up until final printing of the thesis proper. At the consent form signing stage – the participants added their name or pseudonym of choice. Before the first draft findings chapter was sent out to them to read, they were asked to confirm their name/pseudonym in use or make changes (refer Appendix 3.0). Again, before the final thesis was printed, all participants were asked to verify their choice of name (refer Appendix 4.0). Consequently some of the names in this thesis are pseudonyms and others use their real

names. Other than the participants who nominated other exemplary nurses, no other participants knew the names (real or pseudonym) of their study colleagues until they read the first draft findings chapter.

The ten participants: Chris, Jayne, Liz, Kirsten, Joc, Janet, Kate, Sharyn, Anna and Ellen are the most important part of this study. Without them we would have little understanding of Being and Becoming an Exemplary Nurse. These ten nurses are all on the same journey – but also an individual journey – B/being and B/becoming in their own distinctive way. All on a slightly different path yet all interconnected, linked and alike at various times. I do not believe it is an important feature of this study for you to meet them as individuals, as this study is not about demographics or random sampling, but getting an understanding of B/being and B/becoming an Exemplary Nurse. However, they are all registered nurses working in nursing related institutions throughout the South Island of NZ. They are all female and nine are Pakeha<sup>10</sup> and one is Tauwiwi<sup>11</sup>. Five of the ten participants were the oldest in their families. Five worked as nursing or physiotherapy aids before they started registered nurse training and they all went nursing for a variety of reasons, with four having mothers or grandmothers that had encouraged their career choice. Six were Hospital trained and four were Polytech trained<sup>12</sup>. They are different ages - the youngest (at the beginning of this study) was 32 years and the oldest was 59 years old. During the study process, they worked in the specialty areas of: paediatric nursing, palliative care, mental health nursing, surgical nursing, neonatal nursing, respiratory nursing, nursing education, or nursing management. Some were staff nurses and charge nurses; others were nursing educators or managers. All had undertaken or were undertaking higher level nursing education, from post graduate diplomas through to PhDs. They were not chosen for the representativeness but for the sole reason that they were all on a journey of B/being and B/becoming an Exemplary Nurse.

No male nurses or Maori nurses were recruited into this study. There were no restrictions on sampling related to gender or nationality, therefore their non-inclusion was probably solely due to their statistically lower numbers - Maori nurses make up 7.5% of the nursing workforce and only 6.4% are Male (TVNZ, 2005). To have

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<sup>10</sup> Pakeha is the NZ Maori word for European person born in New Zealand.

<sup>11</sup> Tauwiwi is the NZ Maori word for a person who was born outside of NZ and who has emigrated here.

<sup>12</sup> In NZ, Registered Nurse training changed from a single registration education based in Hospitals to Comprehensive Nursing education based in Polytechnics in the 1970s, with the transfer completed by the late 1980s.



purposively sampled Maori or Male nurses would have been congruent with selecting divergent cases as suggested by the Constructivists; however this would have been in conflict with the emergent design I wished to follow. Therefore, I cannot comment on whether a Maori or male perspective may or may not have illuminated different or similar constructs of Being and Becoming an Exemplary Nurse.

Despite having a definition of 'exemplary' in the participant information sheet and all participants signing the informed consent to participate in this study, several of them had initial issues with the notion of 'being exemplary'. While they all acknowledged their own expertise in their specialty area, the word 'exemplary' was often construed as being better than others and this was a notion that many were not comfortable with. These comments and doubts were reported to me during the first round of interviews. However, after the first level analysis it became obvious that B/being and B/becoming an Exemplary Nurse was about reflecting and learning from practice, not being perfect in every situation. Therefore before I interviewed them for round two, I placed a definition in a letter sent to the participants before their second round interviews and asked them to think about this notion before we met again (refer Appendix 5.0).

## **DATA COLLECTION**

Primary data in this study included everything that could be used to illuminate B/being and B/becoming an Exemplary Nurse which was 'grounded' in the participants' information or my own writing that was stimulated by this. Therefore, these included: the transcribed (verbatim) transcripts from three audio-taped interviews with each of the ten participants; poetry, photography and associated documents given to me by the participants to help illuminate the phenomenon; and, the writing and notes in my research journals.

The Interview Journal, Research Process Journal and 'Ah Ha' Journal were invaluable sources of data in themselves. They were not autobiographical, but solely my thoughts, ideas and questions illuminated by the participant interviews, and later the linking of these concepts with the literature. I took the Interview Journal with me during all interviews. The Research Process Journal was used primarily through coding and analysis and I wrote in the 'Ah Ha' Journal whenever ideas came to me. Often when traveling in the car or on airplane journeys to and from participant interviews or resident PhD schools, ideas that occurred were written down on any conceivably useful object.

Hence my 'Ah Ha' Journal holds scribbled notes on backs of envelopes, napkins, and even airplane sickness bags. These notes were reviewed constantly throughout the research process and used to stimulate further investigation, information collection or analysis, and used in writing up.

I also used critical friends during the thesis process and communications and conversations often stimulated writing in my journals. These friends were people who gave critical and practical advice about questions or issues I was considering and who also supported me physically, mentally and spiritually throughout this extended project. They were often colleagues or family in academia from nursing, or other fields or friends who had an interest in my work. Despite their backgrounds, they were all people that gave me honest and constructive feedback on questions I asked. Confidentiality was ensured for the ten participants at all times as my critical friends never read any original participant transcripts or were told any of the participant's 'names' other than the ones they were using at first draft level and beyond.

Confidentiality was also ensured during the research process, where all interview tapes and my diaries/journals were stored in a locked filing cabinet in my home. Transcribed interviews, analyses, and draft chapters were stored in my home computer, which was password protected. All original data will be destroyed within five years of this thesis being completed. The participants received copies of their transcripts, their own quotes in text and draft thesis chapters for their own use throughout the process. They will all receive a copy of the final thesis.

## **Human Instrument**

In this study, I was the primary instrument of data gathering. I concur with Guba and Lincoln (1989) when they stated:

*Humans collect information best and most easily, through the direct employment of their senses: talking to people, observing their activities, reading their documents, assessing the unobtrusive signs they leave behind, responding to their non-verbal cues, and the like. (p. 175-6).*

While interviewing was a new procedure for me to learn, I was comfortable talking with others and had an implicit understanding of nursing in general and an intense interest in the question under study. Lincoln and Guba's (1985) characteristics of: responsiveness, adaptability, holistic emphasis, knowledge base expansion, processual immediacy, opportunity to clarification, summarisation, exploration of atypical or idiosyncratic

responses, and the ability to learn; will be described in relation to how they uniquely qualified me to be the instrument of choice for this study.

### **Responsiveness**

During the research process I was able to sense and respond to personal and environmental cues that existed. Situations where my responsiveness came into play included situations where the participant(s) became upset when recounting stories of significant meaning to them; such as the death of a patient, making a difference in another's life, or when they had made a mistake in practice. Most of the participants described at least one distressful situation during the interview processes and many of the participants stated they had never mentioned or discussed these situations with another person since the incident had occurred (some of these experiences had been in their 'backpacks' for over thirty years). At these times I would ask if they wished to have the tape recorders turned off. Often at these times we would take a break, have a cup of tea or coffee and resume when they were ready. All participant(s) wished to continue their interviews after such episodes and we often discussed the issue on tape. I was always respectful of their stories and reassured them that this was a common feeling when recounting such stories and that it was okay to feel that way. I also often used humour to diffuse the situation, which is and has always been an acceptable 'nursing way' to diffuse a distressing situation. The ways in which I responded to these events depended on the specific situations or the specific personalities of the participants. The responsiveness on my part was intuitive and although I had no objective means of checking that my actions were appropriate, my previous experience as a nurse and 'doing the right thing' in emotional situations was reassuring and supportive. Depending on the incident, I also took note of these situations in my Interview Journal diary for further questioning at the completion of the interview or for further thought as to whether they should be discussed at a later interview. Throughout the research process no participant requested - from me - outside assistance with counselling or support, related to re-experiencing moments of distress in practice.

### **Adaptability**

While I was a relatively neophyte interviewer at the beginning of the study I did have the characteristic of adaptability. In some interviews the participants were comfortable with speaking and telling me their story without interruption or encouragement, while

others were obviously uncomfortable with talking about themselves. My understanding of each participant's 'Being' allowed me to adapt to support them during their interviews in a way that felt comfortable to us both. This adaptability also allowed me to collect information about multiple factors and at multiple levels simultaneously. This occurred, for example, when the verbal facts did not concur with body language gestures. At these times I made a note in my Interview Journal to discuss this either at the end of the interview or at subsequent interviews.

### **Holistic Emphasis**

Lincoln and Guba (1985) believed that only humans were capable of understanding the whole worldview of a phenomenon at one time. This holistic emphasis occurred for me frequently as the interviews progressed. While listening to a participant's story or experience, similar stories from other participants would be recalled. This conceptual linking of ideas also occurred within the same participant interview and from one of their interviews to the next. When this happened I made an \* (asterisk mark) in my Interview Journal for discussion with the participants at subsequent interview and for noting during my analysis.

### **Knowledge Base Expansion and Processual Immediacy**

For the Constructivists (Lincoln & Guba, 1985), only the human instrument has the ability to function simultaneously in the domains of propositional and tacit knowledge and to process the data as soon as it becomes available. This experience occurred frequently during interviews, when participants related stories or incidents where I had both an intuitive understanding of the situation from my own experience or from the emotions projected from the participant's story which in-turn related with the propositional knowledge I possessed from my own various practices and learning. Again notes were made in my Interview Journal to explore the appropriate literature sources at a later date and to take notice during analysis and writing. Often when these situations occurred (and most often at the end of the interview), I would discuss this with the participants. This not only enabled the participants to access the knowledge if they wished but highlighted the incident 'on tape', which would be transcribed and available in the subsequent analysis.

### **Opportunities for Clarification, Summarisation and Exploring Atypical or Idiosyncratic Responses**

As the interviews proceeded it was often the case that clarification about a particular point was needed. In these instances, I made notes and asked the participants for clarification or correction as soon as appropriate, during or at the end of the interviews. If atypical responses were given I was often able to identify these and question the participants further about them. An example of this was when a participant used a term I was unsure about or seemed incongruent with her story. This occurred when Kirsten continually mentioned that she was 'un-confident' throughout her initial interview. I asked her to elaborate this notion at the end of her interview, stating that her story from my perspective showed anything but un-confidence. She described this characteristic was actually a means to how she continually reflects about her practice, checking and rechecking that she had made good practice decisions. Due to re-questioning Kirsten about this and her explanation 'which was transcribed into text', I was able to illuminate what was to become a significant factor in Being and Becoming an Exemplary Nurse that may otherwise have been hidden.

### **Ability to Learn**

Guba and Lincoln (1985) understood the attributes of the human instrument to be very advantageous but not always perfect. While they did not expect that any instrument would function perfectly without extensive background training and experience, they believed the human instrument had the ability to learn and to benefit from the experience undertaken. I was relatively new to interviewing at the beginning of this study, and while transcribing the interviews I realised that my technique was not always ideal. Often I interjected into the conversation too early or I missed cues for further questioning. However these inadequacies were self-identified during the succeeding transcribing of the interview tapes. Once I identified the inadequacies, I was acutely aware of not repeating the same mistake at subsequent interviews and where they revolved around a particular participant I made notes in my research journal to ask about this issue further at the next interview.

## **The Interviews**

In this study, I used three ‘rounds’ of interviews. The first participant interviews occurred during 2001/2002. The second round of interviews were carried out in 2003 and the third in 2004/2005. Each interview was conducted consecutively, and where possible, each interview was transcribed by me, before the next. This happened in most cases, except when time made it impossible. This occurred twice during the first round of interviews. Once an interview was held during one evening and the next interview was scheduled with another participant the following morning. Secondly, where I had to travel an extensive distance, it made fiscal sense to carry out both interviews during the same visit. To complicate matters I was either pregnant or subsequently breast feeding and caring for a new baby when the first round of interviews were carried out. While this did not affect the interviews per se, the subsequent transcribing of these initial interviews was delayed more than usual or desired. For the second round of interviews, except when I travelled for two of the interviews, each interview was transcribed by me before the next, and all interviews occurred within a two-month period. For interviews one and two, each participant was given a copy of their transcript for ‘member checking’, where they were asked to check them for consistency and clarity. The third interviews were short and used to gain feedback and concurrence from the participants on their joint constructions reported in the findings - Chapter 4 of this thesis. They were carried out over a two month time period. All participant interviews and information were recorded in an interview log (refer Appendix 6.0).

For interviews one and two, I audio-taped them with two tape recorders, in case there was a recording error with one. This occurred during one interview, where I did not push the record button correctly and at another interview where the tape quality in one recorder made it inaudible. Had I not had the second tape recorder, valuable data would have been lost.

The interviews were transcribed verbatim by myself. While this was very time consuming, as one to two hours of tape corresponded to three to four hours of typing per interview, I did this myself as I believed it would assist in the analysis. This method was an invaluable strategy as I could close my eyes and ‘hear’ the voices of the participants as I re-read each transcript several times throughout the research process. This in-depth ‘knowing’ of the participants’ interviews and stories enabled my tacit and intuitive skills (as the instrument of data collection) to be used to its full advantage.

## The First Interviews

The first round of interviews lasted from one to two hours long and when transcribed, ranged from 36 to 85 pages of transcript per participant. These interviews were relatively unstructured, where after initial introductions the primary question asked was, *"Can you tell me your story of Being and Becoming an Exemplary Nurse?"* This was in order to allow the data to 'emerge' from the interview, rather than questions and answers to be 'forced' on the participants (Glaser, 1992). Elucidatory questions and statements were also used during the interviews when required. These included statements such as *"you may find this easier to do by starting in your childhood and moving through your training, your career to where you are now, looking at your life through the lens of Being and Becoming an Exemplary Nurse"*. Supportive questioning was based on what other participants found useful such as *"some people find it useful to recount those instances where you remember a critical incident during your life/career, for whatever reason, and talk about that"*, were also used throughout the interview when required. I also suggested the concept of 'backpack patients' during the interviews; this being a construct I became aware of after reading my own life story that illuminated aspects of my own Being and Becoming. This concurs with van Manen who ascribed *"the extent that my experiences could be our experiences"* (1990, p. 57). He believed that being aware of one's own experiences may give clues for orienting others and self to the research.

These first round interviews were placed in a set and coded as a group. This method is divergent to that which the Constructivist Approach supports. They call these interviews 'dialectic hermeneutic circles' and they are carried out consecutively and coded before the next so that they direct further sampling and questioning. I chose not to do this because it was important that each participant was given the chance to tell their story without formal structure or questions based on previous participant's stories or experiences. I wanted the data to 'emerge' for itself; therefore I modified the dialectic hermeneutic circles to that of undertaking each participant's interview, and transcribing it, before the next interview. I also did not formally commence analysis until all the first interviews had been completed, transcribed and returned from the participants after 'member checking'.

Following the first interviews, participants were asked to supply any associated documents that gave a different ‘view’ on B/being and B/becoming an Exemplary Nurse. The documents included: photos, poetry, assignments related to their philosophy of nursing, or relevant chapters in theses they had written. These documents were then used as data and analysed at the same time as the first round of interviews.

### **The Second Interviews**

The second round of interviews occurred after the first set of transcripts were analysed and written up in draft chapter form. The participants had read their own first interview transcripts but no other participant’s data. The focus of these second interviews was to elucidate further about emerging categories and fill in the gaps so to speak. There were two major areas of focus. I sent a letter out to the participants before the interview (refer back to Appendix 5.0) where I asked them to “please reread your transcripts before our next interviews and think about your stories of practice”. I then asked them to think about these questions:

*“How have your stories of practice (backpack patients) influenced your Being and Becoming? How do these stories serve as a mirror for you in your practice?”;*

*“I would also like to know how you stand with the ‘exemplary’ title and the struggles you may have with being this type of person. I want to unpick the notion of authentic being. Your ability to stand as a whole (being greater than the sum of your parts) and the ability for you to continue to practice what you preach. What keeps you getting up each morning and continuing your journey of becoming exemplary?”.*

*“Also how have you made sense of this so far by being in the research?”*

However, due to the emergent nature of the interviews, the last questions - relating to the struggles of being an exemplary nurse, were not formally addressed in these interviews. The major focus instead was their stories of practice and how and why their backpack stories worked. These second rounds of interviews were done consecutively and each interview was transcribed before the next interview took place. They lasted from one to two hours and when transcribed ranged from 12 to 35 pages of transcript for each participant.



### **Third Round of Interviews**

The third round of interviews was short and undertaken to obtain collaboration on the co-constructions of the findings – Chapter 4. At this stage they had read the first draft findings chapter and were asked to comment on it (refer Appendix 7.0). These interviews were made by phone, email or in person as requested by the participants. They lasted an average of half an hour to one hour. Not all of these final interviews were fully transcribed, as many of the conversations were based around a social catch up rather than a full interview. I listened to each interview that was recorded and wrote up their commentary in a document I called the ‘participants thoughts on thesis chapter/being in the study’ (PTTC). I wrote up their comments in sub-headings so everybody’s comments could be read with the other participant’s comments on each topic. Notes were also recorded in my Research Process Journal as they spoke about their feelings on reading the thesis and being part of the study. Email correspondence was printed off and placed with these notes to be used when writing up the special criteria for trustworthiness. All quotes from the third interview, which were used in the thesis, were sent to the relevant participants for member checking.

### **Keeping in Touch**

Due to the length of time this study has taken and the durations between interviews, it was an important feature to keep in touch with the participants. Therefore I regularly sent them letters or emails to update them on my progress as well as personal greetings in the shape of annual Christmas cards and thank you cards after each interview. I acknowledged that their participation was sporadic and that they were carrying on with their lives whilst I seemed to be stuck in a spiralling time-warp. As I humorously explained to them at each successive interview - I was living this research. They all lived in my head - their voices echoing and directing me with further thoughts and ideas for most of my conscious (and probably unconscious) time. However, despite the longevity of this project, the participants were always keen to ask and hear about both my research progression and my growing family – especially since my younger boys Jack and Oscar had successively been in attendance during the interview processes (through pregnancy and latterly with breast feeding). The participants always seemed genuinely pleased to be asked for another interview and looked forward to reading the next ‘installment’ from the thesis. When asked for feedback, permission to record their quote in text or acknowledgment of a joint construction, they always responded in a

positive and timely manner. I am extremely grateful to the relationships that were founded and continue with these wonderful women, in both a professional and personal way.

## **SUMMARY**

This study was informed by the qualitative methodologies of the Constructivist and Human Science Approaches, underpinned by an Emergent philosophy. These approaches share the understanding that everyone has their own appreciation of reality, which have been constructed by various influences over time; that the research findings are a co-construction between the participants and the researcher and inherent in this process is the use of a natural setting, tacit and intuitive knowledge and a human instrument for data collection.

The research participants were ten nurses who were chosen by myself or others as known examples of exemplary nurses. Their selection and participation was governed by ethical actions as stipulated and approved by the HEC of VUW.

Primary data for this study consisted of the verbatim transcripts of three rounds of participant interviews, associated data such as the participants' poetry, photography and writing and my own notes recorded in Interview, Research and Ah Ha Journals. The first round of interviews were used solely to gather data, while the second and third interviews served as an occasion to reflect with the participants about the topic at hand, to elucidate further meaning or to discuss what other participants thought. van Manen (1990) believes that this conversational interview increasingly changes into a hermeneutic interview and turns the participants into collaborators in the research.

While a distinction can be made between the gathering of the data and its analysis, these two acts were often simultaneous, especially during the second and third rounds of interviews. The mechanisms of this analysis process will be discussed in depth in the following chapter along with the use of the computer to assist coding and writing as a form of research. Issues of voice and negotiation with the participants will also be discussed, as well as the establishment of trustworthiness, as part of the rigor of the study.

## **CHAPTER 3**

### **ANALYSIS AND CRITERIA FOR TRUSTWORTHINESS**



This chapter presents the processes undertaken to analyse the primary data from this study, including the use of computer assisted coding and writing as a form of research. It also includes discussion on negotiated outcomes and the reporting of the research findings - including issues of voice. Following this, I discuss the issues of trustworthiness. Inherent in this thesis is the spiralling koru shape, where the research process is curved rather than linear. In these instances process aspects, such as reporting the findings with its issues of voice and use of an interpretive text have been presented before the findings chapter – Chapter 4.

### **METHOD OF ANALYSIS**

I set out to explicate Being and Becoming an Exemplary Nurse in all its facets. I wanted to understand the phenomena and what it means to B/be and B/become an Exemplary Nurse. An insight into this involved a process of reflectively clarifying the meaning of their lived experience. This was not a simple task, as the meanings were both multi-dimensional and multi-layered (van Manen, 1990). To do this I looked for themes that ‘emerged’ from the data. van Manen (1990) wrote that thematic analysis gives control and order to research and writing which allows “*insightful invention, discovery or disclosure – grasping and formulating a thematic understanding is not a rule-bound process but a free act of “seeing” meaning*” (p. 79). This viewpoint mirrors Glaser (1992) in allowing the findings to emerge from the data. This process is also known as inductive data analysis, which can be defined as the process used for ‘making sense’ of data, where the constructions that emerged from the participant/researcher interaction were reconstructed into meaningful wholes, without being imposed prior to data

collection (Lincoln & Guba, 1985). Data analysis in this study was therefore not a matter of data ‘reduction’ but of ‘induction’.

## **The Use of the Computer to Assist Coding**

The methodologies that informed this study involved the recognition of categories ‘in the data’, generation of ideas about them and explorations of the meanings ‘in the data’. Given that these categories and meanings were found in the text transcriptions, there was a need for data management methods that would support insight and discovery, encourage identification and development of categories and be able to store them and their links with the original data (Richards & Richards, 1994). I had 784 pages of transcribed interviews and a further several hundred pages of associated participant’s texts, such as writing and poetry. Therefore I needed a system by which I could store and manage this raw data easily but also code and categorise it while remaining ‘grounded’ in the whole text and its meanings. For this purpose, I used the computer programme QSR NVivo, designed by Richards and Richards (1999) of the Qualitative Solutions and Research Pty Ltd. This programme was extremely user friendly and assisted the storage and coding of the data enormously.

### **Using QSR NVivo**

QSR NVivo was designed to hold and manage, in a highly linked and integrated way, everything to do with an entire qualitative analysis research project, including data on any medium a particular computer could handle (Richards, 1999). For this study, these included: initial research proposals; applications for ethical approval; transcribed verbatim interview transcripts; associated written documents; bibliographic notes, and photographic data. This information comprised the ‘Document System’ - with its many special qualitative-analysis facilities for organising, linking and exploring the documents and their parts (Richards, 1999). QSR NVivo’s second database, called the ‘Node System’, was where all the concepts, topics, people, places and ideas relevant to the project were stored. This system provided tools for relating, categorising, characterising, coding and manipulating both the Document and the Node Systems together. The predominant feature of this system was to assist me to generate Nodes from the documents and the data within them. Richards and Richards (1999) state these tools were designed with the various qualitative research processes and methods of

qualitative data analysis in mind. Their aim was to produce a new, unique and user-friendly way of analysing this type of data.

QSR NVivo had many features which were used by me in the following specific ways.

- It handled all my study documents as editable rich text, enabling me to visually code it. While QSR NVivo could manage any language or font, I used red and black highlight colour and the use of Times New Roman or Times New Roman italic, to differentiate participants from researcher.
- Documents were used as compound or true multimedia, supporting data byte links to any computer file (utilising the appropriate files and program to open and run it). Therefore, spreadsheets, snippets from audio or video files, and pictures could be embedded wherever needed in the documentary data. I made links with the participant's photographic data in this manner, which turned the documents into rich and complex data organisers.
- The Node System provided both structured and unstructured ways of representing the project topic. It was used to code project documentation where the topic occurred and any run of characters in a document could be coded at any number of nodes that applied to it. There were several ways of automating the coding of documents; including drop and drag or highlight and drag into the Nodes or visa versa from a highlighted Node to highlighted text. The rich text Node Browsers then permitted everything that was coded at that node to be viewed via that node.
- The Documents and Nodes were interlinked by a hyperlink-style jump, to provide cross-referencing networks. I often made Memo Documents for a Node, which incorporated extract references for specific topics mentioned in the Documents.
- All documents were fully editable and the editing did not disturb or invalidate the existing coding. It allowed me to build up the Documents over time and to code and link text as it was added, as well as edit text already coded.
- The Documents and Nodes (and what they represented), could be given any number of Attributes (properties) to describe and characterise them. Attributes

and their values provided a powerful way of selecting and analysing the project data as well as the ability to import and export attribute data via tables to statistical and other table handling programmes. Attributes could have any relevant values (dates, numbers, Boolean, strings etc). For this study, attributes such as the participant's ages, nursing registration, years of experience, nursing specialty, nursing education, number of siblings, their position in the family and any relatives that were nurses were recorded.

- The Documents and Nodes could be grouped into any number of Sets for whatever purpose I required. Here they could be studied for their features and contents. A tool, in the Set Editor, allowed for selection and windowing of items in their Sets by their properties, their attribute values, coding or any other featured required. This provided a fast analytical tool for answering 'which' type questions about the project data.
- A graphical Model Explorer supported the construction of any number of diagrams that I wished to create out of project items, such as the Documents, Nodes or Attributes. This was a useful feature when trying to reconceptualise and link the major findings.
- An integrated search tool allowed for the searching of Sets, Documents and Nodes for text patterns, coding and attribute values, when required.
- Reports could be generated on all types of project data. They could be used as editable rich text documents, their profiles being used as stand-alone information or they could be exported to statistical and other packages. Ongoing reports were printed throughout the research process as nodes were generated and then merged and subsumed. This data was used for decision trials and assisted analysis.
- The coded participant transcripts were viewed 'on screen' as rich text with coded words, sentences and/or paragraphs highlighted 'in text' or alternatively indented with all coding stripes vertically positioned - allowing for an overall visual recognition. These coding striped documents were easily printed for ongoing 'paper copies' and assisted, decisions trails, analysis and writing up.

These tools and features were all interlinked and were designed to support any qualitative project and to utilise most qualitative methodologies (Richards 1999). While the attribute, modeling and reporting tools were often used during this study to highlight themes or ideas, the most important feature and common use of NVivo was for actual coding and storage of data, with the ability to link back to the full document and view the coding stripes.

## **First Level Analysis**

Each participant's transcript and associated documents were saved as a rich text file, imported into the QSR NVivo program, and saved under the PhD project file. From there each participant's transcripts were coded. All first round interview transcripts and associated documents, were coded together as a set.

Initial thematic analysis was carried out by 'unitising' and 'categorising' (Guba & Lincoln, 1989). These are similar concepts to Glaser's (1978) substantive and theoretical codes, which in turn encompasses open and selective coding. Unitising was the process used to code the data into units (Lincoln & Guba, 1985). Each transcript and all the associated documents were read several times and analysed "*line by line*", coding each sentence or paragraph as it 'emerged' (Glaser, 1978, p. 57). A unit was sometimes a simple sentence or an extended paragraph, but included enough information to allow the piece of data to 'stand alone', that is being interpretable in the absence of any additional information (Lincoln & Guba, 1985). As each transcript/document was read, I continually asked questions of the data such as "*what is this data a study of?*", "*what category does this incident indicate?*" and "*what is actually happening in the data?*". These three questions (based on Glaser's 1978 work) were used to remind me of what was happening in the data and they kept me from 'getting lost' in the re-experiencing of the data by forcing me to try and generate codes that 'related' to the other codes.

For the first round of interviews/documents, each unit of data was coded into a 'free node' in the QSR NVivo programme and given a title that described its contents. Initially I called each unit a name that was identifiable and understandable to me. This step is equivalent to Glaser's (1978, 1992) open coding, where the researcher codes the data in every possible way in order to generate an emergent set of categories which fit, work and are relevant for integrating into a 'joint construction'. After coding this first

set of ten transcripts and associated documents, 212 ‘free nodes’ had been coded. For each of these ‘free nodes’ various units of data were coded under each title. These were determined on tacit or intuitive grounds initially as to whether they looked or felt alike (Lincoln & Guba, 1985). For example under the ‘free node’ - **The privilege of caring**, the following unit from Kate’s interview transcript was coded:

*The ability to be comfortable with somebody at the bedside, in their private, personal moment of experience and the enormous privilege that gives you...to be allowed ...to enter into that. I just think is quite profound. (Kate, 1<sup>st</sup>, 0, 64-65)*

At this stage of analysis, not only were several units coded under one free node but each unit was often coded at other nodes as well. For example, Kate’s unit was also coded at the ‘free node’ - **Nursing feels comfortable**.

After this first set was ‘unitised’ or ‘openly’ coded, categorising began. Categorising was the process by where the unitised data (free nodes) were organised into categories (Lincoln & Guba, 1985). With the initial 212 ‘free nodes’, I went through each of them checking that the units of data coded under each title were similar or congruent with the title. If the units of data were not related then the dissimilar ‘unit’ was ‘coded on’ into another ‘free node’ that was more appropriate. As this carried on I noted that many ‘free nodes’ were similar, therefore when this occurred I ‘merged’ them. Other times separate ‘free nodes’ and their associated ‘units’ were amalgamated into one, for example **discovery of self** and **revelation of self** were both merged into **knowing and being self**. At other times ‘free nodes’ needed to be divided, for example units in the ‘free node’ **being chosen by patients to be cared for** were spilt into the ‘free nodes’ **having and using a positive reputation** and **meaning making**. As this continued I started to sort the ‘free nodes’ into higher level categories that are named ‘Tree nodes’ in NVivo. As open coding continued it often became obvious that several ‘free nodes’ were related and if they could not be ‘merged’ they could be subsumed into or subdivided. ‘Tree nodes’ were organised into hierarchies and given names that described the contents. For example during first level analysis, the ‘free node’ - **The privilege of caring** was subsumed by the ‘Tree node’ category **Intrinsic Drives** and made into a ‘child node’. Under this category (Tree node) seven other ‘child nodes’ – **good patient outcomes**, **sense of fulfillment**, **self-affirmation**, **being chosen by patients**, **love/enjoyment of the job**, **need/co-dependence** were also subsumed. Categorising continued until 21 other ‘Tree node’ hierarchies were distilled from the data. I then looked closely at these



Tree nodes and decided that they could be split up further into three major groups; **Being** (a person), **Being an Exemplary Nurse**, and **Becoming an Exemplary Nurse**.

Under the group heading **Being**, which I described as the nurses 'own being', I categorised the Tree node hierarchies; **authentic being, intrinsic drives, nursing meant-to-be, a passion for nursing, personal attributes, having a frank and reflective personality.**

Under the group heading **Being an Exemplary Nurse** which I described as the nurses being and caring for their patients and colleagues, I categorised the following Tree node hierarchies; **being an expert, to care for another, connections with others, knowing another, it's the patient's journey, working with colleagues, leadership and working together.**

Under the group heading **Becoming an Exemplary Nurse**, which I described as the journey of becoming an exemplary nurse, I categorised the following Tree node hierarchies; **wanting to become a nurse, training to become a nurse; specialty choice, becoming knowledgeable and critical friends.**

The next step was to shape these groups and categories further. I decided that while QSR NVivo was an excellent tool to sort and store the categories and to see the links and coding from the source document, I needed to write in order to gain a better sense of how everything fitted together. van Manen (1990) also commends writing as the method for analysis. Therefore, after printing out each Tree Node hierarchy and their 'child nodes' and storing them in separate manila folders, I started writing about each category in detail. This writing enabled me to ground myself in the whole data again and work with words rather than headings. It also illuminated a sense of the whole and be able to situate each unit of data into one category rather than having it coded at several nodes. The process of writing took several months and at its conclusion I had the three main headings and several sub-headings written in a chapter type formation. This privileged the participants' voices, with only guidance and linking of concepts from me. This first level analysis was an important foundation to the second level analysis.

## **Second Level Analysis**

Second level analysis occurred after the second round of interviews had been carried out. At this stage, I decided to re-code all the data using QSR NVivo with a larger lens.

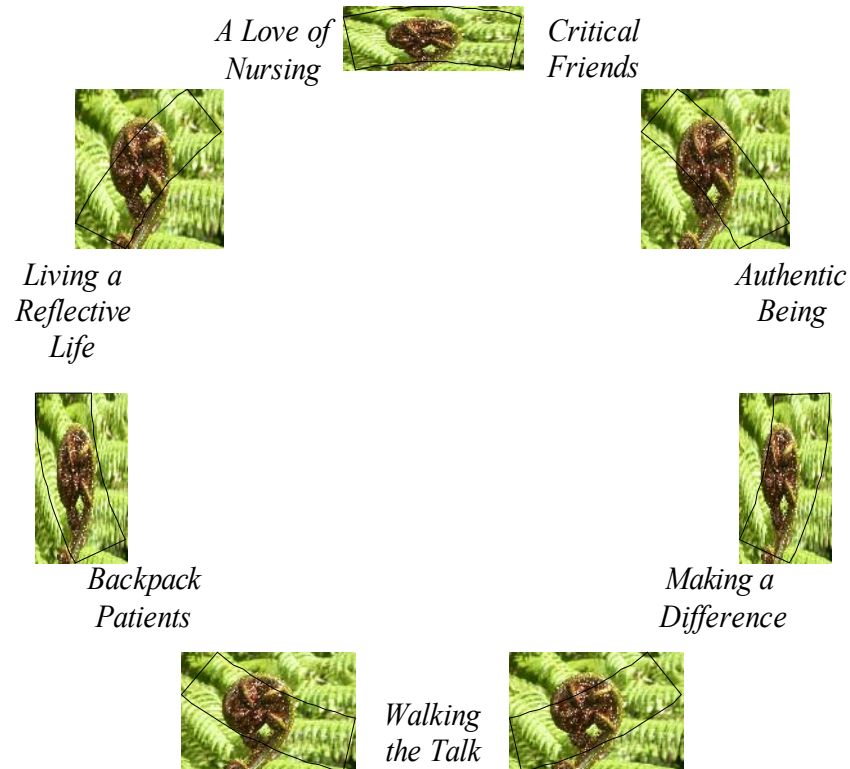
van Manen (1990, p. 92) described this as “*the selective or highlighting approach*” which is reading the text several times and asking what statements or phrases are essential in revealing the phenomenon. For the second level analysis I used the transcripts from both the first and second interviews of all ten participants plus the participants’ associated documents. Additionally I used the notes written in my research journals to assist this process and guide the analysis. At this stage, instead of looking at each word, I looked at the ‘big picture’ – highlighting each topic the participants talked about and asking myself “*what is going on here?*” and “*what is this example an example of?*” (van Manen 1990, p. 86).

I unitised and categorised each emergent theme, using QSR NVivo in the same way as I utilised it during the 1<sup>st</sup> level analysis, until 22 ‘free nodes’ were created. These units were similar to the first level ones but instead of using the notion of nursing as a ‘being’, ‘doing’ or ‘becoming’ approach – the ability to look at the bigger picture allowed for the true essentials to come out. These were then ‘categorised’ into seven major ‘Tree nodes’ (see Figure 5.) The original first level categories were assimilated into and throughout these essential constructs.

### **Writing as a Form of Research**

I found that writing was an inherent part of undertaking the analysis and presentation of this research. This mirrors van Manen (1990, p. 111) who wrote, “*human science is a form of writing*”. Richardson (1994) also believed this and stated, “*I consider writing as a **method of inquiry**, a way of finding out about yourself and your topic*” (p. 25). Writing allowed me to reflect on what was happening in the data. In this way, I was able to connect the various categories and themes together into a coherent and workable whole. For me it became a way of knowing, assisting me to both discover and analyse. Richardson (1994) believed that writing is validated as a method of knowing and assists knowing about self and knowing about the participants. van Manen (1990) stated that a certain form of consciousness was necessary when reading and writing and that it was closely linked to reflection :

*Writing fixes thought on paper. It externalizes what in some sense is internal; it distances us from our immediate lived involvements with the things of our world. As we stare at the paper, and stare at what we have written, our objectified thinking now stares back at us. Thus writing creates the reflective cognitive stance that generally characterizes theoretic attitude in the social science. (p. 125).*



**FIGURE 5: Seven Major Tree Nodes**

The seven categories and their ‘child nodes’ from the second level coding only alluded to the experiences of Being and Becoming an Exemplary Nurse, therefore once more I needed to write to assimilate my ideas. I printed out each Tree Node and its associated sub-categories and stored them in manila folders. At this stage, I used both the initial first level codings and analysis that I had written up in draft format and the second level analysis data. By using the coding stripes view in QSR NVivo, I was able to see if a unit was also coded elsewhere. I also used the data that I had collected as I wrote memos and notes in my research diary and ‘Ah Ha’ Journal throughout the research process. While I was writing, I used these notes to ask further questions of the data and to help me group, select and categorise the data into a meaningful text. Lincoln and Guba (1985) believed the results must emerge from the data, where the information that has been gathered in the field should be used to build a construction that serves to both describe

and explain the system under study. Writing allowed me to do this – to assimilate all the available information to construct the underlying assumptions of Being and Becoming an Exemplary Nurse.

### **An Ah Ha – One Core Category**

The Constructivists (Lincoln & Guba, 1985) and the Grounded Theorists (Glaser & Strauss, 1967) purported that this essential element would be one core construct or basic social process. However, after the second level analysis was written up into a document (named the second level draft findings), I believed all seven categories were equal and essential to B/being and B/becoming an Exemplary Nurse.

It was only after my writing was complete and these findings were placed aside, as I concentrated on other thesis tasks, that I got an ‘Ah Ha’ – Authentic Being **was** the core category. van Manen (1990) stated:

*In determining the universal or essential quality of a theme our concern is to discover aspects or qualities that make a phenomenon what it is and without which the phenomenon could not be what it is. (p. 107).*

Authentic Being was the essential theme that linked the others together. I further subsumed Living Reflective Lives into this core construct as I believed it was the mode and action of being and becoming authentic. This framework of one primary construct with five subsidiary constructs made the phenomenon of B/being and B/becoming an exemplary Nurse what it was (see Figure 6).

I subsequently changed the introduction and conclusions of the second level draft findings to illustrate this notion and sent the changes through to the participants for their comments (at this stage the participants had read the document with the seven equal key categories). After reading the changes, they agreed that being and becoming Authentic, through critical reflection, was related and dependent on their love of nursing; making a difference; critical friends; walking the talk; and their use of backpack patients – in both a personal and social way. This in turn enabled them to B/be and B/become Exemplary Nurses. This amended second level draft findings document became Chapter 4 of this thesis.



**FIGURE 6: Framework of B/being and B/becoming an Exemplary Nurse**

## **REPORTING THE FINDINGS**

The findings (Chapter 4) of this study describe the joint constructions that emerged via analysis of the data. They are consensus constructions with illustrations from individual participants. As the participants commented and critiqued the constructions that were developed, a consensus was made of the findings.

There were nearly one thousand pages of data collected from the participants, as a result of using the open question – tell me your story of Being and Becoming an Exemplary Nurse. Most of the data was used in saturating the categories related to the question and only specific participant examples and quotes were used to illustrate an idea. All the other relevant stories were incorporated into the construct and sit beneath - in the depth and layers of the findings. This notion was fully explained to the participants in the third interviews and they were fully acceptant that their data – although not physically present – was present in the integrated findings. However, the participants also told me many wonderful childhood stories that I did not use in this study. This was due to me changing from a Narrative based approach to one informed by the Constructivist Approach. While these stories located the participants in a particular culture and context, they were not relevant to use as demographical data to generalise from, nor could they be used in the joint constructions. I had thought that they could be used as vignettes to introduce each participant, but the over-riding methodology of emergent consensus construction did not support this use. I also realised that these personal stories of their upbringing could risk their identifiability in such a small population as NZ and therefore, I did not use them. This decision would have been supported by Glaser (1978), who believed data should only be used if it is linked to the core construction/category or basic social process.

### **Negotiated Outcomes**

A major underpinning of this study was negotiated outcomes. Lincoln and Guba (1985) described this as the facts and interpretations that find their way into the findings, being subjected to the scrutiny of the participants. van Manen (1990) also believed that meaningful human research would be impossible without the full understanding and co-operation of the participants. The ten participants in this study were willing to co-operate with me in order to uncover the multiple realities of B/being and B/becoming an Exemplary Nurse. The relationship between us was always authentic and a special form

of reciprocity occurred, where we both received pleasure and feedback from the process. I was aware that if this reciprocal relationship was disregarded, then the data that emerged may be incomplete, distorted and its meaning destroyed. However, while this was an important consideration in the approach undertaken, I felt that it was important that most of the ‘hard’ work be carried out by me. Participants had the right to see and discuss any aspects of the study as it progressed but I did not want the study to be a burden on the participants. Their input was gratefully received but I did not expect them to spend hours on the project either. To this end, modified dialectic hermeneutic circles – (interviews &/or conversations) – occurred between the participants and myself at designated stages throughout the research project. These stages included reading their first and second round interview transcripts for verification and comments; remarking on the joint constructions after the second level analysis had occurred and the findings were written up in draft chapter form; and validating their own quotes or vignettes reported in Chapters 3, 4 and their backpack stories (refer Appendix 8.0).

## Issues of Voice

It was important to me that the participant’s own voices spoke the research findings, however I was also aware that I did not want to present a raw and unedited ‘field text’ but a scholarly ‘research text’. I realised that the search for themes and categories that comprised this study and shaped the field text into a research text needed to be created by me. The dichotomy existed to where and how my voice should be presented. This has been described by Clandinin and Connelly (1994) as the dilemma of moving between field and research texts. They expressed this in an analogy, consisting of:

*Living on a knife edge as one struggles to express one’s own voice in the midst of an inquiry designed to capture the participants’ experiences and represent their voices, all the while attempting to create a research text that will speak to, and reflect upon, the audience’s voices”* (Clandinin & Connelly, 1994, p. 423).

Geertz (1988) wrote that it is harder to be in the text than be in the field. He believed that if the researcher’s voice was too dramatic it could obscure the text, yet on the other hand, if it was too subtle it might risk deception by suggesting the text spoke solely from the participants.

Most importantly, I wanted to report the findings in the participants’ own voices. I believed it was paramount that it was ‘their’ words that I used. While I had coded and analysed the data and therefore my input was a large part of the finding, it was still

‘their’ data that underpinned the whole thesis. This use of excerpts from their transcripts, exemplars, vignettes and anecdotes to illustrate each theme or category, was ideal for reporting the ‘thick description’ that would be essential in enabling transferability judgments (Lincoln & Guba, 1985; van Manen, 1990). It was also congruent with the axioms of both the Constructivist Paradigm and Human Science Approach, due to the multiple realities that are difficult to communicate in any other way. These are not there to make the text more readable but are a methodological device for making comprehensible something that is difficult to describe any other way (van Manen, 1990). Therefore, the use of these stories was a way of elucidating the features of the phenomenon – to make the essences visible. As van Manen (1990, p.122) said, this method is an *“example composed of examples”*. My input, although essential, was to guide the reader through the text. It was important to me that I did not over-write and over-explain what was happening. I wanted the text to communicate and interact with the reader, allowing them to experience what Being and Becoming an Exemplary Nurse was really like. van Manen (1990) alluded to the occurrence of *“epistemological silence”* (p. 131) where the silence of the spaces in the text speak as loudly as the words used. He believed it was important not to overwrite but leave things unsaid, that it is like poetry in that the text speaks partly through silence – the meaning more than it openly says. However, Denzin (1994) wrote that in the social sciences, there is only interpretation and nothing can speak for itself. He believed that it is up to the researcher to make sense of the data by moving from the field text to the research text to the reader. This *“art of interpretation”* allows the researcher to translate what they have learnt from the data and communicate these understandings to the reader (Denzin, 1994, p. 500). Interpretation becomes transformative and illuminates the experience for the reader, where: *“Meaning, interpretation, and representation are deeply intertwined in one another”* (Denzin, 1994, p. 504). He wrote that:

*Interpretation creates the conditions for authentic, deep, emotional understanding. Authentic understanding is created when readers are able to live their way into an experience that has been described and interpreted.* (Denzin, 1994, p. 506).

Moving from the field text to the research text was a complex process. In the first phase, I re-created the research text as a working interpretive document, first to clarify my own thoughts and make sense of the data and then to present a quasi-public text, which I shared with critical friends, whose comments and suggestions I wanted to use. These drafts were read by several critical friends, my PhD supervisor and of course the ten



participants. I knew I had said enough when they could not help themselves but comment (by writing literally on the draft) on what the participants had said. Whilst they all acknowledged the findings, their emotions were stirred when they read what the participants had said - either their quotes or in poetry. Often they wrote on the document, statements such as *'good on you Kate'*, *'I agree with that!'* They also wrote in the margins, giving examples of their own lives as if trying to communicate back to the storyteller their feelings and experiences. Of course this also occurred when the writing went back to all of the participants for member checking. This was the first time they had the chance to read the other participant's experiences and again their comments in the margins assured me that their colleagues had managed to illuminate the experiences of Being and Becoming an Exemplary Nurse. Therefore, reading and writing became central to the art of interpretation. Denzin (1994) wrote that it is only when the researcher sits down, writes the interpretive text, tells the story first to themselves then to their significant others then the public, that the researcher can make sense of or understand fully what they have learned.

I used the tenets of both the Constructivist and Human Science Approaches to present a research text that stressed both an emergent design and emergent understandings, while presenting the socially constructed realities in the participant's own voice. I have also portrayed myself as a unique being within the text - a self that claims to have some authority over the meanings and experiences that I have presented.

### **CRITERIA FOR TRUSTWORTHINESS**

The foundation of interpretation lies with trustworthiness (Denzin, 1994). Because conventional trustworthiness criteria such as reliability and validity were not suitable for the Constructivist or Human Science Approaches, I used the concepts of credibility, transferability, dependability, and conformability to affirm the trustworthiness of this study (Guba & Lincoln, 1989). Further to this notion, in criteria taken from Glaser and Strauss (1967), the Constructivists believed these grounded constructions should have *"fit"* and *"work"* (Guba & Lincoln 1989, p.179). 'Fit' relied on the categories of the joint constructions being allied with the information and data supplied by the participants. It also had 'work' because the findings were credible and easily understood by the participants as encompassing being and becoming an exemplary nurse and were useful for the participants themselves, for their future Being and Becoming.

## Credibility

Credibility is a criterion analogous to internal validity in that the constructed realities of the participants were congruent with the re-constructions that I attributed to them. Lincoln and Guba (1985) suggested several techniques that would assist credible findings to be found. They proposed an initial prolonged engagement for the study would overcome the effects of misinformation and distortion and build the trust necessary to uncover constructions and understand the culture the participants were working within. As discussed previously, this study took over five years and it would be fair to say that significant relationships were built up over that time. As I was a nurse, I was able to understand easily the context of their stories and therefore I re-presented their stories accurately. The constructions depicting mistakes in practice or the participants' shortcomings also give you an idea of the 'truthfulness' of the participants as their stories told not only the good but also the bad.

I also used different methods such as interview, exploration of written data such as the participants' poetry and writings and member checks to 'validate' the findings. Often this has been described as triangulation (Denzin, 1994) but I like the metaphor used by Richardson (1994) which she calls crystallisation, described as:

*Crystallization, without losing structure, deconstructs the traditional idea of **validity** (we feel how there is no single truth, we see how tests validate themselves); and crystallization provides us with us with a deepened, complex, thoroughly partial, understanding of the topic...What we see depends on our angle of repose. Not triangulation, crystallization. (Richardson, 1994, p. 522).*

Finally, the use of member checks was used throughout this research process. Guba and Lincoln (1989) believed this strategy to be the single most crucial aspect for establishing credibility. As discussed previously, the participants and I were in contact regularly over the duration of this study. At each step, they were all given their transcripts to validate and comment on. During the final third round of interviews the participants commented on any aspect of the findings chapter they wished. In particular several of the participants commented on the use of the koru metaphor, their congruence with the findings chapter as a whole, how they related to the other participants exemplars, and the importance of the backpack patients.

There were multiple congruencies with the notion of the koru metaphor that I used throughout the thesis with many participants stating that it was great choice and really

worked for them. Janet spoke for the majority when she stated, "*I think your beginning with the koru and how the fern unfolds and the spiralling and stuff was nice – and I thought Oh! What a good way to do that*" (Janet, 3<sup>rd</sup>, PTTC, 4).

Ultimately, the participants all felt that the findings were credible, although some in the beginning, believed it read too much like a "*fairy tale*", stating that it was not pithy enough – that the "*headings are too sweet – they are too romantic for the harsh world of nursing which actually makes exemplary nurses the way they are*" (Ellen, 3<sup>rd</sup>, 1, 32-33). Chris also stated that on starting to read the findings chapter she had a vision of "*nurses running around with little halos on their heads and saying 'Oh! Aren't we great!' and I am thinking 'Oh, I need to vomit!'*" (Chris, 3<sup>rd</sup>, 2, 4-5). However as she read further, she noted that "*all the categories were actually very pertinent really because they all resonated and had something to say – they felt right*" (Chris, 3<sup>rd</sup>, 2, 13-15). All the participants felt that the findings were truthful and had 'fit' and 'work'. Kirsten and Sharyn, noted that the findings "*rang true for me*" (Kirsten, 3<sup>rd</sup>, 2, 1) and "*being able to identify what each person said. The words passion, comfortable and instinctive – sort of fit for me. And the whole privilege of caring- is right*" (Sharyn, 3<sup>rd</sup>, 2, 3-4). Janet did not feel it was too 'sweet', stating that it read well and was well connected, she said:

*There was a nice variety and it wasn't all syrupy and sweetness. It sounded right. You pulled out, particularly for me, the critical friends, the mentors, the making a difference sustains your practice and walking the talk. You explained it well and the way you led into each person's little example was good. So you linked them together and it was an easy read. It was easy to follow.* (Janet, 3<sup>rd</sup>, 2, 1-6).

Kate also noted the ease of reading the chapter, stating that simple, clear and concise language is often more effective than complex language.

*I like simplistic writing, simplistic as in real...I think there is a huge profoundness here and I just loved it. It was gorgeous writing. I just thought it was neat. I think the headings are great and I knew from those headings what I would find and I found that they were perfect. I think it's a great sequence – they were exactly right – those topics came out – they were clear. The sub-titles are good too. I don't have any real critique on it – I just think you have allowed it to **be**. Its just fantastic – it's lovely!.* (Kate, 3<sup>rd</sup>, 2, 1-13).

## Transferability

Transferability may be thought of as equivalent to validity or generalisability. Guba and Lincoln (1989) stated that thick description establishes transferability. This thick description enables the reader to make an informed decision as to whether the findings of the study can be transferred to another area or not. This study used the voices of the participants to give a thick description and therefore allowed the reader ample data in which to make transferability judgments to their own situations. Anna highlighted this feature with her feedback from her third interview when she said would use the findings to teach leadership:

*I enjoyed it, its great and I think its going to be a wonderful piece of work. And certainly from a leadership point of view or an advanced practice point of view – what's here will actually be really important, because the themes are really important and I understood them definitely, and I like the way you named them too. I think from a leadership point of view, they are really important concepts. I am in the process of organising a leadership day and just looking at these themes, they are actually really good because I can see the transferability. I think some of this would be really useful just to give them as a concept to think about. When you think about authentic being or making a difference – I see that as very much part of leadership in whatever context you want. I mean – walking the talk – nurses are so bloody critical of each other – that whole credibility issue, I mean how do nurses become senior nurse and leaders? So there is transferability there. (Anna, 3rd, 2, 4-16).*

## Dependability

Dependability is parallel to the criterion of reliability in that it is related to the stability of the data over time. As discussed in previous chapters the emergent design of this study brought about several methodological changes and shifts of constructions over the duration of the study. As Guba and Lincoln (1989) said: “*far from being threats to dependability such changes and shifts are hallmarks of a maturing – and successful – inquiry*” (p. 242).

It is also important to note that one of the premises of this study was time and therefore the recognition that the participants may not hold the same construction forever and that this research will remain ‘true’ only for a ‘time’. This notion was acknowledged by several of the participants. Liz noted that on her first reading she felt her transcript was too superficial, that she was too subjective and critical of it. At a later reading, she noted that time, personal reflection and her mother’s death had made her able to move on, be more objective and comfortable about her feelings and herself. She also stated:

*I wonder if I said it now whether I would say things differently, whether they'd have some greater sense of depth, but I think all the things we talked about before like holograms and who you interview first and where you put people and what comes out.. I think its all part of a bigger picture. (Liz, 2nd, 0, 685-698).*

While for some participants being part of the study had caused them to reflect and move on, others stated that they had not “*had any great revelations about who I am or what I am*” (Jane, 2nd, 0, 497). Nor had they changed their perceptions and stories over time:

*There's very little in it that I would change. So in fact, in that sense, whether it's right or wrong, my thinking about my career and nursing is very set. Which I think is quite interesting. It hasn't shifted particularly, yet in that two years a huge amount has happened to me. So I suppose at least you can be reasonably confident that if you interviewed me again today, you'd probably get similar data. (Ellen, 2<sup>nd</sup>, 0, 499).*

## **Conformability**

Conformability is a similar notion to objectivity. It was about assuring that data, interpretations and outcomes of the inquiry were embedded in the contexts of the participant's stories and that all the findings conformed to similar ideas portrayed by the other participants. To guarantee the findings were based on the original data, I ensured that all participant exemplars and stories could be traced back to the original source by referencing (in text) them back to the original documents in QSR NVivo. I also wrote in my Research Journal, where all my thoughts, ideas and changes in thinking throughout the study were recorded – which allowed for ongoing and rigorous self-review. However, the most important component was that the participants not only agreed that their own individual excerpts were correct but they also approved the joint constructions. They commented on this aspect in the third interviews. Jayne stated that it all resonated and authenticated her own feelings:

*It made sense and it fitted together really beautifully and I really liked the themes that came out of it. When I read through it was really nice to see what other people had thought as well. It made me feel good because in a lot of ways, I would read a bit and think Oh! – that's just like what I said! So reading other people's excerpts and stories authenticated my feelings and experiences which was really good. I think in all of those different themes there was something from the other participants that was so similar to my experiences. (Jayne, 3<sup>rd</sup>, 4, 1-9).*

Liz commented on two important features. She realised that although her own stories may not have been used to illustrate a theme, other participant's stories had the same fit. She also noted that areas where she had less ‘voice’ were areas where she needed to look further into her own Being:

*I think for me it's the skill of being able to integrate everybody else's story into making a pattern. I think that became apparent to you when you were interviewing us but to read it (and we haven't had any contact with anything except our own stories) and then to actually see them alongside other peoples stories has been really a great experience. Although not all the stories we told are there physically – I can see they are! With all the themes I could see where that fits or that was my thinking along those lines as well – that's were that fits in too! And I think that's what made it such a rich experience – to actually see other people stories. There were some areas where I had little input and they were management ones. I think that's interesting because I thought these are the areas where I think – yes! that's the area I need to focus on more. The areas where I didn't comment on are the areas that I need to look for some more roundness for myself. But it's interesting because I didn't have a sense that I didn't understand anything – there was an understanding of everything everyone else was saying. (Liz, 3rd, 4, 4-17).*

Sharyn also noted that she had some of her Being illuminated by reading about others experiences and realizing they were also her own:

*It was interesting, noting about Chris and being in control. That is a reasonably strong attribute of my own personality and your comment about actively choosing clinical areas that suit personality – I wouldn't have consciously thought about that before – but I obviously do go to areas where the patients need direction...also I found – having a sense of the patient's experience was quite thought provoking because we so often think that we know best – even the art of nursing – being able to anticipate the patient's needs, even being good at doing that is being controlling. (Sharyn, 3rd, 4, 1-4).*

Kirsten, Kate, Jayne and Chris also noted that other participants had similar experiences and told stories they could relate to:

*It was really interesting to read that other people have had similar experiences and there were things that they others talked about or came up that I could relate to. So that was all good – definitely. I thought it was quite amazing really. There was nothing that jumped out and made me feel No! I don't think that at all, it's great. (Kirsten, 3rd, 4, 1-4).*

Janet noted that although the participants came from different clinical areas the themes used were familiar to all:

*I thought you did a good job of pulling out the themes that seemed to be familiar to most people. We were quite different – our areas of practice were quite different, so you did a nice job of having a variety of examples. The nurses had commonalities but you could see their practice areas were different and even how they thought. I mean obviously their thinking was different but at the end of the day, you were able to pull out the similarities and give examples of that. (Janet, 3rd, 4, 1-5).*

van Manen (1990) wrote that Human Science research is rigorous when it is rigorous in a moral and spirited sense - when the research text differentiates itself by its courage and resolve to stand up for its own uniqueness and meaning to which it has devoted

itself. In this instance, the use of the backpack patient stories was a novel and unique way to present stories. For Jayne, Kate, Chris, Janet and Sharyn, they stated that the backpack stories were very interesting and that they raised many personal issues and were very thought provoking. Kate illustrated this notion when she stated:

*I liked your backpack patients – it impressed me a lot. The whole thing does actually! It made me think about missed moments – sometimes we think Damn! we have just missed a poignant moment – but we can actually go back. And I think that your writing stimulated me to think about that. And if for whatever reason the timing is not right – it is a flag raised. If people are giving you the ok option – then you do have the permission to revisit it quite successfully. (Kate, 3rd, 5, 1-6).*

van Manen (1990) also believed that the standards of objectivity and subjectivity need to be re-thought. He wrote, objectivity in Human Science denotes that the researcher remains “orientated” and “true” to the object (participant) in front of them, while subjectivity represents the “perceptive, insightful, and discerning” nature of the researcher as they reveal the object in its full richness and greatest depth (van Manen 1990, p. 20). Kate reiterated this when she stated, “You can hear how deeply other people feel about their practice too. The depth is here – not just what is said – it is kind of between the lines as well – which is very powerful for me” (Kate, 3<sup>rd</sup>, 4, 1-2).

## **Usefulness for the Participants**

It was an important feature of this research that the process gave something back to the participants of this study as well as the nursing profession in general. I stipulated this in my ethics proposal and in my letter of information to the participants. I wanted them to be comfortable in recognizing their own expertise and exemplariness and have a degree of satisfaction that their data had given new knowledge to the nursing profession.

Being exemplary was initially an issue for some of the participants. However, by the end of the research process, the participants were accepting of the title. For Jayne, returning to clinical practice during the research process had made her more comfortable with the label:

*I didn't think much about being in the research until I came into clinical practice. And then I suppose I was working alongside others and I started to think about myself as an exemplary nurse. And it had changed from when we did that first interview, whereas I sort of felt uncomfortable with the title. Now I feel more comfortable with it. (Jayne, 2nd, 0, 475).*

For others such as Sharyn, it had both encouraged and affirmed her practice and illuminated her development:

*It has done a couple of things. In some ways, it has been encouraging and affirming that somebody thought I was exemplary. And therefore, it has made me think more consciously about that sort of role. It has reminded me that there is a responsibility (not as an exemplary nurse as such) but just being a senior nurse – not to be perfect but because I am a role model it has reminded me to reflect a bit more – to look at my own practice. To bring things to mind that were in my unconscious and open my eyes on the process of how I have developed as a nurse. (Sharyn, 2nd, 0, 427-450).*

The participants in this study were always modest and while they did not feel more special than other nurses that were not in this study, they recognised that being part of it had its rewards:

*I don't see myself as being particularly special. I have some special qualities but you don't think of yourself as being particularly more exemplary than others that you could easily name. I have had the opportunity to tell my stories and to contribute to nursing knowledge and that is something really special. (Liz, 3rd, PTTC, 2).*

For Kate the experience of being in the research was humbling, yet affirming of her worth as a nurse:

*It has been a really positive experience and it has been a very humbling experience. It's been a great honour and humbling, yet it reinforces in a way, that the things you do make a difference in your chosen field. So you kind of think its worth something. (Kate, 2nd, 0, 190-205).*

Being in the study also provided some participants a way to give something back to the nursing profession. For Sharyn it allowed her to give something back in a way she could never have done in an academic sense:

*I am not an academic person in any way so I would never be giving back to the profession in that sort of way but with this study – being asked about me as a nurse is sort of giving back I guess. Not that I ever consciously thought about that before. But it is reinforcing, affirming of why I want – why I am still nursing. (Sharyn, 2nd, 0, 452-470).*

Jayne felt that participating in the study contributed to both nursing knowledge and was also reconfirming of her own nursing passion:

*Being part of the research, I think being willing to be part of it – putting yourself out there is sort of important. Like it's important to share these things – contribute to nursing knowledge. And the willingness to do that. I don't imagine someone who didn't feel passionate about nursing would do that. So in some ways, being part of the research is reconfirming I suppose for me and my passion for nursing. (Jayne, 2nd, 476-490).*



Jayne also said at her third interview that:

*I am really happy about it; I think it has been a real privilege to have had the opportunity to share the stories and to know that I have contributed – that I will add to nursing knowledge. It has come at a really good time for me - it made me feel really good that I am in this and that I said these things! I want to keep it and give it to my children and grandkids to read. (Jayne, 3rd, 6, 1-5).*

All the participants acknowledged that exemplariness was not a static thing but was ongoing. Sharyn aptly stated this when she read the joint constructions in the findings chapter:

*Being exemplary is not a static thing, you don't necessarily arrive at being an exemplary person. It is something that is ongoing. At times, just in general, reading other people's stories – some of them are just amazing – its hard not to feel Wow! They are amazing nurses. I mean they would be people to learn from. Learning from our mistakes certainly came through and it was certainly encouraging to me – it definitely was. (Sharyn, 3rd, PTTC, 1).*

## **SUMMARY**

In this chapter, I have presented the methods used to analyse the data. This complex process revolved around the use of the computer programme QSR NVivo to store, manage and code the data before transforming it from a field text to a research text through the use of writing as method. Through the use of negotiation, the participants' voices were an important part of presenting the findings and they assisted in imparting trustworthiness to the project.

In the following chapter, the koru unfurls and the findings are explicated. These findings revolve around being and becoming 'authentic' – the pivotal construct to being able to B/be and B/become an Exemplary Nurse.

## CHAPTER 4

### THE KORU UNFURLS – TO REVEAL THE FINDINGS



#### MULTIPLE KORU WITHIN THE FERN

Like a koru unfurling, this chapter illustrates the journey that is B/being and B/becoming an Exemplary Nurse. It is a story of individuals yet it is a story of them all. It is a narrative told by individuals who reflect, like the multiple koru curled up within each fern, the stories that illustrate the whole.

The pivotal construct or outer stem of the koru symbolises the participants' journey of Being and Becoming an Exemplary Nurse - being and becoming '**Authentic**'. This primary koru is the pivotal piece that joins the exemplary nurse together. Within

this construct is 'Living Reflective Lives'. This pertains to the participants continually, consciously, and unconsciously reflecting on all the facets of their lives. Linking each experience and lesson taught, back into the whole - into their journey. Examples of the importance of Living Reflective Lives are evidenced in the Backpack Patient Stories in Appendix 8.0.

'**Authentic Being**' is a combination of being able to be yourself, your own person and be the nurse. Authentic being symbolises relating self with others – the Being with the doing. It encompasses knowing and being oneself – understanding your impact on others and having moral courage to act where others fear to tread. It also includes an appreciation that 'B/being' is a constantly revolving construct and involves having balance in one's life and being able to move on when appropriate.

This outer koru (pivotal construct) encompasses and nurtures five subsidiary koru (major constructs). Each of these, while separate are all connected within the whole. In

turn, like a fractal – the divided koru reproduce and mirror themselves - within each koru are smaller koru again (categories and sub-categories).

The first subsidiary koru is the participants' **Love of Nursing**. Without this they would not be able to be and become exemplary **nurses**. It encompasses the recognition of the privilege of caring for others and the acknowledgement of enjoying being with patients but not having to seek it out for self-gratification.

The second subsidiary koru – **Critical Friends**, is a nurturing one and includes being pushed beyond your boundaries; being impressed by another and having like-minded friends. These critical friends helped the participants to be and become the exemplary nurses they are today.

The third subsidiary koru is **Making a Difference**. This is one of the sustaining factors that allow the participants to continue on their journey. It consists of being the best they can be by being life long learners; by being on top of things and in control and going the extra mile. It is also about having a sense of the patient's experience and having caring communications and connections with others by respecting them and acknowledging that it is their journey.

The fourth subsidiary koru – **Walking the Talk**, is associated with relating to colleagues and includes communicating and connecting with their workmates and walking alongside them as a team builder and leader.

The fifth subsidiary koru - **Backpack Patients**<sup>13</sup>, is the mechanism by which the participants relived and learnt from their 'sacred moments in practice'. These remembered times, assisted the participants to make sense and meaning from these interactions; to construct a knowledge base of skills, experiences and methods to relate with patients the next time a similar situation happened and facilitated communication and 'talk the talk' with colleagues.

In this chapter I have used the words of the participants, and myself as the researcher, to describe these phenomena. Most of the sub-headings are words and statements taken directly from the participants transcripts. And while there is obviously a subconscious impingement of the literature on both the participants and my own knowledge and therefore our use of vocabulary, I have kept the conscious use of referencing from literature sources out of this chapter. This is in order to allow the voices of the

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<sup>13</sup> I explained the notion of 'Backpack Patients' to the participants during the research process and it became a collective metaphor for all of us to describe our stories of practice and how we remember and carry our patients with us.

participants and myself to speak as we emerged, unfurled and constructed our own meaning of B/being and B/becoming Exemplary Nurses.

**AUTHENTIC BEING – “A COMBINATION OF BEING ABLE TO BE YOURSELF – BE YOUR OWN PERSON AND BE THE NURSE”**

Both the participants and I used the term ‘authentic’ during our interviews to describe such notions as being yourself, being your own person and in-turn being the nurse. Authentic B/being is both being oneself and being the nurse. It is where the multitude of experiences that make up one’s B/being combine in the many different patterns that are life/nursing. The participants were aware that to truly ‘know’ another they must first know themselves, and to be able to make effective relationships with others they must ‘be’ themselves – they must join the professional and the personal (i.e., their nursing being with their personal being). They were aware of their impact on others and used moral courage to remain authentic. To Be and Become exemplary they harnessed all their knowledge of self and their interactions with others to become truly authentic in all aspects of their lives. They did this through reflection – living their reflective lives as a means to put their authentic being and becoming into action.

*It is a combination of being able to ‘be’. Be yourself - be your own person and be the nurse and give from the whole of you I guess. And the spin off of that is I guess fulfillment for you. That being, that sort of giving, I guess that sense of - it is not like you are just working as a nurse, which is only a part of the whole of you that is that way but its relating and caring and doing, it is yeah, from all of you, from the whole person I think. (Sharyn, 1st, 0, 223-235).*

B/being and B/becoming, though, is a journey and different situations occurred for the participants during their lives that altered this for a time. For all of the participants there were times where things seemed to slow down, where they felt they had been spiralling out of control, not moving forward or where they had felt their nursing being had been at odds with their own Being. At those times it seemed as if they are were not moving at all, yet by the use of reflection the participants were able to control the issue, make the changes necessary to alter the pattern and in turn alter the spiral. This often meant moving on, making a change or reconciling their being with their becoming - in essence caring for themselves.

## LIVING YOUR REFLECTIVE LIFE

The participants were able to be and become Authentic Exemplary Nurses, through a myriad of processes and experiences throughout their lives – but primarily through the use of critical reflection. They had reflected on and acknowledged their love of nursing; they had used their backpack stories and communications with their critical friends to make sense of and meaning out of these interactions, learning from each interaction and used these to ‘walk the talk’ with others and make a difference for those they cared for. They lived their reflective lives. These nurses continually analysed and scrutinised their interactions, actions and decision making. It was both a subconscious and conscious mechanism to ensure they continued to make a difference for their patients, for their own self knowledge, growth and authenticity. The participants and I believed that reflection in/on practice was a pivotal feature of their Being and therefore, their Becoming an Exemplary Nurse. *“I think if you live your reflective life, if you actually take on board what’s occurring to you in your practice and walk the talk then perhaps you are doing it in a way that becomes second nature”* (Kate, 2<sup>nd</sup>, 0, 76-80).

For Sharyn, reflection was a constant, innately subconscious action. As she had grown, matured and gained more experiences it had also become more conscious – a technique to become the best she could be.

*The process of thinking what do I do? It happens at the time, on duty and on the way home but I don’t do it in any sort of formal way - its subconscious. But over the past few years it has also become something that I have done consciously at times, especially in my personal life because I have needed to work through things and as a result doing that becomes a bit more of a day to day thing and professionally it just seems to flow onto that I guess. Until the last few years when reflection became sort of part of the polytech training, you’d hear it was a particular sort of concept, it wasn’t something that you thought of consciously or necessarily did consciously. It seemed like it was something you did anyway because you wanted to be better at what you do. You want to avoid the same mistakes I guess, but certainly be better at what you do. And part of the reasoning behind that I think for me has been this sort of an evolving think of the patients not just being a patient but as another person. Not just that they have a right to receive the best that you can give of the best care, it sort of goes beyond that, it’s a bit more than just the right or the entitlement. They deserve the best you can do.* (Sharyn 2<sup>nd</sup>, 0, 180-209).

For Liz reflection was also an innate and instinctual act.

*I think when I am practising there’s a sense of it on the whole being right or me knowing that it right. So its instinctive. And in solitude there is a reasonable amount of personal reflection, that’s possibly why the reflections side is so important.* (Liz, 2<sup>nd</sup>, 1, 420-435).

The participants use every patient interaction, both positive and negative, to inform the next, reflection on/in practice being interwoven into the fabric of their nursing.

*There is something about the uniqueness or profoundness perhaps of every situation that you reflect on, or I reflect on. And within the uniqueness there is always commonality. Within the uniqueness of two people in the bed next door to one another I say to myself what can I learn from Mrs. A and Mrs. B and take to my practice with Mrs. C? (Kate, 1<sup>st</sup>, 0, 108-118).*

The participants reflected on their decision making, questioning the outcomes and always asking themselves whether they could do better. They believed that if they ever stopped reflecting and questioning it was time to get out of nursing.

*I think that one of the things I used to say and I still firmly believe is that I have always questioned. Well before reflective practice was a thing, I would question how it went, how it could have been different. It's a sense of responsibility in a way. I think it is one of the things I always used to say is, if you don't, as far as I am concerned, if you don't question it is time to get out, because you should never take it for granted I think. ...Yes its part of that reflection isn't it? Actually saying how did I do that? How well did I do in that situation? (Liz, 2nd, 1, 156-173).*

While Joc loved nursing with her whole heart, she stated that if she was getting feedback that she wasn't performing she would stop herself, reflect, learn from it and change her practice.

*I just loved it...and what gets you up every morning? Well what keeps me in the job when I really should be retiring and my problem is I just love it! You know? ...and you can't help wanting to do the things that you enjoy and that you still get a feedback that you are doing a good job. If I started getting feedback that I wasn't doing a good job I think I would stop and learn by it, but I am still getting feedback that I am doing a good job. (Joc, 2nd, 0, 320-414).*

Reflection for the participants was not just a reflection on thoughts and feelings and observations but a critical analysis of the whole incident - looking at the whole picture from every angle. It was about looking at the consequences of decisions and being able to see beyond the outcome at hand.

*For me when you reflect on something you should be reflecting on what is going on. Not for example, what one staff nurse said to another staff nurse but what it is about the conversation that's rooted in a history and where does that come from? And how is that history framed by the context in time? What structures serve to keep in that particular place; who's advantaged; who's disadvantaged; what does this mean for nursing; the health care system and what does it mean for our consumers? I suppose what I am saying is when you start looking at reflective practice stuff you will find people talk about critical reflection but they don't actually do it to the depth that is required. (Ellen, 2nd, 0, 293-306).*

Reflection was not about regurgitating a story or telling a story for its own sake.

*I think they're fantastic and we learn by story telling. But where is the reflection within this? Because it's not the stories that change practice its what we do with the reflecting on them that does... I use the analogy, in terms of reflection, of the movie sliding doors. If this happened this is the consequence and in a way I sort of see that in terms of reflection, its like ok, I might take this step or that step, but what would have been beyond those sliding doors as a result of that? And next time I will walk through them knowing what I know now that I didn't know before. And where did that take me on my journey and in my practice? (Kate, 2nd, 0, 6-68 & 279-287).*

For example, in many instance during our interviews the participants recounted stories which illustrated mistakes or errors in practice. All the participants described these instances as profoundly disturbing. However, they continued to reflect on them and learn from them.

*We get these wake-up calls that just make you reflect on your practice and think what was my role in that? It is a great reflective tool ...I think the important part of it is that you can think and reflect and many people don't, you know? Truly they don't reflect on their practice. So reflecting is actually a good thing because our practice lives are not full of doing the right thing all the time, but when there is a problem we can learn from it. (Kate, 1st, 0, 101-105).*

For some of the participants they described feelings of impostorship, fraud, doubt, or lack of confidence in their practice decisions. However, on deeper discussion with them it was often a method used for reflecting on their Being and examining each situation to see how they could have improved the interaction or situation. It was used to reassess and check they were doing their best, that they were well prepared and not taking themselves for granted - to keep control over ego.

In the following conversation with Chris, she reveals how she feels when she takes up a new position. Although she says she feels like an imposter, on further questioning it is her Being – a reflective person who continually wants to make a difference.

*"You know a lot of the time I feel like an impostor...it's that sense that you're picked but that you never feel quite prepared enough for what you are supposed to be doing. And I did try to get into a different mindset when I picked up this clinical lecturing job because again I went through my old stuff about Oh! I can't do this! I can not do this! And I thought Oh don't be stupid of course you can, you know how to do it, why can't you do it?"*

*"I wonder if this is part of it too? This way of your Being? Is it part of being a reflective person?... that in fact it is not necessarily a bad thing? Do you know what I mean? That you think about all this? That you analyse it and you question it?"*

*"But in some ways it constricts me, whereas I think other people would perhaps just think yeah I can do that, just go for it!"*

*"But they might be bloody hopeless!"*

*"Yes I know but a lot of people don't actually worry about that!"*

*"Well you see that's the point they are not exemplary. I think exemplary nurses do! Which is their whole Being"*

(Chris & Rae, 0, 201-223)

Joc also talked about impostorship. The culture of nursing not allowing her to take pride in her own 'goodness'.

*Impostorship, now that's another one that's hung over me in my life, its like going back to my mother, if I did get a good mark or an A or something like that, I'd think next time they would find me out. Or if I did well in the job, in nursing, or it was an emergency and I managed well, I'd think next time they will find me out. And I find that quite interesting that that hangs over quite a few people's heads. That I'm really not as good as they think I am, somebody will find out that I am not as good. (Joc, 1st, 0, 207-215 & 300-342).*

In another conversation with Kirsten, she clarified her feelings of lack of confidence as not a negative thing but a mechanism for reflection.

*"It's like this exemplary nurse thing isn't it? You've got that background of knowledge and expertise that you have but what we are talking about is what's on top"*

*"Yeah"*

*"And not everybody has it and I am not sure why. Well that's what we are looking at isn't it?"*

*"I wonder if it's about the ability to reflect?"*

*"To be making a difference and be truthful to oneself?"*

*"Yeah. See you were saying before that I lacked confidence and you were saying no but I didn't. I have always lacked confidence and I still lack confidence but as I reflect on that more it makes me angry... I think well Hey! That is not necessarily a negative thing. That is just me saying to myself is this right? Do you feel ok about what you are doing? Is this the right decision? How does this person feel about this? you know what will other people think about this decision?"*

*"That is your reflective circle, so it is not such a bad thing at all"*

*"Yeah"*

(Kirsten and Rae, 1.1, 360-401).

Many of the participants had a full understanding of their personality type and how it linked into their being a reflective person. Most often they had found out this information while running or being part of a structured programme of learning. The participants described being an introvert as part of their personality type.

*I mean if you look at Myers Brigg personality I am an introvert and its part of what I do. I think-do-think. And that's what I am like about most things in my life. Think-do-think. Yes. Yes! (Liz, 2nd, 1, 498-511).*



*I am an INFP which is introvert, intuitive feeling and perceptive. It is fascinating.* (Kate, 2nd, 0, 313).

*I think because I am an introvert and so introverts don't generally get their energy from other people a lot of the time they get it from within themselves and stuff.* (Chris, 2nd, 0, 328-339).

The participants all reflected constantly on their interactions, reactions and conversations with others. Being and Becoming an Exemplary Nurse was an interweaving of Loving Nursing; Critical Friends; Authentic Being; Making a Difference; Walking the Talk and Backpack Patients. These were all linked in a spiralling koru by the ability and capacity to reflect and take action - to 'Be' and 'Become'.

*I think that's probably what being and becoming is a bit like isn't it? It's not overwhelming but it is part of you constantly. It's an integral part of you that is influenced by your practice and influenced by things around your life. And it gets to the situation where it's an 'Ah Ha', Ah! This is what it's all about really.* (Liz, 2nd, 1, 57-67).

## **Knowing and Being Oneself**

Knowing oneself and being true to oneself was *'the fulcrum or hub'* (Sharyn) of Being and Becoming an Exemplary Nurse. This was a critical knowledge – recognising their good and bad points and knowing how they were when they interacted with others and how this impacted on others. They did this through living a *'reflective life'* (Kate) - reflecting and learning from both positive and negative situations and experiences. Because they knew themselves, the participants were then able to be authentically present in each relationship they had. This meant they were able to be themselves, feel comfortable doing so, provide professional care to their patients and have supportive and productive relationships with their colleagues. This knowing and being oneself allowed a genuine understanding of their impact on another's life. Having an awareness of cultural safety and the notions of power also meant authentic relationships could form. Participating in this authentic nurse/patient relationship permitted the participants to use their moral courage and take risks in situations where others may have feared to tread. This allowed the participants to have genuine and therapeutic relationships with their patients and families.

All of the participants came to know themselves at different times on their journey of becoming exemplary. It was a time where their nursing being and their own being was becoming one, a joining of the personal and the professional - where they acknowledged

their love of nursing and enjoyed making a difference in another's life. There was an understanding of their own strengths and weaknesses and an understanding of their impact on those they worked and lived with. It was a time where true authentic connections occurred with their patients. A time where constant reflection and re-action became their force for becoming.

Liz wrote a poem that beautifully illustrates knowing and being oneself:

*A wise woman told me to go and sit by the sea,  
I discovered strengths in knowing,  
symbolism,  
age and experience,  
wisdom and authority  
Understanding of the connectedness of mankind, to each  
other and the environment.  
I recognised fear of stumbling or being out of my depth  
An understanding that I had been inclined to not take the  
smooth path along the waters edge,  
but had climbed up the rocks  
making life more complicated that it should be.  
A recognition that life comprises of rocky pools as well as  
calm seas, the crustaceans add the texture and challenges  
to our lives.  
I could place myself to face the incoming tide, choosing  
whether to climb over the rocks or get my feet wet  
My recognition regarding my personal realistic goal is my  
desire to be fully present in the moment,  
not to hide behind insecurities. (Liz's poems, 0. 3-29)*

It is a profound time when one begins to understand oneself. For the participants in our study it was a watershed, an 'Ah Ha' (Joc), a time where being yourself 'made sense' and this in turn fulfills the nurses' desire to 'make a difference'. These 'Ah Ha' times were different for all the participants and occurred at different times on their journey.

For Anna, this time came when she was sent to work in a different practice environment and to care for a patient with an unfamiliar condition:

*And so I thought well I have made a difference to this woman today. Because I've just been me and she's responded to it. I mean from a nursing point of view I mean - what is it?, what was I doing? Well I'll tell you. I was being human and being with her and doing what I thought I would have done with anybody. So that was a real eye opener, because suddenly I realised that what I have from a practice point of view ... That's some of those, I suppose essences of what nursing is about. It doesn't matter where you work...So that was huge. I mean that was quite affirming really. Because it made me refocus around what is the essence of nursing and what are we here to do. (Anna, 1st, 2, 112-113).*

Undertaking higher nursing qualifications and education was important for both professional and personal growth for all the participants. It allowed them time to reflect consciously on their Being; their behaviours; their upbringing and in-turn its relationship to their practice being. For Joc and Kirsten this development occurred when they undertook a Master of Nursing Degree.

*When I was doing my Masters and I was busy working in busy surgical type wards and I was writing about my practice, I suddenly had this revelation that here was this motivator, motivating the surgical patients to be up and here was me nurturing and tucking them down sort of. And I could just see my mother there. And yet I had fought my whole life not to be like her. So that was like, when I reflect on things one of my Ah Ha's. I simply did not know that about myself. I didn't know I'd brought motivation to my nursing practice and didn't know that I'd brought that much caring and cuddling. (Joc, 1<sup>st</sup>, 0, 15-23).*

*Completing this research has profoundly radicalised my thinking. Not only through the expressed interpretation but also through the process. It has challenged me to critically reflect on my own nursing practice and on the role of nursing in general. Through this reflexivity I have become increasingly self-aware and self-understanding. (Kirsten, AD, 0, 19-20).*

### **A Joining of the Professional and the Personal**

For the participants their lives as nurses were not separate, but part of a whole self – a joining of the personal and the professional: *"You see nursing is to me, if I have to say a word, its being. It's your whole life, you don't turn it off when you walk out the door, you simply don't - you are a nurse and you are never not a nurse" (Joc, 1<sup>st</sup>, 0, 57-910).*

Amalgamating the professional and the personal took time and a commitment to learning new things. Being confident to 'be' themselves in practice, created an authenticity that permitted deep and meaningful patient/nurse relationships to grow.

*I mean even from a personal level let alone a professional level I don't think you can say that you have arrived. You have to be open to learning new things, discovering and yeah how you respond to those things or what you do with them molds you or makes you I guess. And as I get older I think the personal journey is not separate to my professional journey. But I can see the growth probably professionally is influenced by the personal journey, which makes sense. And I guess that's the way life is. And I suppose you can't help but be that way really because in nursing you are dealing with people and so are relating with people, you are not just doing for them. It brings your being into it as well. ...And there are certain aspects of being a nurse that are always sort of consciously professional. In the way that you relate and do. But I think I have found that I more and more have been able to be myself when I am working. I guess that comes from probably being more comfortable with myself as a person as well as the advantage of a number of years nursing. And that enriches how you relate together. And therefore whether you can move on or grow deeper perhaps - rather than stay at what some people would say is a professional or a client sort of level. (Sharyn, 1<sup>st</sup>, 0, 4-19 & 223-235).*

Being authentic allowed the participants to connect with their patients in a meaningful and therapeutic manner:

*To be authentic, I don't think you can separate out the personal from the professional. Because I think that you in some sense in one world you would have to be acting if that was the case. And that's not to say that you don't have to behave in a professional manner ...I think we live in a society that encourages us to switch off the personal and I think that you can't. It's very hard to grow and develop if you don't know who you are and you can't tune into who you are. And it's also hard to connect with others in a way that is meaningful and moves them forward if you at first don't know yourself. (Ellen, 1<sup>st</sup>, 0, 218-273).*

### **Impact on Others - Bit Players in Other Peoples' Lives**

The participants had a deep understanding of themselves and therefore their relationships with their patients. They were fully aware that they were only part of another person's life for a short time, that they had a very powerful role and that they were able to make a significant difference.

*We are as nurses very small, you know we are bit parts in other people's lives, we are bit players. We have a small part, we are only there for a very short period of time and we can make a phenomenal difference one way or another and I think for me that's really important to remember that. Because it's an incredibly powerful role, I mean unbelievably so. (Liz, 1st, 1.5.1, 198-206).*

Liz again put this so well in another of her wonderful poems:

*My visits to the beach are like visiting patients, they are full of surprises. I imagine what it must be like but each week it's a different picture. The coast is the same, the time of day is similar, the weather has been similar, but my ability to observe the scene has been very different.....*

*I became aware of the others I shared the coastline with. On my first visit, I could see only the big picture; The skyline, the sea, rocks, and houses. Last week, I became aware of about three swallows that kept circling round me, they appeared as if they wanted to communicate in some way.*

*Today, there were about six swallows, they would fly back and forth around me. There were numerous seagulls, a small black butterfly was also making its way back and forth along the beach. I walked around the rocks and came across two kingfishers. The uniqueness, but similarity of the situation struck me, how like our own situation.*

*The sea-scape, was framed by mountains to the north, a rising sun in the centre of my view, and to the south cloud. It was difficult to distinguish the cloud from the mountains, they frame the horizon to balance the scene. I had to look closely to see that they were both very different. That the mountains were solid immovable forms, whereas the cloud would change and dissipate.*

*Last weekend, the brilliance of the sun-rise took my breath away. As the sun first appeared over the sea, there was a moment, when it appeared, as a pure white light, It made me exclaim in wonder. The situation, so familiar, but every experience is so totally unique. This is what each human encounter is like for each of us. We may imagine we know what is important for another to discuss. However, the reality may be very different.*

*As I walked along the water-front this week, there was an image of my shadow. When I first became aware, it was an upright shadow, many metres high, and a mere finger's width. I was a surprised to see it. I thought, this is the impact that I, as a nurse, have on others lives. It has made an impression, but left a narrow perspective, for a very short period of their lives. A continual reminder of our role, to merely stand alongside.*

*Today, I sat by the sea, it was wet, raining, the sky was heavy and grey, the sea was grey with big rolling waves, and spume being lifted off the waves by the wind. There was a sense of excitement about it, for me it felt hypnotic, I had a sense of energy, of being part of their environment.*

*(Liz's poems, 0, 51-103).*

Liz was well aware of the importance of this poem for both herself and others. She stated that she should share it with others to inform them of the importance of being a small but significant part in another's life.

*I think I'd really like to do some sort of presentation about this poem. Because I have taken some photographs and I think I've talked about this sort of thin shadow. I am thinking this is the impact we have on other peoples' lives you know it is just such a small part of their lives but you have the ability to affect it negatively or positively. (Liz, 2<sup>nd</sup>, 1, 383-391).*

The notion of cultural safety was also an important component of knowing oneself and being aware of the powerful role nursing has. To be truly open to another's 'Being' you must at first understand oneself.

*I think what most makes sense to me now is Irihapiti's cultural safety, the notion of cultural safety, the notion of knowing self and being aware of power in a health patient relationship and nurse patient relationship. (Ellen, 1<sup>st</sup>, 0, 248-254).*

*In order to be truly open and attentive to another we must approach the individual as a 'unique being'. In doing this we must be aware of our own beliefs and values in order to recognise the way they may influence our understanding and response. (Kirsten, AD, 0, 9-10).*

### **Moral Courage – To Act Where Others Fear to Tread**

Having 'moral courage' (Janet) was a common theme for the participants in my study. It was about being open, sincere, honest and truthful with patients and families. The participants were truly authentic and were able to look beyond the consequences for themselves. They had confidence in their 'Being', which allowed for judgment calls and certain risks to be taken when they dealt with situations which were often meaningful and challenging for all involved. It was about going the extra mile and going where other colleagues 'feared to tread' (Chris).

*It's about making decisions about whether to stay quiet about something or not and its really part of that whole reflecting and deciding what you are going to do – its about moral courage. Moral courage is about the ability to be able to not*

*worry about the consequences for yourself. To look at the bigger picture and the consequences of the greater good for the greater numbers. (Janet, 2nd, 0, 103-111).*

*There are no easy answers. Facing a new challenge requires flexibility, innovation, creativity, and confidence in your nursing knowledge. Do not be frightened of being a risk taker – try new things and revisit old ones. Use the resources that are at your disposal. Most of all be with your patients, listen to their concerns, be guided by what is comfortable for them and acknowledge and deal with what is uncomfortable for you. (Anna, AD, 0, 110-111).*

Higher education, wisdom with age, and multiple years of nursing experience all assisted with gaining both self-knowledge and self-assurance in practice. This in-turn enabled the participants to practice with moral courage.

*I mean it didn't happen overnight...for me there was a confidence in what started out as initially fairly well yes I can be with someone... and I think it came with experience... and it was probably after the Advanced Diploma in Nursing and that was a year out and it was probably after that I probably was a bit more confident. ...And I think you get to the point and I think that's where I am now is I am quite happy to be I suppose what is my true self. And I will take risks with that. Whereas before I probably wouldn't have. (Anna, 2<sup>nd</sup>, 0, 154-158).*

Situations often occurred for patients in times of crisis, such as when they became critically ill, were dying or had been given distressing news or diagnoses. The risk occurred when the nurse made a decision to use her moral courage and intervene in the situation, possibly bringing their relationship with the patient/family into jeopardy.

*I think it's about not wanting to be on the surface and I think that on reflection everyone else was just on the surface and they weren't getting anywhere. So you had to try to go deeper. And it's the stuff about whether nurses actually want to go that extra mile or be responsible for perhaps getting in where you might now fear to tread...And I was terrified in the sense of what am I going to do? ...I felt somebody had to do it, nobody was taking any blinking responsibility for trying to help ... there was nobody else doing anything. And I often wonder, I don't know that any of my colleagues would. I sort of think that some people would have felt that it wasn't sort of part of their nursing, that I sort of had gone off on a sort of a tangent, that should I have been dealing with that, you know? (Chris, 2<sup>nd</sup>, 0, 301-324 & 1<sup>st</sup>, 1.1.37, 270-295).*

The need to use moral courage also occurred with relatives. In these situations the nurse needed to be authentic, honest and up front. They also needed to find out what was causing the problems and work together to fix them. Again, like any time that moral courage was used it was important for the nurse to reflect on their behaviour and question how they might undertake this type of situation again in the future.

This type of situation occurred with Kate, who used a straight up, direct approach.

*So reconstituted families, who have lots of issues, which is where I've had that sort of tough approach. And its usually been lots of back-stabbing and twittering going on ...and I would call them to attention, very firmly and say, that I will not have that going on. I have been very out front and direct and just giving them the bare facts, it is unacceptable behavior, and I won't have this going on. I appreciate that their family member is dying here, but this is not the time for this, now I want to cut the crap and let's sit down and really find out what is going on here...and meanwhile I am so tachycardic! But I have been able to and each time that I've done it, it has always worked out. Its like needing scapegoats, I understand that, and they need to fire some shots when they are out of control, and we are dealing with people who are stressed, so we are likely to see that and its about knowing the balance of taking on personally, versus being able to see through the mess, to find out the gutsy stuff that is going on for the family and dealing with that. But I think that can take a bit of getting used to because we don't like hurting ourselves and trouble like that can so often be personalised. So I think although I did that on a number of occasions and it worked successfully, it wasn't without some degree of personal cost in the beginning, to challenge was I right in this approach? The outcomes were right but could I have done it differently? How would I do it again for the next troubled family?... and I thought about it a lot. But that dealing with it direct and head-on in language which they understood, seemed to work. And so I actually didn't change it and it didn't trip me up, it turned out positive and that is good. (Kate, 1st, 0, 132-156).*

Moral courage was about looking deeply into the circumstances for the individual patient, weighing up the pros and cons and then meeting them at a level they were comfortable with. By caring for patients authentically, with confidence and honesty the participants created both a sense of normalcy and safety within the nurse/patient relationship.

*I think for me it has always been meeting them at a level that they're comfortable with. And you can sometimes find that easily and I think is how you are in your interactions with them and it depends on the individual. And to deal with I guess some risk taking, I think I mean I think you need to ask question why? – this could go either way, I mean it could go ... like I could loose the whole lot here and I am talking about things that are meaningful for them but also challenging to them. (Anna, 1<sup>st</sup>, 1.1, 330-356).*

*I think it is a safety issue. I think for the people who are dying, they need to know, they need to feel safe. And it, I often liken it to a child who, who's allowed to go swimming in the sea, to just go out there. They have no, you know they go out that far that they could drown, which is a bit like the process of dying in a way. But if there is a rope support pulled in on you, that you actually can't swim beyond this point here, then it actually might fell annoying but its safe and I think that people need to feel safe in their dying. I think they need normality to feel safe. I remember that being drummed into me during that paediatric oncology experience where they would ask the parents of the littlies how they disciplined their children and said that whatever that method was, you must continue that now because when they are sick it is now that they need to know the boundaries, so that they are safe and still loved, if you suddenly give them the trips to Disneyland and all the cuddly toys, then they are lost. (Kate, 1<sup>st</sup>, 0, 132-156).*

## Being is a Constantly Revolving Thing

All of the participants' were interviewed three times, with up to four years between the first and last interviews. Life had carried on for the participants during that time. For some they had lost loved ones and this had caused life-changing realisations, for others they had become parents and were trying to balance a career with bringing up children. Some participants were nearing the end of their careers and taking stock of where they were and why they had done what they had done, while others were moving onto new challenges. Almost all of the participants had moved to another job in nursing during the research process.

For some participants who were spiralling at a slower pace during the first interview they had speeded up by the second. For others it was the reverse. Others remained the same but had talked of episodes at other times in their lives where things had not run as smoothly as at present. Whatever the reason, it is important to note that the participant's journeys had their ups and downs, and during those times, it was the balance between their nursing being and their own being that was the cause of the discord. This was critically reflected on by the participants, often in consort with critical friends, family or partners. A decision was then made, changes occurred - or not - and life continued on.

Liz and I discussed this issue during our second interview. She perfectly described it as a constantly revolving issue – but you are not revolving in a circle but a spiral – each time you rotate you have moved on slightly:

*"And I think it is a constantly revolving thing".*

*"And you were doing some spinning of your hands there too and it was something that somebody else was doing and as I was listening to the interview I was doing this – drawing koru which was really interesting".*

*"Yes! yeah! Yeah that's interesting I was talking with someone the other day and he said it feels like I am going around and around and not getting anywhere. And I said if you look at it you will find that it is more of a spiral. When you do come around you're not quite in the same place as you were before. You know, you have moved. And so we take that on board we actually take on as much as we can and that actually affects the spiral, so you know we come up and we understand things a wee bit better more every time we go round that circle. It isn't like we are chasing our tails all the time and that's certainly how I see it" (Liz & Rae, 1st, 0, 132).*



## Creating a Balance and Moving On

For all of the participants, creating a balance was an important feature of Being and Becoming an Exemplary Nurse. The participants gave 100% to their work life and occasionally this caused their home life to suffer. Conversely when their home lives were busy - they felt unhappy about not being able to give 100% at work. At these times they came to the realisation that they needed more balance and they took stock of the situation and made changes.

*I don't think you can work in oncology or palliative care for a length of time, without having a sense of where you are at as a person and how you manage that and I mean there are times when you feel extremely sad and this is an awful situation but it is being able to balance that.. I like to put forward a view that, I mean yes I am passionate about nursing, yes I believe what I am doing, but I have also got another life. I mean you can get completely overwhelmed and at times I do too and I am quite happy to put the graft in but I have still got a life, so it's being able to create that balance. (Anna, 1<sup>st</sup>, 1.1, 400-402 & 2<sup>nd</sup>, 0, 624-632).*

The participants acknowledged that if they felt they were not able to make a difference for their patients by going the extra mile or giving 100% they would change their hours or move on.

*I think that's because I quite like to give 100%, 110% to everything I do. And I probably did that at a cost to myself but I know that I don't feel – I feel annoyed if I am not doing that. I think I would feel like I would seriously look at nursing. And I think some of my dropping my hours over the years and now that I am 0.8 and not full time has probably been a way of being able to keep the full involvement up. (Chris, 1<sup>st</sup>, 1.1.15, 51-59).*

Moving on was a common element in the career structure for the participants. They moved on if they were not challenged or if they were unable to give the care they felt was required. Often this meant moving out of clinical positions into areas such as teaching, management or nursing policy or cutting back their clinical positions to part-time. However, when they were unable to give 100% to these non-clinical posts they moved back into clinical: “*And that's probably why I came to the job that I am now in. Because after things got a bit sort of politically out of hand, I sort of thought God, I can't be bothered with all this crap anymore ...I need to get back to what I know*” (Anna, 1<sup>st</sup>, 1.1, 595-599).

To undertake a challenge or to make changes was an important reason for moving on.

*I always go to a place to make changes. Because I know how the practice is and I think it should be another way...and then I get to a point where I hit the wall and I have done what I can do and I don't knowingly but all of a sudden you just*

*feel, you wake up in the morning and feel there is nothing left for me here to do, so you move on to another place. (Janet, 1<sup>st</sup>, 0, 24).*

Most of the participants had been sought out and asked to apply for nursing positions at one time or another during their careers. They moved to these new positions for the challenge involved.

*I had been leader of that unit, director of nursing there for you know, three or four years and I needed to spread my wings. I mean I either stayed in Melbourne or I came back to NZ and they did a cunning thing. They had been advertising the job and they didn't have anybody, so they said "why don't you come over?" anyway the long and the short of it was they approached me. (Anna, 1<sup>st</sup>, 1.1, 565-570).*

*I mean somebody rang me, I didn't apply for polytech, and they rang me and said would you do it? And the other job was the same...they basically said would you do it? So I haven't applied really officially for that job either. (Chris, 2<sup>nd</sup>, 0, 166-171).*

The participants also moved on if they felt the 'system' was impinging on their ability to practice to the best of their ability.

*I think I always used to say that if I could carry on doing the job if I didn't have to compromise my own integrity. If I had to do that it was time to get out ... But from my last job, I think it was time for me to move. I don't think from necessarily a Palliative Care perspective, probably from a systems perspective it was time for me to move. (Liz, 1, 436-475).*

*Even in the last years when I was managing, I could, I was having some very, very stressful days at work and I would go home and I would just be, you know? You go home and you can't give any more because you are so exhausted. But I would have days where we would be so short staffed that I would take a patient load and that would be very stressful for me because I would have to do my other work as well and catch up. But I would go home on such a high because I had been fully involved in caring on these days and it just lifted me up. It was so amazing. I blame the system anyway. You know it's just that thing, it would take more that is reasonable from nurses. (Kirsten, 1<sup>st</sup>, 0, 1.1, 299-320).*

Authentic Being was an inherent part of all the participants. It was about knowing and being oneself. It enabled the participants to love and acknowledge their enjoyment of nursing; understand their impact on others; move on to retain balance in their lives and make a difference in their patient's lives.

## **A LOVE OF NURSING - "IT FEELS RIGHT" AND "MAKES ME HAPPY"**

For the participants in my study, nursing was meant to be - they loved it. Being a nurse was where they could authentically be who they were and who they were becoming – joining the personal with the professional. Having a love for their work was the basis for

all the participants to start their journey of B/being and B/becoming Exemplary Nurses. They loved nursing primarily because of the patients and their relationships with them. They felt it was a privilege to care for others and looked at their enjoyment through a critical lens. They were comfortable that their love was not co-dependence but a reciprocal caring act.

For the Hospital trained nurses: Anna, Joc, Chris, Kate, Liz, and Janet, their early immersion into the clinical world gave them this insight early on:

*The bottom line was I went nurse aiding in the holidays and fell absolutely in love with it, and I spent most of the time in the sluice room! But I fell in love with it! So in a way it was just what I always did and there was an inherent sort of understanding right there for as long as I can remember. And I had a sense of feeling comfortable, feeling right really. I mean I don't think I ever didn't feel comfortable nursing. (Liz, 1st, 0, 33 & 1.5.1, 34-40).*

For the Comprehensive/Polytech nurses: Sharyn, Jayne, Kirsten, and Ellen, this did not occur until they were more comfortable in their practice roles once registered. However once this occurred, they felt just the same: “*Nursing makes me happy you know? It's my passion but it also nurtures me in a way. It keeps me going, keeps me alive*” (Kirsten, 1st, 1.1, 310).

Despite their training style, all the participants described nursing as ‘feeling right’; ‘natural’, ‘innate’; ‘instinctive’, and ‘comfortable’: “*I think maybe it was a sort of an innate thing in me. I did feel comfortable talking with people, or just feeling like I could. And I felt like this wasn't like a great chore that it wasn't, that I guess it felt, felt right*” (Chris, 1st, 1.1.15, 51-59).

Others, like Kate, described nursing as a calling:

*The first time I felt connected to death and dying and felt as if I could make a difference was working in acute surgical placement. I was absolutely bottom of the ranks on the ward and I was walking past all the side cubicles, that the first nurse looked after and a man rang his bell. And I went in and he was full of drips and drains and stuff and it was like the Intensive Care Unit to my naive thought. And he wanted to talk to me. And I said I will go and get your nurse, because I felt so out of my depth. And he said he didn't want the nurse looking after him, he wanted to talk to me. And he had been watching me and what he wanted to do was talk about what it was like to die. And I thought Holy Shit! I would have been about seventeen. ...And then we spent this incredible sort of half and hour talking and listening and although I didn't know anything I had this sense of knowing ...and he told me that he believed this was my calling if you like. That one day I would be working with people who would be dying...so that was quite a significant experience quite early on that gave me the confidence to explore that area of nursing and set me on this track if you like. (Kate, 1st, 0, 28-46).*

The participants worked in different practice areas. There were those who had a love of their specialty area and continued to work in this area and those who had moved on from their original specialty to other practice arenas. Wherever they ended up they all spoke with passion about their original clinical specialty and many of their practice stories came from those times. They had chosen those areas carefully for various reasons: that they knew they made a difference to their patients' lives; because of the enjoyment they received from each patient encounter; and, because they had an inherent understanding for the specialty and its patients. They made a difference to their patients' lives; they acknowledged it, they enjoyed it, and it made sense to them. *"As nurses we endure the complexity of caring often to our detriment but how we deal with these complexities both personally and professionally influences how and where we choose to work"* (Anna, AD, 0, 108).

For some of the participants their original specialty remained *"the love of my life; so to speak"* (Jayne, 1st, 0, 46). These participants all continued to have a love of and for this area of nursing: *"I have energy for palliative care and I have some sort of love or passion for it. It speaks to me personally and professionally in my practice"* (Kate, 1st, 1.1, 232). They often stayed in these areas because of their belief that the relationship was unique with these types of patients:

*I certainly probably have specialised myself into a very narrow scope of practice...and I think there is something different about paediatric nursing and I think that's probably the difference in the client interaction that you potentially might not have with an adult. Although I often think some people might actually quite like being nursed the way that we nurse children and families.* (Chris, 1st, 1.1.37, 317-319).

For others, their love was based around the patients and the participants' relationships with them:

*I loved surgery the best and yet I love everywhere I go. I've always actually really loved mental health which is actually not all that technical actually like the things I liked best about surgery. I've always liked patients so it doesn't matter where I go.* (Ellen, 1st, 3, 686-689).

### **It's a Privilege to Care for Others**

The enjoyment of nursing was part of a feedback loop where the participants felt privileged to be able to care for others and to be part of another's life. This in turn sustained their love and passion for nursing.

*I remember saying to somebody once about my job and that it was a privilege to do it. And this woman said that I must say that to everyone and I said "oh well,*

*yes I do, but I actually believe it". And I do believe that it has been privilege to have contact with everybody that I have had contact with. (Liz, 2nd 1, 262-266).*

As Kate described, often feelings of satisfaction and privilege came from sharing and caring in another's life.

*And the patients and the families have been my biggest form of education, more profound than any study I have done. Really the ability to be comfortable with somebody at the bedside in their private, personal moment of experience and the enormous privilege that gives you, to be allowed, to enter into that, I just think is quite profound. (Kate, 1st, 0, 63-65).*

Kirsten believed, that part of the privilege of caring was being chosen by patients who wanted the participants to talk to them or to care for them:

*And it was the nature of the people that we looked after, once they got to know you and trusted you; it was just something very special about it ...And they would basically say "I want you to look after me now" which I think is just neat. (Kirsten, 1st, 1.1, 115-125).*

Occasions around the death of patients whom the participants had special relationships with, often gave a sense of privilege for the participants:

*"The ultimate privilege was when she died. They had a funerals service for her here and her mum rang me and said I would like you to do the eulogy. Well I thought that was just amazing" (Chris, 1st, 1.1.37, 191-193).*

These times gave meaning to the participants and in turn sustained their love of nursing.

*She was a heamatology patient and she wanted, when she came to die, she actually wanted to be where I was. So she actually ended up dying on the ward and that was really meaningful for me, that she had made this conscious decision that she wanted to die on my ward. (Anna, 1st, 1.1, 304-330).*

While all the participants had an inherent understanding and knowing that nursing was right for them and that they enjoyed it - having a patient or their family give you verbal feedback that you were doing a good job was very rewarding: *"Its certainly part of the rewards that you get from nursing is that feedback. That you were a special person to the families"* (Jayne, 1st, 0, 119-167).

This overriding passion for their patients and the privilege of caring, was the reason the participants continued to nurse despite its occasioned lack of professional respect or money.

*You know sometimes I ask myself why do I do this to myself? What the hell? And I guess it's a crusade. I mean why would you do it? You wouldn't do it for the money. And you certainly wouldn't do it for the way other people treat you as a nurse certainly. So it's something about the patients I suppose. (Ellen, 0, 591-601).*

*I think it's interesting because when you were talking about being paid, I don't think I have ever equated being paid with what I do. And certainly more in palliative care, it's that sense of being privileged to be able to be there. (Liz, 2nd, 1, 471-475).*

## **I Can Enjoy Being with Somebody But I Don't Need to Seek It Out**

All of the participants had looked at their love and enjoyment of nursing through a critical lens during their constant reflection processes. They spoke of understanding and acknowledging their enjoyment:

*You know I can enjoy being with somebody but I don't need to seek it out. Co-dependency is troublesome if it is not managed and contextualised. I think there are different levels. I think most nurses do what they do because of wanting to make a difference, having an impact on someone's life for a short period of time. I don't see that as necessarily co-dependency, I see that as part of their role. However, I think that it's a fine line for some personalities around what is healthy and unhealthy and part of that is if they have insight into it because a lot of people don't. (Anna, 1st, 1.1, 678-707).*

The participants were also aware of the context and circumstances of their enjoyment. They knew that it was the patient's best interests rather than their own self gratification that kept them loving nursing:

*I think the bottom line for me is whose interest is being served here? And if you can seriously say that it is the patients then you are on the right track. Whereas if you are having fun and or just feathering your own nest from the need to be needed or a need to belong then I think you have got to stop in your tracks and say Oy! What am I doing?! (Joc, 1st, 0, 243-245).*

The participants had insight into their enjoyment and in some ways believed that this self acknowledgment and authenticity allowed them to be the exemplary nurses they were becoming.

*Like the need to be needed thing and the need to belong, for a long time we looked negatively at those attributes and thought it was all co-dependency, its all this and its all that and we need to knock it out of ourselves and our potential students ... But maybe its what makes us the nurses we are? That it is a positive thing and it's all right. (Joc, 1st, 0, 415-421).*

All the participants described their love of nursing. This was evident when they talked to me about their life stories and when they gave examples of practice. Not only did they verbalise about being passionate, they also spoke passionately about it, with the intonation of their voices revealing their feelings during our interviews. They often used words such as 'love', 'enjoy' and 'privilege' to explain the way they felt about nursing. This love allowed the participants to be authentic when practicing and in-turn ensured they made a difference when caring for others. This love was also supported by

mentors, role models and critical friends. These critical friends encouraged the participants to continue being and becoming exemplary nurses and to love doing so.

### **CRITICAL FRIENDS – MENTORS, ROLE MODELS AND LIKE MINDED FRIENDS**

All the participants had people who had encouraged, nurtured, supported and yet 'pushed' them to be the exemplary nurses they were becoming. These critical friends were not just people to talk with and to - they aided the participants in their reflections and their actions; they challenged their ideas; supported them to maintain authentic practices; and motivated the participants to go further than they would have on their own. Many times these interactions were not just '*static relationships*' (Sharyn) but associations which carried on throughout lifetimes.

Critical friends included mentors who had taught, challenged, pushed and encouraged them; role models who by their own exemplary practices had stimulated and impressed the participants to be and act like them; and like-minded friends who had stood beside them and supported them on their journey.

### **Being Pushed Beyond Your Boundaries - Charge Nurses as Mentors**

Mentors were more than role models; they could see the potential in the participants and were instrumental in moulding them into the exemplary nurses they were becoming. They were the ones the participants remembered not only for their exemplary practices but who also stimulated, challenged and pushed them to 'be' exemplary. For most of the participants, it was their first Charge Nurse who had a huge influence on their journey of 'becoming'. These Charge Nurses fed the participants' curiosity and enthusiasm for knowledge, encouraged them to take up more senior roles and to undertake further specialist training.

For Jayne, having a mentor who pushed her beyond her boundaries in a supportive and nurturing way led her to become an exemplary nurse in neonatal nurse education.

*I was very fortunate that in the unit where I was working, I was in contact with a woman and she had come back from England at about the same time as me and she was about ten years older than me and had a lot of experience. She was a very experienced neonatal nurse and she really developed into my friend and mentor, for the next ten years or so. She was really instrumental in me developing, in lots of different areas within my nursing. And she must have seen something in me that she thought was worthwhile nurturing, because she helped*

*me in a lot of ways. She helped me get the hang of neonatal nursing, but also pushing me, pushing my boundaries in things, like teaching. And she started me in Neonatal Nurse education. And I think in some ways she is an exemplary nurse for me! I think probably one of the things that help to make you an exemplary nurse are having a mentor or role model, or someone that is there to nurture you and guide you, and test your boundaries. As well as getting someone who can support you but also push you forward and, and find your boundaries and push you beyond them, is, is really an important thing, I think in becoming an exemplary nurse, you need to have an example. (Jayne, 1st, 0, 114-118).*

For Janet, having a role model who pushed her to work at an advanced level from a new graduate made her the nurse of the caliber she is today.

*My very first Charge Nurse was an important mentor to me and she influenced me because of her energy and her commitment and wanting to know more. And we worked quite autonomously and she pushed us to do very advanced things. I mean she just threw us into stuff that I look back now and think Oh my god! I was doing things that were quite risky probably for the patients. Obviously at the end of the day she was over my shoulder, she wasn't going to set herself up to fail or to have something happen to the patient. But she was a firm believer in "You are not going to get good at it until you do it over and over again and you have gotta start somewhere". So she just, its sort of like, and in a way I believe that now, there is a certain philosophy that as long as you have a good swimming instructor and somebody that that's on the edge of the pool, throw people in at the deep end and give them the really hard things as long as there is somebody there, to you know? keep their heads above water. But they will learn much quicker and they will learn you know? They will catch on to the nitty gritty stuff that you really want them to catch on to, rather than spoon feeding and nurturing and going slow.. And I question today, what if I had been a graduate and had just cruised into it, you know? and had a different kind of a head nurse where I was? I don't know how that would have been? But I do really believe that those early years have made me much of how I am. (Janet, 1st, 0, 42-47).*

Kirsten remembers two Charge Nurses who influenced her by pushing her boundaries, encouraging her to work autonomously and supporting her to follow her career. They believed in her, supported her and became her friends.

*I've been so lucky having those two as Charge Nurses. One of them supported your autonomy - you were completely involved and your opinions and assessments were central to the team. She would call you in and say "Oh look, the psychiatrist is here. Can you come and talk to them? You know more about this person, you are their primary nurse". That sort of thing. And she pushed my boundaries. And like the other Charge Nurse I talked about originally, you didn't get away with passing the buck, you had to do things yourself. You had to make phone calls yourself, you had to speak for your self. And this Charge Nurse has since been very pivotal in my career and pushing me in directions and supporting me and funnily enough they were both definitely role models, still are, big time! And both of them I became friends with. Not when I was working in the area, not when we were working together but both of them became good friends of mine. So maybe you could say that they became mentors I would say. They have stood by me and supported the whole way and are great friends of mine. And have believed in me, the whole way and who have said "You can do this!" and I*



*have thought "Are you completely mad?, I can't do that!" (Kirsten, 1st, 1.1, 177-189).*

For Ellen, having Charge Nurses who allowed her to be an autonomous practitioner and who provided a ward culture where respect and innovation was an important factor, allowed her to assimilate her polytech training with her practical experiences.

*I got my first glimpse of really good leadership and the notion of total patient care and so a lot of what I was taught - learnt at polytech came rushing back and it made a lot of sense. The Charge Nurse was actually very young at the time, when I look back (I thought she was old) but when I look back she was 24. And I was 22. But she wasn't old, she was very young. She seemed very old, very mature, and the thing about her is that she very deeply much cared about the patients and the nurses, and there was no notion of hierarchy. You had two psychiatrists and we had a physio and a social worker, so we were sort of multi-disciplinary but the place was really run by nurses. And the student nurses there were treated with a lot more respect. It was sort of the way the place was. It was a very exciting time to be there. People were trying new things and the students dared to be different, they were encouraged to be, and it was just fun. And suddenly all this stuff I had learned in polytech, just came back for a moment. This was in the acute unit and I think it was strongly influenced by the female Charge Nurse. There were two, there were always two Charge Nurses - there was a male and a female in every ward. Now the other was probably more old school. And he was older than her so he was like the sensible, old school, but he had some good ideas. But she was young and new and had a wonderful personality and they just complimented each other really well. And he let her have her head I think. We just, it was such a fun place to work. And I left there to have my son. So I left, simply because I was pregnant, not because I wanted to leave. So she was a role model and I suppose a mentor as well. (Ellen, 1st, 0, 108-282).*

For Kate her first Charge Nurse encouraged her to take up the specialty and fed her enthusiasm for knowledge by suggesting that she go overseas and take up specialist training in oncology nursing. This support began a journey that continues in Kate being a Specialist in palliative care nursing.

*The Charge Nurse then at the time was quite a significant influence for me as well. She was tremendous to me as a student, I had several placements in the Oncology Unit. And I was offered a Staff Nursing position there when I registered. And she was, yeah, somebody that I really respected. And she fed my curiosity to know more, fed my enthusiasm for knowledge. And suggested that I might well, have some of those needs if I went to The Marsden. This was true. Because through that exposure then was the ability to change direction slightly and look at the whole Hospice/Palliative Care scene. And I had tremendous opportunities there that I would never have had. (Kate, 1st, 0, 52-54).*

Chris was also offered her first Staff Nursing position in the field that would become her specialty. This Charge Nurse then encouraged her to go overseas and do further training in the specialty of paediatric nursing.

*I got a call from the Charge Nurse of Paediatrics, because people said "Oh she never offers anybody a job! You'll never get a job in paediatrics!". But I got a call from her. She just said "Come and see me in my office". And she said that she would really like me to come and be a Staff Nurse in her ward, after I had finished training. She said "I can see Chris that you have a huge potential in paediatric nursing, and I think that it would be good for you to come and start here after you have finished training. When you have passed your exams". And then she said "And then, after a wee while staffing you have to look at some sort of formal qualification in paediatrics". So I think she probably had a bit of a sense of, that I was, maybe worth while pursuing. (Chris, 1st, 1.1.37, 310-314).*

For Sharyn and Ellen, their Charge Nurses recognised their potential early on and persuaded them to take up more senior roles when they would not have applied for those positions themselves.

*There was a point where the Charge Nurse became the Supervisor and I was the most senior one on the ward. Two years out!. And I got to be Acting Charge Nurse for a couple of months - it was quite daunting but it seemed to happen all right. It was the woman who had become the Supervisor who encouraged me. Because I wouldn't have volunteered, No, I wouldn't have. I certainly wouldn't have felt senior enough...The supervisor who used to be the Charge Nurse and the new Charge Nurse after me were really nice people and good to work with. There was a degree of, not necessarily friendship, but camaraderie I guess. They were encouraging and they were there to support me. (Sharyn, 1st, 0, 83-104).*

*This Charge Nurse – he actually asked me to be the new Acting Charge Nurse. And I said "No, no - Hell no. I couldn't be that!" and he said "Don't be ridiculous!" and almost pushed me into that role. Otherwise I would probably; I may still have been a Staff Nurse. (Ellen, 1st, 0, 729-730).*

## **Being Impressed by Another - Role Models**

All the participants talked about people who had influenced their becoming. These were nurses who acted as role models – helping sculpt the participants into the exemplary nurses they would become. Most often these nurses showed positive behaviours such as caring, kindness and respect, although occasionally it was negative behaviours which made an impression as behaviours not to be followed.

For Chris she remembers being impressed by nurses who were caring rather than by those who did not respect their patients.

*I remember being impressed by nurses, that I would now probably explain it as - I perceived them to be caring. They were careful of people. They were careful in their physical dealings with them. They were careful in the way they spoke to them. Whereas there were some nurses that were just like, arrhh! I felt it was not right! You do not speak to people like this! You don't! And that has something to do with respectfulness and there are some senior nurses that I worked with as a more junior nurse that I still remember today. (Chris, 1st, 1, 121-123).*

Ellen was also influenced by nurses who were respectful. The Maori Mental Health workers were particularly influential on the way she practices today.

*I got a new role model in a woman who taught me a lot about being assertive in a way that is respectful. She was a lot of fun and she is really warm - but she didn't put up with crap! She was egalitarian - like pulling everybody in. So she was a very strong role model. And I also worked with staff nurses in my age who were also good role models, peer role models... When I went back into Mental Health I first met the Maori Mental Health workers. And watching them with Maori patients I suddenly realised that there were lots of other ways of doing things that were wonderful. And we could learn a lot. So that had a big influence on the way I practice now and I am very grateful for that. The Maori Mental Health service for what they taught us. (Ellen, 2nd, 0, 134 & 1st, 0, 418-432).*

Chris was influenced by seeing her Nan being cared for in a caring and loving way. This particular nurse was used as a role model by Chris when she went nursing.

*My Nan, she'd been in hospital. And she had one Staff Nurse in particular - I don't know why, whether I just liked her as a person or something about her sort of fired me up - and I thought I really like her. And I always remember her, just the lovely way she had with my Nan. I remember her calling around and seeing Nan. And yeah being quite impressed with her, and I thought she was quite neat and sort of impressive. (Chris, 1st, 1, 13-17).*

On reflection, Joc, learnt from both the good and the not-so-good nurses. There were those that were just capable and others that were wonderful. Expert nurses in the ways they utilised touch and voice. These were the ones she used to learn by.

*I thought well, what were the things that made me nurse the way I did? And it was role models. You would look to role models. And you would know good nurses. But they were good nurses only in the technical sense, they were capable... But in intensive care you could see expert nurses and that was wonderful. You could see this one woman, (who is the epitome of the motivational surgical or intensive care nurse). I'd go off to morning tea for ten minutes and my patients would be virtually comatose and intubated and all the rest of it, and I'd come back and they'd nearly be ready for discharge! She was just such a, you know?, I liken her to the students I teach, and say "She is Christ like", in the sense of - Rise and you shall walk! She seriously can do that! But you could also see other wonderful nurses and in particular one nurse comes to my mind, And I knew her practice. And her practice was just that she utilised touch - so effectively. Like she'd be extubating a patient (in intensive care) and you know they are lying on their back looking at the ceiling, they can't see anything. And on extubation (often because of drugs) they would forget to breathe and I would hear her say "Now just as a reminder to breathe, I will give you a wee nudge and I will keep a hand on you at all times, so you will always know that I am here. Just because sometimes I am at the foot of your bed and sometimes I am at the head of your bed. But I will always keep a hand on you so you know I am here". Because they couldn't see her. And that type of nursing, I could, I learnt through. There were other nurses who were hideous! Technical nurses in intensive care, who would yell out "Oy!". But we learned through looking at the others. (Joc, 1st, 0, 81-167).*

Chris remembers nurses who, although technically proficient, were not very nice. She learnt skills from them but was influenced by nurses with a nicer way with patients than others.

*Even the nurses that were bitches, they were actually very experienced. And this sounds awful, I say that in the sense that they - some of them probably had a nicer way with patients than others. And they were quite experienced and I did learn quite a lot of the tricks of the trade from them. But there were some really lovely ones that I remember wanting to be like and it was probably them rather than the other ones that influenced me the most. (Chris, 1st, 1.1.37, 310-312).*

Liz and Kate used different parts of different people to become the type of nurse they wanted to be and become.

*I don't think I have ever talked about role models with you? Probably it's how I see the world - more abstract than most people see it. And so for that reason it wouldn't be this person or that person I'd follow. But I'd be following a part of something and a part of somebody else. Yes and recognising aspects of somebody that I would really admire and actually using them or learning from them and then yes discussing something with somebody else and realising that there's a close relationship there and you relate. You see things through the same eyes and actually have an understanding of the something in the same way. So probably there's a combination of different people and different philosophies that I have used. (Liz, 2nd, 1, 526-549).*

*I certainly do have role models. I'll have a bit of this person, a bit of that person, because I want to improve my practice all round. (Kate, 2nd, 0, 13-22).*

## **Like Minded Friends**

Like-minded friends were very important for the participants throughout their careers. Initially during their training the camaraderie of their nursing colleagues gave them the reflection on practice, support and encouragement they needed to continue. Latterly, mentors, role models and critical friends listened, challenged and supported their ideas.

Many of the participants, like Chris and Anna, who had lived in the nurse's home during their training, felt that talking with their friends was invaluable in allowing reflection on their practice.

*We had to live in for the first three months, but there was still that expectation that you lived in the nurses' home so it was fun for me. It was sort of like a bit of an adventure but it was very sort of closeted sort of in a sense you were very safe and, but it was fun in a sort of, I guess the camaraderie. I guess in some instances that's how we got through, you know? When you got into the wards and you came off a shift particularly like an afternoon shift and we would all sit in the kitchen and make toast and tea and all talk about, you know, what you had done and how you had done it. So it was sort of I guess it was sort of a, I guess we were doing a little bit of supervision we didn't know we were doing. Yeah well reflective practice of a sort on a limited scale I guess. (Chris, 1st, 1.1.18, 28-33).*

*I think one of things that just sort of reflecting on that. The fact that we had to live in was actually really important. And I can remember being you know sitting in, we had quite nice lounges, and we all smoked in those days. And we'd sit for hours talking about what had happened during the day, or wasn't so and so a bitch or, you know, all that sort of stuff. So that, and I mean, which now I mean would be reflective practice, I suppose. And you know, but it was a time for debriefing it was a time for sharing - it was a time for laughing. (Anna, 1.1, 48-52).*

Joc believes that the type of reflection on practice and sharing of experiences that occurred in the nurses' home was an invaluable part of becoming a nurse.

*Because we were brought up in the nurses' home which I think has been a wonderful preparation for this type of nursing. Well I talk about this type of nursing - the type of nursing we teach now. The journaling, the reflecting on practice and what have you. And we did that in the nurses' home! When we finished duty, we all sat around and we rubbed each others backs and we massaged each others feet and we cared about each other enormously! And we told stories about our practice. So I mean I think that oral tradition of nursing is just so valuable. And it went down the plug-hole for wee while there. I think it truly did. Especially when Comprehensive Nursing started and people weren't in nurses homes. And we were still in that mixture of - Where are we at in nursing? What is it to be comprehensive? But we threw the baby out with the bath water. I really believe we did. We didn't know all those hidden curricular things like the nurse home, and the journaling. Which was the hidden curricular, we didn't know that fact. (Joc, 1<sup>st</sup>, 0, 63-77).*

The participants that trained in the Polytech system, like Sharyn, found the camaraderie and support of their Comprehensive trained colleagues invaluable.

*There were a couple of people, one was a staff nurse who had also trained in the Polytech system and there was a woman who I was buddied with for a wee while but there was no formal buddying or preceptorship like there is today. There was support I guess, through a group of us that were the first Polytech nurses they had encountered and it was a bit them and us at times but I mean during our training you sort of felt that a bit anyway. (Sharyn, 1<sup>st</sup>, 0, 35-37).*

Once the participants were out of their training they found it important to find and talk with like-minded friends. These people often shared the same goals. They were constructive, critical and very supportive. They see the world through a similar lens and therefore when working together much could be achieved.

Ellen liked to talk, converse and connect with people. She had a varied set of like-minded friends with whom she received ideas, advice and support.

*I'll tell you who I would call like-minded people. When I was a Charge Nurse, this woman was in charge of in-service at the time - she was a like-minded person. I would go and talk to her about things, because she was a like-minded person. Another colleagues is someone I would consider, a not a role model or a mentor but a bouncer of ideas, and another person who I work with now is too. Some of*

*my PhD colleagues were also. They were people that I talked with, who had an influence on me and me on them, probably in a collegial way... I do a lot of talking with colleagues about where I am going with things. And what I am thinking and I sort of include my husband in that category because we have a lot in common. And so we often think about systems or patients or staff. And another person is the same and we have spent a lot of time talking about issues. We spend a lot of time together and we spend a lot of time talking about the things that now cause me discomfort. And I think why is that? What is it about that? And I might talk to people about that, yeah critical friends. More than, even more than mentors or supervisors, they're people that, they're my peers...and I find it quite collectivising. We were Charge Nurses together, she's a nurse, she's got a Masters Degree. She's got a great sense of humour and so a lot of things that I am interested in policy wise, she's there and they're right up her alley. And so I can ring her for that sort of conversation. Or I can wonder down to this other chap for another sort of conversation...I can be totally seduced by ideas and in fact I spend a lot of my day in conversation with people...so I think it is very connecting. (Ellen, 1st, 0, 707-742 & 2nd, 0, 186 -349).*

Liz had a group of colleagues and friends who shared the same language and ideas. These conversations gave her the opportunity to discuss things that were important to her.

*I've always had colleagues around me that I have been able to share ideas with. Colleagues who quite clearly understand - we talk the same language. And I think over the years that I've focused on that network maybe a wee bit more. I have friends and colleagues who I meet with regularly and talk about philosophical type things and yes a group of people who see things through the same sort of eyes that I do. So there's an opportunity to talk about things that are important and we explore those things. (Liz, 2nd, 1, 420-435).*

Anna had critical friends who gave her a depth of conservation which was challenging but also supportive.

*This woman was a huge mentor to me - who to this day will challenge me, and we can sit down and have a conversation which really makes me think about things. And another woman has quite a huge influence on me personally. She's still doing some practice work and also doing academic stuff. So she was quite a mentor. And having access to somebody like her and working with her. I mean it was like-philosophy, like-minded. And we would sit down and have conversations with a real depth. (Anna, 1st, 1.1, 471-513).*

For Joc and Janet, having like-minded colleagues who worked in similar positions assisted them to make changes and influence practice.

*We were working really closely together, (she was the supervisor on the floor when I was a Charge Nurse) so we were determined to get together and make it the way we really wanted it to be. She of course being the absolute leader in that. But I really wanted to follow on in her shoes. And I think that has been one of those lovely things about nursing, is you have people that lead the way for you and then things change and you lead the way for a little bit. You know things change and they lead the way and it's been like that with her and I. We've mixed and matched for a long time, all our careers. (Joc, 1st, 0, 250-254).*

*I met up with another American girl at the time she came to the hospital and had her Masters. She became a clinical Nurse Specialist in Medical Services and I was in Surgical Services. Anyway there were a few others of us too. And we just went and really ploughed through the hospital with innovative stuff and I really missed her when she left because finally somebody was there that understood how I thought. Because she had trained in the same model that I did and agreed with a lot of things that I had been wanting to do. I finally had somebody, who could help me do a lot of that stuff...And I think, and I said before, that was always helpful, having that American girl work with me and I think that when you have, other people that think like you, you can do a lot more. When, and presently the Charge Nurse of the other ward, that work like sister brother units, we do think alike. And we keep reminding ourselves that we do think alike and we have fundamental differences of which a lot of it is do with experience. But that way we do things on sort of a combined front. And so that if there is an expectation or competency, standard or whatever that is expected all the way across the whole floor, then that has been very helpful. I have really appreciated that...So I find that I do my best work when I had one or two other dynamic nurses to share ideas. (Janet, 1st, 0, 109-217).*

Kate and Jayne also like to talk with others. They use like-minded friends with similar specialty interests to help deal with different approaches to problems and to reflect on practice.

*I am a talker and so if I have got the opportunity to hear myself, just talking it through, by the end if it I have worked out the next strategy. And I do that with somebody that I really respect in the Palliative Care world. She has put up with me drifting on for many years. And she has the ability to sit and listen. (Kate, 1st, 0, 246-250).*

*I certainly have two good friends that are nurses, that I talk nursing to. And talk about experiences that you have as a nurse. They don't necessarily push me, although they do (if you know what I mean?). And I suppose its reciprocal...and we reflect a lot together. (Jayne, 2nd, 0, 72-98).*

Critical friends such as mentors, role models and critical friends were hugely influential on the participants B/being and B/becoming. Initially the camaraderie of colleagues in training assisted them to continue their education and to love what they were doing. Later on Charge Nurses helped the participants to choose their specialty and encouraged them to further their specialty education. Role models along the way guided the participants to treat their patients with care and respect and like-minded friends supported and nurtured their ideas and practice. This support gave the participants a confidence in their self and Being which allowed them to be able to practice with a true authenticity.

## **MAKING A DIFFERENCE - SUSTAINS ME**

For all of the participants, making a difference for their patients was the underlying drive for being and staying passionate about nursing. This acknowledgement enabled the participants to maintain an authentic presence and to practice to the best of their abilities. They did this by making sure they had the knowledge and expertise to do the job well – by being ‘*life long learners*’ (Janet) and by making sure they were on top of things by being organised and in control. This often meant going the extra mile and always giving ‘their all’. They make the time to understand their patients’ experiences by creating caring communications and connections with them; they were respectful of their patients and were aware that it was the patient’s journey and not their own. This in turn sustained them and kept them on their journey of B/being and B/becoming Exemplary Nurses. As Jayne illustrated:

*“My earliest response to the question - why did you become a nurse? - was that I could make a positive difference to the lives of patients and their families” (Jayne, 2<sup>nd</sup>, 1, 1-2).*

Making a difference and being the best they could be, in-turn became their affirmation to continue on. It empowered the participants in their practice, sustained them and kept their passion alive. *“Certainly getting it right is the main aim for families that you are working with and that actually empowers you in your practice or sustains you” (Kate, 1<sup>st</sup>, 0, 108-118).*

*The thing that keeps me passionate, still nursing is that I know that I have made a difference...That there are children or families that I know have had a good or had maybe a better experience than they might have had because I have looked after them. (Chris, 1<sup>st</sup>, 1.1.37, 180-185).*

When the participants moved out of direct clinical care it was the influence over their colleagues that sustained their Being.

*“Yeah I do enjoy my work and part of what sustains me and keeps me getting up in the morning and doing all that kind of stuff is the influence I will have over your staff and then what they do for the patients” (Janet, 1<sup>st</sup>, 0, 299).*

*I am not a teacher but I’ve fallen into it. But the only reason that I can do that is because of those practice wisdoms that have occurred and I still use them as teaching moments for others. And I can become passionate now, and I am not at the bedside anywhere as near as where I would love to be. But there’s that same passion transferred on to supporting colleagues that are and I can get the same amount of satisfaction out of knowing that, they can make a difference. (Kate, 2<sup>nd</sup>, 0, 63-126).*



## Being the Best You Can Be

*'Being the best you can be' (Kate, 1st, 0, 238) was an underlying element related to 'making a difference' for all of the participants. It concerned being a life-long learner and having the knowledge needed to make a difference. It involved being on top of things and being in control. Control, like the enjoyment of nursing was looked at critically by the participants. They often chose to work in areas where control and direction was a positive feature of the nursing and requirements of the patients and going the extra mile and always giving 'their all' was an integral part of their Being.*

*That's quite a significant aspect, knowing that you do a good job. I guess we all have some sort of sense that we need to be good at something or I don't know if it comes down to being able to contribute but I think its partly confirmation of self in a way. (Sharyn, 2nd, 0, 543-565).*

## Being a Life Long Learner

All the participants were experts in their fields. This was an acknowledged fact of participating in the study and was illustrated in the many stories told in the interviews.

*And clinical competence is really, really crucial as well because you can't be seen as being exemplary if you don't have a really good understanding of what you are doing, a really in-depth knowledge of your specialty. And never assuming that you have finished learning because there is always something else to learn and making an effort to keep up to date. (Jayne, 1st, 0, 144).*

The participants were at various stages in their work lives and their ongoing studies ranged from post-graduate polytechnic certificates through to Masters and PhDs in Nursing. Continuous learning was recognised as a major feature of being the best nurses that they could be and in-turn being and becoming exemplary nurses. *"The sheer amount of information and knowledge needed for advanced practice may be overwhelming, therefore rather than trying to know everything by graduation a recognition of self as a life long learner is essential"* (Janet, AD, 0, 242).

Also part of being a life long learner was their commitment to nursing and their careers. Many of the participants planned their education in order to be prepared for specialist roles in the future.

*I saw the new polytech graduates and I said I want to be a part of this, I really do. And I was determined then that I would prepare myself...we knew that comprehensive training was going to come at some stage, and we looked ahead. And I mean it was another Ah Ha, that I knew then, I'm going to prepare myself for this, for this event when it comes. (Joc, 1st, 0, 110-115).*

## Being on Top of Things – And in Control

Being on top of things and in control was about being one step ahead and having the information to potentially make a difference in another's life. It was an attribute of all the participants.

*I think that's reflective of my personality, I don't like to be disorganised. I guess that I like to be on top of things and in control. Well its something that's about being in control often in situations, that often the workplace has become, where you feel a bit out of control. And it's is trying to be one step ahead and trying to have as much information as you can to potentially make a difference in somebody's life. (Chris, 1st, 1.1.15, 67-69).*

It involved having the knowledge and information prudent to the patient available, in order to be able to assess, anticipate and act appropriately for another. Again like all of the participants' actions they had looked at control through a critical lens and utilised it in order to support making a difference for the patient rather than for self interest.

*When I am feeling good about my practice, when I feel on top of my practice I can just really put it all together ...and I love that in nursing, that anticipating peoples needs, looking at them as a whole, anticipating their needs and their not having to ask, not that I mind them asking... And I think continuity of care and dare I say it? being in control and I think control was huge for me. And I think that has to be critically looked at especially when the attributes of control I aspire to and still hold firm for in nursing, being one of those concepts in nursing that I hold firm to is – anticipation. Anticipating patient's needs. And I do this all the time with students. I say "look you are not just washing the patient or doing their hygiene care, you are looking at the whole. Is the locker tidy? Have they got their morning paper? Is their IV up to time? Have they got pain relief?" You know? you do the whole thing! And then the patient knows exactly where they are with you today and they won't be ringing their bells. (Joc, 1st, 0, 39-43).*

The participants, who liked to be on top of things and in control, actively chose clinical areas where the patients needed guidance and direction.

*Firmness and giving the patient direction - in a sense I often said I wanted to be a sergeant in the army. Patients will often say "ah yeah! You would have been good at that!". But it's knowing when to do that. But often times in post-operative care you have to do that. People don't want to move - they don't want to do stuff necessarily. And so it is firmness, it's just not so much what you say, it's actually how you actually touch them too. And often giving them that direction. And always I will tell them, I will always be here, and I am not going to leave, but I expect you to do this. You have not forgotten how to get out of bed - you have not forgotten where to put your feet on the floor or put your arm through this jacket or whatever it is - you have done this a thousand times. And I'll be here with you to do it. Let's do it now. Firm but nice, you know? That sort of thing. And I think patients and then patients will say later, you'll here them say, "well my nurse is, my nurse is very competent" because they feel, perhaps confidence in them - in someone who more-or-less makes a lot of decisions for them, at the point where they require that to be done. (Janet, 1st, 96-106).*

The participants critically reflected on their decision to use control, coming to the understanding that when it was the patient's best interests being served, their decision was the right one.

*I have really critically reflected on that a lot because that's one of the attributes I will admire in myself is the anticipation of patient's needs...and that's been one of them that I have had to step back from a little bit and not just be Madame efficiency out there. But step back a little bit and ask is really that the patient's needs or what? Whose interest is being served here? but I think in my heart of hearts I like being in control and I like being proactive and I like being on top of things and I like the whole thing to go smoothly. And they are in a vulnerable state and I think I rationalise it because they do need it and I choose that type of nursing. (Joc, 2nd, 0, 224-259).*

### **Going the Extra Mile**

Going the extra mile was a special part of the participant's practice lives and being. *"I think it has a lot to do with the relationship, I mean you got to know these people...and I think the nurses, because we lived in, we went the extra mile.."* (Anna, 1st, 1.1, 198-205). Special situations such as taking patients on outings and visiting them in their spare time, going to their funerals, or working longer hours in an effort to stay with a dying person or make their last days or hours better were common stories from the participants. They often took 'out of the ordinary steps' to make a difference in extraordinary situations of need. *"I actually spent the night with the family that night that he died. Its funny isn't it, the sort of things that alter from a society perspective. Things that were acceptable as a nurse then.."* (Liz, 1st, 1.5.1, 167-174).

While the participants often gave examples of doing things the hard way for the benefit of their patients they also acknowledged that it was always very personally rewarding as well.

*"And this job, you just used to sweat – it was so heavy! But if you wanted people to be challenged and to begin rehabilitation then you could take the easy way or the hard way. I took the hard way ...but it was great and very rewarding as well"* (Kirsten, 1<sup>st</sup>, 1.1, 205-207).

### **Having a Sense of the Patient's Experience**

Having a sense of the patient's experience allowed the participants to make a difference in another's life. *"And I think for me that has always been the thing, that there has always been an implicit understanding of what it's like, of how people feel"* (Liz, 1st, 1.5.1, 32).

*I was very attuned to what was what and what you did but I think it was also probably some thing even way back then, I was also attuned to what it was like,*

*for what the experience or whatever hospitalisation was like for the patient.*  
(Chris, 1st, 1, 33-37).

The participants made caring communications and deep connections with their patients. They respected that it was the patient's journey and not their own. This was an integral element of their practice being and they were able to do this by having a full understanding of their own self and by being an authentic nurse. They knew they were good communicators, easily able to make caring relationships with others. They also acknowledged their enjoyment of these relationships and critically reflected on them and used what they learnt to enhance relationships with others.

As an example, Kirsten related a poem, which tells the story of a woman terrified by her experience; a family - desperate and helpless; and of doctors and nurses too busy to care. The poem also depicts the way that Kirsten, as a nurse, understood Mary – how she had a sense of Mary's experience, and of the way she believed nursing could make a difference.

#### *Caring for Mary*

*"Here's a bowl and flannel, and that pretty nightie with the frills  
I've other patients to attend to, but I'll be back to bring your pills  
You need to make an effort; you know you'll soon be going home  
And I won't be there to help you; it'll be up to you and you alone  
So up you hop, You'll be fine you'll see  
And then you can sit relax and enjoy a nice cup of tea"*

*Terrified and angry she struggled to her feet  
This bloody emphysema ain't gonna have her beat  
Then it started sudden and without warning as it had before  
She held her breath tightly and lunged toward the door  
Luckily the woman's daughter arrived with little Molly dressed in red  
She took her mother by the hand and helped her back to bed*

*"What were you thinking Mum, you could have had a fall"  
Stepping from the doorway, she stopped a nurse who was hurrying down the hall  
"I'm very busy but I'll find your mother's nurse"  
"Please hurry, she looks bad, and I think she's getting worse"  
The breathless woman laboured on, with a look of terror in her eye  
"Help me please" she gasped, "I think I'm going to die"  
The doctors bustled in, in their starched white coats  
One pulled out a stethoscope and the other scribbled notes  
"It's OK deary, you just try and relax  
I can see you are having one of your wee attacks  
The nurse is getting you something that is going to help you breath  
I'll just pop this needle in and we'll soon be rid of that nasty wheeze"*

*"It's not helping" cried the daughter "she's worse and turning blue  
Quick hurry, help her, there must be something you can do"  
The doctor barked the order, "nurse record her peak flow if she's able"*

*The nurse lurched to get the peak flow and sent the breathless woman's flowers  
flying from the table  
Little Molly sensed the panic and began to cry and croon  
The nurse gathered the daughter and Molly and hurried them from the room*

*The shifts were changing over, report was running late  
The morning staff were shattered and the ward was in a state  
I hurried to her room and stepped into the fray  
There was hardly room to move I had to clear the way  
Kneeling down beside her bed, I took her hand in mine  
"Everything's okay Mary, you're going to be just fine*

*Thanks for helping out guys; you've all done really well  
If Mary and I need you we'll ring you on the bell"  
They looked at me with disbelief and then again in doubt  
The doctor charted Valium and they all went shuffling out  
"I'll open the window Mary and let in some fresh air  
No I'm not going to leave you; I'll be staying right here*

*Now let's breathe together like I showed you yesterday  
In through your nose and out through your mouth, Yes that's the way  
Concentrate on your breathing and let your shoulders drop  
I'm going to rub them gently, right here on the top  
I know you're very frightened but you're doing really well  
You're getting enough air; this machine helps me to tell*

*I'll go and get your family and we'll show them what to do  
They'll need to know the routine so they can help you too  
At times this will happen, and you really need to know  
That panic doesn't help you and you need to take it slow  
If you practice what I've showed you, and try to stay calm  
Your breathing will ease and you will be safe from harm*

*There you are, that's better now you're doing it on your own  
I can see you're going to manage really well when you're at home"  
(Kirsten's poem)*

The participant's never made assumptions about another's life, always looking at the situation from the patient's perspective and trying to get a sense of the patient's experience. Chris wrote a poem to depict how a young boy with cancer struggled with an anaesthetic the day his mother was away. While her colleagues blamed an anaesthetic reaction she dealt with him rather differently.

#### CARTOGRAPHY OF ANGER

*It seemed insignificant to the adult intellect, an unavoidable change of plans,  
which meant that she could not be – was not there.*

*But after ten days away, your eyes clamour to catch sight of her, because stories  
have been stacked, until they balance precariously near the edge of your tongue,  
about that surreal, cartoon cut-out land called Disney,*

*where they send kids like you, so for a while you can pretend, that cancer is just  
the star sign of a very famous mouse, and you are really one of Peter's Lost Boys  
(that's why you'll never grow up),*

*and when these stories escape, tumbling from your mouth, she will be there to  
gather up your pain in her soft brown arms, and whisper that it's all right, to feel  
angry.*

*But you realise now she is not there, assurances that she will be back soon,  
do not placate, your precariously stacked stories are suddenly balanced,  
you are silent, up against the road block of internalised anger.*

### CARTOGRAPHY OF CONTROL

*It's the smell you hate the most, you've been watching Our World and know, that  
animals smell fear,*

*you wonder if it's a collective fear that you can smell, because no one comes to  
this place without facing crisis.*

*It's harder to pretend here, they have the monopoly on pretending  
"come on don't cry, be brave ...you're such a good boy"*

*it's like a game played over and over, and you have joined in eagerly, while  
secretly hoping someone will let you in on the rules, nobody has,  
so today you will play it your way, trying to show them, the sadness, the anger,  
the humanness, of the boy on the bed, crestfallen, his stories impinged on by life  
– she is still not here.*

*The acquiescence of body after first introduction to anaesthesia,  
today you make a choice,  
and object to sleeping with the enemy.*

### THE CARTOGRAPHER

*As the blinds of anesthesia are pulled up,  
you are screaming,*

*arms flailing like a drowning swimmer, no life buoy in sight – she is still not here,  
and they are still pretending,*

*"it must be a reaction to the anaesthetic, he's usually such a good boy"  
above your plaintive screams, they peck and fuss amongst themselves,  
their tongues immobile in the face of your anguish,  
instead their hands busy, with needles and syringes, regain control of the game.*

*They deliver you to me, with technical concern – "you will need to monitor his vital  
signs frequently, we had to sedate him again"*

*I accept you with intimate concern – "where is she?  
He's never been through this on his own before"*

*The oximeter's neon numbers cleverly monitor and signal your physical well  
being,*

*but is rendered incompetent, unable to monitor nor signal your tears.  
I dispense with the prop between us and sit up on the bed with you,  
fists are clenched tightly, your body a taught fiddle string about to snap –*

*(vital signs)*

*"I think its ok to feel angry, it must have been really tough without her here this  
morning. I'll just sit here beside you for a while and I don't mind if you kick and  
scream and cry because I know that you can choose to stop when you are ready  
... hey afterwards you might even tell me some of the stories I know you'll have  
from Disneyland..." (Chris's 1991 poems)*

## Caring Communication and Connections with Others

Having a caring relationship with patients and family was an important part of making a difference, respecting and therefore having a sense of the patient's experiences. Each of the participants spoke about feeling comfortable talking, listening or just being present, with their patients and families. Having caring communications and connections with their patients was acknowledged by the participants as being an essential part of nursing another and being an exemplary nurse.

*What I think about me, that you could say ok is exemplary, is that ability to make connections with people. The ability to make connections with the people that you are caring for, or your patients, and their families as well. And I think that that was something that I was able to do, you know quite successfully. Gaining the parent's trust was really, really important and when I think about it, well how did I do that? Well I think I sort of, talking a lot is important and just always never assuming that the baby is like your baby. Like it is always recognising that it is the parents' baby. And maintaining that they still have the control or authority or influence over what happens for their babies, making sure they understand what is happening and always sort of being open to them as well. (Jayne, 1st, 0, 132).*

The participants understood that caring relationships between themselves and their patients produced a reciprocity and synergy that encouraged healing. The believed that if they could be fully present in the moment – in the moment of connection - true healing could occur.

*That synchrony and synergy between the two and that synergy is like you are more than greater than the sum of your parts. Or when you get two people you have human to human interaction and rather than just the energy between the two of you, you've got synergy, that's where people get the energy to get well. That's where healing comes from. I truly believe that nurses do enhance healing. (Joc, 2nd, 0, 510-522).*

*Being fully present in the moment - with absolutely no expectations of any outcomes at all, but being so truly and honestly there, I think allows a healing of, something to occur for the person and that moment of connection. Its like you have to go deeper with somebody before they can actually see for themselves, you're facilitating a way for them to come back up and rise above and see with clarity what's going on for them. So it's the time that you have with people I don't think needs to be huge in turns of length of time, but you can get such a really powerful moment in a few minutes by just talking somebody deeper within themselves to allow something, a healing to occur for them and maybe for ourselves as well because I think the nurse has significant amount of reciprocity And when I looked then took a moment just to reflect back... something occurred for that first man, that was, I was able to facilitate some connection with him that meant that he could talk to me about his dying, so it was meaning making for him. (Kate, 2<sup>nd</sup>, 200-244).*

Being aware of self and their own Being allowed the participants to make caring relationships with another. Many of the participants were aware of this ability from a young age.

*I was aware of making a difference as soon as I got into Palliative Care again, other patient related stories made me realise that I could make a difference somehow. And I think it's largely a communication issue...there is something to me in communication. And caring communication is a significant part of Palliative Care. (Kate, 1st, 0, 54).*

*I think if anything, it is interesting, I mean when I was a midwife I was still very young, I was only 21, but I think it was, I remember that I was able to engage the mothers. And gain their confidence in some way...I think once again it was the ability to make a connection. And this is the area that I have always been interested in, you know that sort of nurse-patient relationship and the relationship with the premature infant has always been something that has really interested me. And even in the days before developmentally supportive care was a foundational principal that Neonatal Nurses worked with, I think I practiced a lot of that and it was just something that came instinctively. (Jayne, 1st, 0, 70-74).*

Communication for the participants was a fundamental part of caring for another. It relied on respecting and knowing another and taking the time to listen to another's views. Interpersonal relationships were dependent on this dialogue and through talking and listening; the participants were able to understand their patient's experiences.

For the participants, having a caring relationship and connection with another was more than just verbal communication. Many participants spoke of the first time they cared for patients who couldn't communicate due to language barriers. After caring for them they suddenly realised that they could communicate in other ways.

*"..It was like the start of a journey which I think I reflected hugely on – that whole sense of you are working with a person that you mightn't know anything about and you can't even communicate verbally with them – but you can...it was really meaningful.." (Anna, 1st, 1.1, 409-440).*

*I did my consolidation period on the Oncology Course prior to Palliative care with paediatric oncology. And I looked after two children particularly in isolation. One was a little girl, a Maltese girl, and a little guy from Uganda. Neither of which spoke English. And so this threw me into how you communicate with children when you don't have a common language. They couldn't understand one another's languages either, but had interconnecting doors that they could talk through, or communicate through. And they did that by drawing and writing and comparing blood results. And I have this delightful collection of slides that we produced from that on how you can actually teach children to give their own chemotherapy through their central lines. And yet it was all done without the commonality of English language. And I thought then, you know, you can.. There was something that woke up my whole realisation about the art of communication. Which I took with me then, into palliative care. (Kate, 1st, 0, 54-62).*



Chris wrote another awesome poem about understanding how a young seven year old was feeling despite him being unable to verbalise to her what was wrong. She spoke to the Doctors and managed to stop his surgery and postpone it until he felt better.

#### THE ROAR OF SILENCE

*I remember that morning shift when your silence perforated my eardrums.  
Demanding an interpretation,  
Ascribe a language to it (as if this would provide clarity for those unfamiliar with  
Sontag).  
Silence never ceases to imply opposite.  
It distracted me from ritual and routine (you were first on the theatre list).  
Instead I floundered with the burden of institutionalised speech, juggling words,  
phrases, how to legitimise, objectify,  
a 7 year olds metaphor for survival.  
This was not a dramatic or manipulative silence,  
but one of complaint and indictment.  
Surgery would not be a suitable respondent. (Chris's poems)*

The participants often talked about their backpack patients and the relationships within them as having 'clicked' with another - or having had a sense of another's feelings. They explained this as having an understanding of another at a conscious and subconscious level - a true and deep connection.

*The other weekend I was asked to go out and see a young guy, whose young wife, she's just celebrated her fortieth birthday on the oncology ward. She's dying and he wanted to talk about that. And we had this great Sunday morning sitting in the sun over coffee talking about life, and death and the universe really. And it was just a wonderful experience...and when I look back on my conversation with this guy and his dying wife. He said to me "how do you know what you know?, how do you know this stuff?" when I was just able to ask a question or say something that was pertinent for him, had meaning for him. And he said "how did you know I was thinking that?" or "how did you know that would be happening in our home?" I believe it is because of some deep level of connection, yeah. (Kate, 2nd, 24-96).*

These special patient/nurse connections were not always verbal but also physical presencing and a conscious being-with.

*I think that's also one of the things that I have a sense that I relate to that in people. I mean it's like Kubler-Ross saying that, you know, when people are unconscious that they can actually hear, transmit, you can transmit thought, you know? They can pick it up. Well I believe that emphatically and it's interesting because, It's a sense like there is some understanding there between myself and what's happening to that person. I would tell them "That this is ok, it's ok, it's time and it's an ok space to be in". And I can recall sitting with people and actually consciously thinking "I am not sure that you, whether you want to be on your own or whether you would like me to be here with you. I will remain for X minutes, an X amount of time and then I will leave you and you can be on your own if you want". So that, if there is, if there is some knowing between*

*individuals at that time, I mean if there is that understanding, that I will do whatever is right for them, you know?* (Liz, 1st, 1.5.1, 208-222).

Often the connections with their patients and family became close and were often regarded as friendships. Because the participants practiced with authenticity they were able to make friends with some of their patients with whom they had special and meaningful relationships. The participants talked about treasuring their memories of these patients and in many instances still had mementos of them. *"I can remember the card that they sent saying, you came as a stranger and left as a friend and I think that's the professionalism and the friendship"* (Liz, 1st, 1.5.1, 172-174).

*And she gave me in this envelope these green glass beads. Absolutely hideous! hideous! But you know I treasure them to this day because she brought them, she had gone home to see her garden but she had also gone home to bring something back from her to all of us. Ahhh! Special stuff! Special, special stuff! Those things they just stay in your mind for ever!* (Joc, 1st, 0, 268-288).

*I mean here he was - he was blind and beautiful. He did that sculpture there actually. He was a lovely painter and of course he lost his sight and he couldn't paint, so he started sculpturing, and he had a left hemiparesis. So, anyway so that was quite an intense involvement.* (Anna, 1st, 1.1, 489-492).

Caring communication is beyond doing the physical tasks of nursing. It was about knowing and wanting to know another at an individual level.

*One of the things that is really important is the one to one thing, the having the time for individual people...I mean its not a wildly academic thing. I believe most of us have the ability to learn technical stuff, that takes some putting your mind to it, but you can learn it but I think the understanding is different and think that's what makes a nurse, it's the understanding that we have.* (Liz, 1.5.1, 345-354).

*All of our training and all of those early years of nursing, and you know sinking or swimming and all of that rubbish is all about technical, its all about tasks, it s all about proving yourself physically and that not what nursing's about to me at all.* (Kirsten, 1st, 1.1, 360).

## **Respecting Another**

Respecting others was part of caring for another. To respect another, the participants were able to know their patients, understand them, acknowledge their differences, and allow them to 'be' authentic as well. It was about being truly present with another, accepting and respecting the values that made up the patient's life.

*An elderly woman that I looked after, and we are talking about, you know there were very few side rooms. We are talking about blocks of rooms where there would probably be four or maybe six women to a room. And this particular woman who had been in the ward for I don't know how many years, and I was helping her. I was giving her a sponge this particular day. And all she had was her bed and her locker. And I remember I was sponging her and I remember at*

*the end of the sponge I was putting her things back in her toilet bag. And I put her toilet bag on a particular place on her locker. I hadn't thought anything and she said "Dear, don't put that in my kitchen". And it just struck me, I thought my goodness! This is this woman's home! And you know, I need to respect that and think about, she's got, you know, so many inches of space and she's broken it up into what she would have. And so that really stuck with me, whereas I think some other people might think, Oh silly, you know, silly old twit, what are you talking about, a kitchen! But it really just, you know? And I sort of thought I've got to be really careful that I'm, you know, respectful of people and try to find out what it is like. (Chris, 1st, 1.1.10, 33-37).*

Respecting is about caring for people holistically. Being present in relationships that respect another's values and autonomy.

*How nurses care for people as a whole, not as parts or even the sum of those parts has to do with being truly present with that person and their family. The state of being present is a special interrelationship in which the nurse acknowledges and respects the values that make up that individuals quality of life. In this way the nurse is not the authority on what is right for the person. In the presence of the nurse the individuals own values, needs and goals for their life may be illuminated. In this way nursing is a special form of communication. (Jayne, AD, 1. 5-6).*

*I guess it's about trusting and respecting. I think there is a lot to be said in remembering that. It is respecting people no matter where they're at and what they look like. I think a lot of people make assumptions about people of the basis of how they look and how they might act. And I mean we are dealing with, particularly in paed's, we are dealing with parents and caregivers of children. They are not at their best; they are in a stressful situation where their child is unwell or having a big operation. And we are often expecting them to be often what they can't be. (Chris, 1st, 1.1.32, 119).*

Chris wrote a poem and presented it to her colleagues to depict how a number of people were not respecting the differences of some patients and families on her ward.

### Boxes

*Jack lives in a box.*

*We can be assured that Jack lives comfortably in his box because we have been creating and constructing boxes for many years.*

*Built as always to our own exacting specifications, we can offer Jack a guarantee that his box will be both durable and portable.*

*In line with mainstream 'box theory'*

*Jack has been fitted with our regulation spring an illusory device providing him with the perception of movement and experience of self expression, whilst remaining firmly anchored in his box.*

*What if Jack cried out?*

*Listen;*

*Jack is crying out -"I want to live outside my box!"*

*Tidy boxes untidy humans*

*Isn't it time **we** started to think outside the box? (Chris's poems, 1998)*

Being aware of our nation as bi-cultural and respecting another's cultural being and views was also an important part of caring for another.

*I suppose the whole cultural safety thing has been a big influence on my life. Something I hadn't even entertained, I always I suppose I always worked in a kind of a, respectful way with people, but I hadn't actually been particularly aware that we were a bi-cultural nation, I'd grown up in the South Island, it was fairly white really. I came across Irihapiti and I was aware of her cultural proposal for nursing education. And I remember reading that. And what struck me about it was, it was the first time I actually realised, about the issue around colonisation. And so I have been really fortunate. And then I went to the States. And being aware of being a person, a bearer of my own culture, being out of culture and working with, like Jewish doctors, mostly Spanish orderlies and Jewish patients and mostly African-American and Caribbean nurses, so I was very aware of culture. (Ellen, 0, 4128-432).*

### **It's the Patient's Journey**

The participants understood that it was the patient's journey not theirs and that their role was to walk beside; to empower the patients to make their own decisions when needed and to support them: *"Because what you are doing is, basically you are walking along side them, and it's like a journey"* (Anna, 1<sup>st</sup>, 1.1, 340).

*Because that is what nursing is for me. It's moving people through a patch in their life. You come across a sticky patch and there might be, you know, bowel cancer or breast cancer or some operation they are needing to have. And it's nice to be able to work with them through it...seeing the patients through their experience, walked their journey with them, to me is the epitome of nursing... That's what nursing is for me. I know its all about human to human interaction and walking along side somebody on whatever journey they happen to be on. (Joc, 2nd, 0, 510-522).*

For the participants knowing themselves and their impact on another was about being aware that they could relate and know another at one level and yet they could not always comprehend what a particular experience was really like.

*I remember the Burns Unit ...and I can always remember having this young chap who came in, he had been a commercial cleaner at the railway station and he'd been cleaning with white spirit and then using a rotary cleaner and it had ignited and he, it was absolutely horrific. And when we talk about whether we make a difference or not, I mean that sense of relating to them but not comprehending at all what it must be like to one minute sort of be able to do exactly what you want and the next minute be lying there in so much discomfort and for such long periods of time,. You know that sort of sense that it goes on forever for them. (Liz, 1st, 1.5.1, 101-105).*

Empowering their patients was an important feature for the participants in acknowledging it was the patient's journey. They gave autonomy to their patients by respecting their right to make decisions and supporting them to carry them out.

*I think that I always had this sense too that, that there was a need for people to have more autonomy, you know? They need to be more supported to, to have more control over what they do. We had a young chap out there, I don't, if I remember I think it was some sort of accident he'd been admitted with, he was in hospital for months and months and months. And sort of supporting him to go out in the weekend and knowing that it, that that's what he needed more than anything, needed some space of his own. You know? Just to be as normal as he could for a while. Yes that's, that's probably one of the times that I can recall most, had one of the biggest impacts on my training. (Liz, 1st, 1.5.1, 107).*

Instead of wanting to change or be in control of another, the participants, when appropriate, had stepped back and stood beside their patients on their journey - guiding, supporting and giving expert care.

*I can remember having that sense of having to alter things for people, which is really interesting because I fast got to the stage where I realised I couldn't do that and actually, the sort of revelation of what right, or who did I think I was, to think I actually could alter what was happening. I could support people and I could use my expertise to make them physically comfortable and I could support them as individuals but it wasn't my journey. It was their journey. I think that there was that sense of, initially I had to be God and that was an incredible responsibility. I mean, quite exhausting really. And I discovered that I didn't have to, nobody expected that of me, and I certainly wasn't able to do it. It was a lot easier to support people. Yes I think that time probably helps you become more effective in supporting people. (Liz, 1st, 1.5.1, 129-130).*

Chris's stunning poem about a young girl struggling with having cancer and its demand on her autonomy; illustrates how she supported her to remain independent and yet to take the pills that would help her.

### Pills

*She won't take that new pill, I've tried and tried!"  
is the first thing her mother tells you when you arrive in the room  
and she is 11 and sick of hospitals and sick of pills but here, nevertheless  
courtesy of the big 'C'*

*And even though you've talked and joked and played with her,  
you know today she means,  
definitely,  
absolutely,  
not to swallow another pill.*

*You smile and admire her bold resistance,  
She is as defiant as her few remaining strands of hair that refuse to be  
intimidated by scientific literature which claim they should fall out!*

*So you do not cajole, do not insist,  
Instead you leave her room,  
and sweet talk the pharmacist into giving you a seven day pill dispenser,  
fetch her drug sheet, all her pills, some paper, felts and stickers,  
Only then do you return and sit crossed legged with her on the bed, letting her  
know that you think its tough having to take so many pills,  
and really frustrating when people who don't have to take them keep asking*

*"have you had them yet?"  
 She grins at this and offers you a nod,  
 So you ask her if she would like to be in-charge,  
 And she has answered you already by laying the drawer labeled Monday,  
 on the duvet,  
 And showing you that she knows exactly which pills she takes each day.  
 She now has her own drug sheet (she calls it her pill chart),  
 and she signs with a sticker when the pills are taken.  
 "Its only nine o'clock and she has taken all her pills!"  
 is the first thing her mother tells you when you arrive in the room (Chris's poems).*

Making a difference was an important feature of Being and Becoming an Exemplary Nurse. It was where the participants carry out and do the work of the nursing they love. It was about relating and caring for patients, by being the best nurses they could be, and giving exemplary care. By knowing and being themselves they were authentic and able to have a sense of the patient's experience and either anticipate and control the situation or allow the patients to have their autonomy and freedom. It was about respecting the wishes and the needs of the individual – in the moment. They did this by acknowledging it was the patient's journey and not their own.

However, the participants did not practice in isolation. They used their mentors, role models and like-minded friends to support their ideas and decisions - that made a difference in their patient's lives. The participants also worked with colleagues and how they practiced, influenced others. The participants were not just practitioners but teachers, leaders and team builders.

## **WALKING THE TALK**

*'Walking the talk'* (Ellen) was how exemplary nurses relate and work with their colleagues. They knew themselves and were authentic in all their relationships with their colleagues and this enabled them to be role models and leaders for their work mates. They were aware of this role and enjoyed it – using their positive reputations to influence and support their colleagues to give exemplary care. They had many skills as teachers, team builders and team players and worked **with** their colleagues to provide exemplary care for their patients. They challenge their colleagues when needed and dealt with conflict in an authentic manner. They were also leaders, innovators and agents of change. As Ellen stated, *"That's what makes or breaks good management structure. Is management walking around, walking the talk?"* (Ellen 1<sup>st</sup>, 0, 222).

## Walking Alongside

Walking alongside their colleagues was an important part of mentoring and being a role model for the participants. This included creating a positive team culture, leading by example and being available for their staff. The participants were all of the opinion that to lead one must walk alongside rather than impose on others. They believed they were not the holder of all the knowledge but open and respectful leaders who helped their colleagues discover their own strengths and walked beside their colleagues in a coaching and mentoring way. *"I like to think that I am walking alongside, there's a coaching and mentoring role happening rather than an imposing one"* (Anna, 1<sup>st</sup>, 0, 556-600).

The participants became aware they were role models for their colleagues and used this reputation to reinforce their own behaviours and to continue role modeling for others.

*I have that position of being a Nurse Educator which is based in the clinical area which I think is, should be role model type of example. And I think it should be the type of role where you are not just the sort of, like the holder of the knowledge and you'd sort of hand out portions to people when they ask for it. It should be a role where you help people discover their strengths and how to find out by themselves, and I think I have done that.* (Jayne, 1st, 0, 119-122).

Chris was initially surprised to find out that one of colleagues had intently watched the way she behaved and wanted to emulate her.

*I remember having this lovely conversation with one of my work colleagues. One of the things she said to me was how she had noticed some things about how I am at work. How I am with people and that she was trying to emulate that. And something bizarre she said was "Chris, I watch you when you go out of, when we have report in the morning and you know? We have hand over from the night staff and then we go out, or you know we do the board, we allocate our patients and then we go out and collect in our notes and you do a more thorough reading of the notes and sort out what your days sort of vaguely going to look like" and she said "I notice, that how you do it, which is different than everybody else, you actually, we all go out there and take the opportunity to have a bit of a yarn with all the other people that are on mornings about what everybody has done and dah de dah. You actually go and get your notes and you go away from people. You will either go into the office, or that is where you usually go, and I can see that you are totally focused on what it is you have to do. And I have watched you when you are actually talking or when you go into your patients" and she said "you really want to, sort of know about them" and I hadn't really I hadn't even thought about any of that, you know? That it was actually even anything that somebody would notice. And she said "I have tried to do that, I make a point know of, not joining in with that 15 minutes of irrelevant conversation. I take that opportunity to really think what it is that I am going to do, to offer, or what it is that I am going to try to do.* (Chris, 1st, 1.1.15, 65).

The participants enjoyed teaching others. They enjoyed practicing what they preached; role modeling to influence behaviour so that care was given at the level that it should be. They did this by leading by example.

*I have my own personal practice when I deal with patients and I do that because I enjoy doing that, wanting things to rub off. I believe in talking out loud while you are practicing. Because so much of what you do is behind the curtain or behind the door, people don't actually see you work. Because what you are really doing at the end of the day is influencing staff behaviour so that their care is at the level that it should be. And I do the lead by example. And it goes a long way. So if I am seen to work hard and to be very attentive to patients and their needs and answer bells and whatever. And I still believe that it, it is part of influencing peoples practice and behaviours, their work ethics, and their work behaviour, is if the boss is there on the shop floor doing the stuff and tidying up the loose ends and making sure that the staff are ok. (Janet, 1st, 0, 133-139).*

### **Being a Team Builder**

Building a good team to work together for the benefit of the patients was an important feature of the participants. Team building relied on being available for staff, listening to their opinions and giving them autonomy. They supported, guided and encouraged their colleagues to be the best they could be. *"I just love team work. I love pulling together as a team and I love motivating people to pull together as a team"* (Joc, 2<sup>nd</sup>, 0, 106-128).

The participants were not autocrats but shared appropriate decision making with their staff. They were aware that being an independent and autocratic leader was not as effective as working together as a team.

*Something I have always known or done as a Charge Nurse is the notion that if you encourage contribution you get paid back a hundred fold. That in fact to lead as a one-off leader by yourself is just such a waste of energy. You can be a ward of thirty leaders, I mean obviously you have to have somebody that facilitates but I guess if there was philosophy for me it's about bringing out the most in everybody opposed to trying to be someone wonderful, the person at the top, because if you do, you are doomed to failure. (Ellen, 2nd, 0, 399-413).*

They were aware it was important to facilitate but not control; and to develop staff by building a shared vision for the future. To do this they gave support and valued their colleagues.

*It is about facilitating but not controlling. To develop staff by building a shared vision for the future, giving support and encouraging dialogue and empowering staff through knowledge. I push the staff, you know? A little bit further than they have been pushed. But I always have something to back it up and I am always there for them and never leave them in the lurch. And then building a reputation on that. I think that is again part of my reputation, is that I am fair. You know?*



*In rosters and that, and I will do the lousy shifts as well. You'll find Janet on night shift or she'll work a cover for somebody that wants to go to this and doesn't want to come in until seven tonight, I'll do that for people. (Janet, 1st, 0, 174-186).*

Sharyn believes that it is incredibly important not to be a lone practitioner. Being part of a team not only benefits patients but also the team itself.

*I think just the bit about being part of a team I feel that quite strongly. That comes from working in the hospice where team work was very important. When I think about being an exemplary nurse or a senior nurse you still can not be a lone practitioner. Being part of a team is still very important for both the patients and your own sake...I feel strongly that the ideal of being able to care for the whole patients is the aim and you can't do that without being part of a team. (Sharyn, 2nd, 0, 567-579).*

Supporting, encouraging and guiding staff was an important feature of team building for the participants.

*The more junior staff...like working with me in the High Dependency unit. They like being in there with me because they feel safe and they know I will support them and I can guide them. I won't sort of leave them hanging there. And they know that they're in a learning environment. (Jayne, 2nd, 0, 14-46).*

*I have tried to make a point of encouraging nurses, yeah, If I witness something, yeah, being positive or caring or, something important I will try and encourage them. (Sharyn, 1st, 0, 454).*

Part of valuing and supporting their work mates was trusting and respecting their colleagues' individuality.

*I am interested in how do people get to be where they are?... What does that mean? And it gets back to the trust thing. It gets back to the openness, being able to trust your colleagues. Being able to work with them; being able to trust and, respect them. Respecting that everybody has a different way of being. All I wanted to do was have nurses that were happy in their work, felt supported, felt valued. I mean I think I have always respected and valued, who people are and where they are coming. And you know some people might call me bossy Charge Nurse Anna and in one sense that was true but I also connected I believe with not only with patients but with staff. And I was respected and I tried to think about well how we can make the best of self rostering and documentation. I mean a whole lot of stuff we changed for the better or worse. I mean things come round in circles but I think there was a real sense of, during the time that I was on the ward that it was a really good ward to work in. (Anna, 1st, 1.1, 396-619).*

Kate treats each of her colleagues as individuals and thoroughly enjoys recognising their unique skills and passions.

*I have used some of what I have learnt from profound moments with patients, then in supporting staff, who worked with me and getting a real buzz in later years or recognising something unique within each staff member. Identifying*

*where each of their particular passions are within palliative care and helping them foster those dreams for themselves. (Kate, 1st, 0, 63-64).*

The participants were open and always there for their staff. They listened to their staff and believed that visibility was an important feature of a leader and team builder.

*I am a real easy touch when it comes to getting people what they want. Because I feel if the staff are happy in their roster, in their work-life, it will show in how they behave in the ward toward their patients. I have no time or feel any credibility for anybody that will not be there. If you're asking the staff to do something then you must be prepared to share that experience with them. So if it's a failure or if it's successful then you are there. And that's being available; I get to work early because I am one of those people that don't necessarily hit the ground running all the time. I have to organise things and I get to work early to do that. So that by the time the morning shift starts everything is in order. I also do it because then the night staff get my undivided attention for half an hour, three quarters of an hour before anybody else gets there. That's very important. I've found the same thing for staying on at the end of it you know? And then the other shift has that time. And not just now and then, but over and over and over again. So yeah, just because I've always felt that visibility is essential in any leadership position. (Janet, 1st, 0, 176-184).*

### **Creating Environments that Get the Best Out of People**

Changing the culture of the work environment to support their staff and to acknowledge that their ideas were important was an important component of being a team builder.

*People motivate themselves, and I think we can create environments they get the best out of people. If you show people that they are people with ideas, that they have contribution to make, that whatever they say and do makes a difference. Then whatever they do say do will make a difference. It just does. (Ellen, 2nd, 0, 367-391).*

Encouraging reflective practice and being available to listen to others was an important feature of building a positive ward culture.

*We need to create a culture that encourages reflective practice and peer consultation. Being able to talk to colleagues is the fundamental essence of reflective practice. We do this all the time when sitting down to morning tea or lunch and we discuss the challenges, interactions and conflicts of the day. This is an important part of our verbal culture and probably keeps us sane. (Anna, AD, 2, 117-130).*

Chris is aware that she is seen as a role model who practices at a high standard. She uses this knowledge to influence the culture of the ward.

*People do sort of respect that I practice to a high standard. And I just sort of feel like we need to keep that sort of culture within the ward going. Because I get really concerned about the younger nurses coming through, you know some of them look as if they have been nursing for 20 years! They look disinterested, they don't have any spark. Some of them do and I think the ones that don't, we*

*need to get them on board and show them that this place isn't where you take short cuts. So if you can try and encourage that. (Chris. 1st, 1.1.37, 175-1770).*

Kirsten knew that working as a team was incredibly important for a positive ward moral and culture. She believed that avoiding power relationships was an inherent element of ensuring this philosophy prevailed.

*We had the best year, it was quite amazing! The staff said, "Ok we don't want to wear uniforms" I said "That's ok. Wear a uniform or not if you don't want to. We are rehabilitation, we are not clinical. Lets make this environment as homely as we can". That sort of cut the power relationships out. And the team were just amazing. We said "Ok you are a doctor but there is no reason why you can't empty a bedpan". "You're a hospital-aid, there is not reason why you can't answer those bells". "You are a Charge Nurse, yes you are a leader and you have to be accountable and at times you need to do various things but you can empty bedpans too!". So it was fantastic! You didn't know who was who and it meant that everybody felt part of the team. God it was just such a great, great, great year! The staff grew and learnt and contributed and we did, we all grew together. (Kirsten, 1st, 1.1, 240-242).*

Joc fought many battles over hospital policies but managed to change the hospital culture for the positive.

*Just last weekend I was talking to one of the nurses I used to work with and the boss for the Base hospital, said to her, "What was it? that Joc did?" Because they put big submissions in when I left to keep me and, what-have-you, because, I was doing a good job. But I was intrigued because this boss actually did say to her, "What was it that Joc did, that was so good?" And she said "Oh Joc, she just brought us kicking and screaming into the 20th century!" Now I wouldn't say I did, anything spectacular, but what I did, was at least identify, that these are not only human beings that we are caring for here but that they were local human beings. And it was the locality of the people that pulled at my heart strings because these were people that had given their all to that area. And these were people that wanted to die in the area. And the last place they ever wanted to die was in an ambulance going to Base. Or in an ambulance coming back from Base. (Joc, 1st, 0, 177-193).*

## **Being a Leader**

Being a leader involved being an innovator and an agent of change in order to provide and improve services for the patients. It was also about dealing with conflict in an authentic manner.

## **Being an Innovator and an Agent of Change**

All the participants had stories which showed their innovation. Stories about: setting up Canteen (a support group for adolescents with cancer); setting up specialist nursing roles; developing performance assessment tools; introducing foundational documents

and standards of practice; introducing IV programmes; developing and running education modules and bringing in primary nursing.

Bringing in primary nursing where nurses took responsibility and saw the patient through their journey was a common innovation of the participants. *"One of the big things I did in that ward was introducing primary nursing. I think it was your autonomy and that you were completely involved and your opinions and assessments were central to the team"* (Kirsten, 1st, 1.1, 186-187).

Primary nursing for Joc was an end to task orientated nursing.

*That was one of the big things I did when I worked in that ward. I got there and it was fairly task oriented and hideous! Nursing things that I used to just shriek over. One was pushing around the drug trolley and saying things like "You are not in any pain are you?" You know, people actually walked into a four bedded room and said to patients "You are not in any pain are you!?" I mean! It just blew me away! How you could possibly function as a nurse? So to bring in primary nursing where a nurse took responsibility, saw the patient through their experience, walked their journey with them, to me was the epitome of nursing.* (Joc, 1st, 0, 31-35).

For Ellen, primary nursing allowed her to integrate her comprehensive training with her practical experiences. This had benefits for both the patient and the nurse.

*So we went through this wonderful period of setting up primary nursing and that would be probably the happiest, that I ever felt. Because everything that I was thinking about at University, everything I had figured out so far had come into being. And we started really working with the patients. Because it was very difficult. Complex people with very complex cases. I remember particularly a man with Crohns disease, who was having lots and lots of issues with his naso-gastric feeding. And I took on the role of primary nurse for him. And I think having had Psych training, helped (he wasn't mentally ill, but he was distressed). And what we figured with him, myself and the associate nurse that I was working with, was that he felt that he was losing control. And so we got him doing his own TPN and his own naso-gastric feeds and his own fluid balances. Well, I mean this was so easy, so obvious, isn't it? But it was very revolutionary in those days.* (Ellen, 1st, 0, 274-284).

The participants in the study continued to look for better ways of doing things. This was inherent in their Being and related to being the best they could be and making a difference for their patients.

For Ellen making things better was a legacy of the way she practices and influences those around her.

*I always think; Well, what do we need to do here, to get it, to make it better, to get it fixed, to whatever? And I remember, though I can't remember who said this to me, but when I was a staff nurse, I always used to be really content with being a primary nurse and making it, getting it fixed or whatever (or whatever*

*word we picked for my own patients). And then we started looking at other peoples care and seeing that it was not up to scratch. And then you know, I would work with my colleagues. And then I was a Charge Nurse and I wanted to fix the ward, but when I was a charge nurse, I suddenly wanted to fix the whole hospital, and I started running, or through the in-service department I started running days on primary nursing. And staff nurse study days and enrolled nurse study days. And so there's this notion that, and someone said to me "Ellen, you will not be content till your running, you are trying to run the whole world" and its not that I am a megalomaniac, but it's interesting because here I am now a leader of a large Service! (Ellen, 1st, 0, 515-519).*

Janet always goes to a new area and new role with the intent to make change.

*And that is probably another thing that has followed me through all the years, I always go to a place with the intent to make some changes. ...I mean I don't go through the process of change that is in the literature necessarily because I would never ask anybody to do anything I would not do myself. And I think that's probably one of the reasons I have been successful in almost everything I have done in that way is – if I ask them to jump off I will jump off first, and make sure that it is ok. Or if you fall and hurt yourself at least there is a band-aid out there to stick on it. (Janet, 1st, 0, 221-233).*

All of the participants were passionate about the profession itself. Believing that being part of local, national and international networks was a trait of leadership.

*Being part of local, national and international networks is a trait of leadership... It is when nurses collectively team that we have the biggest chance to create change that will benefit our patients and community. In my view giving your time and expertise to groups, committees, forums and the like are essential components of professional behaviour. (Janet, Info, 0, 143).*

*I have always had a political sense of being too. I mean I was always involved in the, you know, special interest group and you know I have always been involved in the professional groups, because I am interested in what the profession is doing and in what we are doing and you know? What is nursing and why are we there? (Anna, 1st, 1.1, 515-517).*

*What I see of NZNO<sup>14</sup> and what I know about it, is that in fact it's very much in line with my philosophy. It's about valuing women's work and valuing patients care, those sorts of things. (Ellen, 1st, 0, 557-558).*

## **Challenging Colleagues**

The participants were able to connect and create positive relationships with their colleagues by remaining true, honest and authentic. This was extremely important when changing roles, working with former opponents or being in unknown situations. Challenging colleagues to be the best they could be was a difficult task and could often cause conflict. To challenge effectively relied on being honest, authentic and offering constructive alternatives.

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<sup>14</sup> NZNO is the New Zealand Nurses Organisation and supports nurses in both a professional and industrial capacity.

For Ellen, knowing herself and being genuine was the prerequisite to knowing another and being able to have a productive relationship with former adversaries.

*If you don't know yourself then you don't have the ability to connect with and have an understanding of where the other persons at. When I talk about engaging with former adversaries - groups that we've had difficulties with. It's about creating relationships and I don't think you can do that unless you are fairly sure of what you are. And I don't think you can do that in an acting way. I don't think you can pretend. I think you have to warm up to a genuine wish to engage ... so I think that you actually, the only thing you have to fall back on then, when you are in a context that you don't know what's going on and it all seems very strange, the only thing you have to fall back on is yourself. And you have to trust that and being genuine about wanting to know how things work. (Ellen 0, 218-273).*

Chris challenged her colleagues with constructive comments aimed at encouraging them to reflect on their practice in a positive way.

*What I've tried to do and in a really constructive way is to actually challenge my colleagues about things. And generally I have to say that, (not that I do often, I don't make the point of doing it all the time, its only when I really feel like its absolutely necessary), but the reaction I have had has been really positive. Especially if you do it in the right manner ... When I make a mistake I am honest and say yeah I didn't do that right, or that's gone a bit pear shaped, or yeah I guess that might be why. So I guess I've tried to in the last few years to be a lot more out there maybe. Because I think if we're going to encourage colleagues to maybe reflect on their practice or look at how they are practicing, it can't be a destructive thing; it has to be constructive. (Chris, 1st, 1.1.37, 153).*

Kate also believed that dealing with conflict required an honest and authentic approach.

*I am absolutely pathetic when it comes to dealing with conflict, I hate it. So I would rather not get that far down the track. But in my experiences of having to do something, it has been that direct straight up, tough love, or authentic approach that has felt right. (Kate, 1st, 0, 188-190).*

Moral courage was often needed when challenging colleagues or dealing with issues about staying quiet about something or not. In these cases the participants often upset their work mates in order to make the situation safe for other colleagues and patients.

For Janet, two instances where she did not challenge her colleagues have made her change her practice. These experiences carried in her backpack, were used to teach others not to ignore things and to remind herself not to ever do the same again in the future.

*I tell people these stories about the consequences of my own personal denial or problems with not having the courage to deal with it at the time when it was recognised as a potential problem...I spin this around this moral courage thing. There were two different times, they were similar circumstances and they were years apart. They were different wards and they were both night duty. And the*

*first one was I noticed that the behaviours of the night shift (how the organised their work) was not right! That it was not good practice. But they had been doing that way for quite along time and you never mess with the night staff because they are permanent night staff and you don't want them to be not permanent night staff and that sort of thing. But it always bothered me and I would make some sort of subtle suggestions or ask. And they'd say just this is the way we do it. Well! Something bad happened. A particular man got sick and he got sicker and it wasn't noticed because of the way the organised their work and blah, blah, blah. And so the next day I took all the night staff together (because it was really a collective issue, it wasn't one particular person) and I said "This is how you've been organising your work and its going to stop today ok? And you are going to do it this way tomorrow". And I should have not of tolerated it. I should have gone through whatever -whether I went through this nice stages of change business and done it all properly or just you know taken the bull by the horns and said look this unsafe practice you are not doing it! And the reason you guys can't see it is because you have been doing it so long, blah, blah, blah. Anyway, a couple of years later, another ward, night shift! And the way they allocated their patients. Who was looking after who was very vague. And I thought this isn't very good either but I didn't do anything about it. And the same thing happened. I came on one morning and they gave report and I said "Well what about so and so?" And they all looked at each other and this person hasn't been assigned to anybody. He hadn't even been seen the whole night. He had an epidural and he had a central line. The mind boggles. The man survived and nothing bad happened to him. But the point was that again there was a situation that, I wouldn't call it totally unsafe but it was very messy in a way they, they weren't very organised about the way the allocated their patients. So it changed! And both of those were the same thing. In other words I was more interested in not messing around with the culture of the night shift, and not wanting to be seen as the new ugly Charge Nurse. Worrying about myself rather than looking at the issue at hand that was unsafe or potentially unsafe or whatever. And I would never do that again - being in a way afraid of rocking the boat with the staff. (Janet, 2nd, 0, 116-130).*

Ellen recalled challenging medical staff until she got the correct treatment for her patients despite being berated by them each time she called.

*A couple of times I got into trouble because I challenged the medical staff. Once over a patient who had an epidural and clearly was in pain. And in fact I rang the medical staff right through that whole twelve hour night shift to the point where the medical staff were just about ready to kill me! (Ellen, 1st, 0, 344).*

Walking the talk was how the participants went about relating with their workmates. This, like all aspects of their lives, was done with a pure authenticness that enabled constructive feedback, teaching moments and team building to occur. The participants were all leaders and innovators in their fields. They encouraged and role modeled positive ward behaviour and a culture where the staff were happy and the patients received excellent and safe care.

## **BACKPACK PATIENTS – SACRED MOMENTS IN PRACTICE**

The use of backpack patient stories has been interwoven into this thesis and is the mechanism by which the participants relived and learnt from their '*sacred moments in practice*' (Kate). They were powerful in their significance for personal connections and sense making and they were remembered and their stories retold because of many things. These included: a significant meaning making relationship or connection which occurred between the participants and the patients/family; where a difference was made for the patient and family; where learning occurred as a consequence of a complex or unusual situation; or where the participants learnt from situations where they had made errors or mistakes in their practice. Whatever the situation or experience, it made a profound effect on the participant for the rest of their lives – they carried these patients and their stories forever. They could close their eyes and see the situation and the patients in their minds, as if had happened yesterday.

'Backpack patients' and their stories were used for many reasons. Many of the participants' early clinical stories were based on learning skills and gaining knowledge. These stories were used for the construction of a knowledge base of skill and experiences. Later on these became more significant for learning about the nurse/patient relationship. They were then used as reminders of the situation when the experience was about to occur again. They acted as moral imperatives to improve the participants practice. Often though, the stories had multiple significances and included a mixture of meanings, understandings and knowledge learnt. While the participants also used these stories when teaching and communicating with other nurses – in order to walk the talk with their colleagues, the major significance and meaningfulness of the experience was always for the participant - the story teller.

### **Making Sense and Meaning from Experiences**

The participants believed their backpack patients' stories were tied into their search for meaning or making sense of their lives. Many of the stories were retold because of the multiple meanings they portrayed and the profound effect they had on the participants. They believed that a special and personal connection had occurred between themselves and the patients and therefore there was a '*reciprocity of spirits*' (Kate).



Anna illustrated the idea that backpack patients were there for various reasons and you take out what you need to learn from it, depending on the situation. She showed us that what one may read or hear in a story may not be important for the reader or listener but instead moved something in the storyteller.

*If you think about the meaningfulness of the story, of the patients, I think it is multifocal because I think you take out of a situation what you want to, at a particular time. But in the complexity of the whole, what you see or what you read in the words seems superficial. Because it must move something within you, I mean whether its your soul or whether it your mind or whatever and I mean surely the emotiveness, I mean I think about the woman that I interviewed for my research I mean I can still, I mean and I will probably do it next week because I am presenting again next week, I mean they still, those stories still make me cry. (Anna, 2nd, 0, 452-521).*

In my conversations with Kate she eloquently explained the complex nature of backpack patient stories. She, like many of the participants, told many negative stories. She believed that although negative stories may have a more profound effect, positive stories also have much power. Kate saw her life as a search for meaning and the backpack patient stories functioned as sacred moments in practice that were compelling in their meaning of connection and meaning making.

*Why did I tell negative stories?, how interesting because there are many positive stories too, but maybe it's the ones that you goofed that have some sort of profound effect on you? ...Its interesting because there is so much power in both... I was just thinking about the other stories and how negative they were and then going back to last Sundays positive conversation with this young guy and his dying wife and I thought that accompanying the dying and supporting colleagues to do the same, because that is more my role now, I think I have got to the stage of viewing life I guess as a search for meaning. Helping patients to search for meaning in face of their dying but also my own practice meaning, so some reciprocity comes in there maybe. So search for meaning, a purpose and a personal connection. I think that's the thing that really does it for me. And as I was thinking about those words I was thinking search for meaning, purpose, personal connection, and then I went on a kind of a tangent of thinking back to, Victor Frankles book, Man's Search for Meaning. It's gorgeous and divine. It's a book written from his time of being in both Dachau and Auswitch concentration camps, and observing people in the face of devastation, this kind of amazing beauty emerges from that and he really came up with the idea that, salvation of man is through love and in love. I think if I'm right, I have to go back to the book now and I've read it that many times but, you know, I start to blur the boundaries about what he actually did say and what I've said around it, but where he talks about walking, tripping over rocks and stones on the way to some work somewhere, in this concentration camp. And it was surrounded by lots of negativity and then, the guy in the line, chained up behind him said something about "If only our wives could see us now". And then suddenly the horror of what he was actually experiencing paled into insignificance because the image of his wife was so in front of him made everything else disappear. And his love and the beauty of their relationship and her as a person, made everything else bearable. And I think that's certainly something that I've mulled over the years,*

*in practice. There is a love that happens between you and your patients and your colleagues to do the job really. Then I was thinking what is it about that connection that's important to me? And I was also thinking, grappling with who said what last night but I think it's TS Elliot that calls it a still point or a timeless moment in that connection, personal connection and meaning. And then I didn't know if I am blurring the boundaries here but certainly having just, done my thesis, last year, that whole, I've called it sacred moments and maybe that's a similar sort of thinking that I think of TS Elliot. But that still point, or timeless moment for me, sacred moments in practice that are powerful in their meaning of connection and meaning finding and something that does it for me with people that I have spoken about in these exemplars. And it's an existential moment, and somehow I wrote down here, I find power, the power of our attention, yeah there's an existential moment of finding power in our attention to fundamental for people. It's really back to basics, it's not clever. Or highly technical or specialised, but there's something, powerful in the fundamental human to human connection for me, and working with that to find meaning. (Kate, 2<sup>nd</sup>, 2, 24-244).*

For Anna many of her backpack patient stories were meaningful because they were stories where the principles involved continued to influence her and her practice.

*Why do you tell stories around them? Well obviously because they were meaningful at the time... I think you think about the stories because you are thinking about a theme or you are thinking about it but you are using it to highlight a point...well I suppose some of it to do with risk taking, you know the initial stories. The story of the arrest well that was meaningful because it sent me on a journey, I mean it did or didn't it? I don't know. I mean putting butterflies into patients I mean that's a skill thing and that was for patient's convenience really but it was a risk at the same time. The story around the boy I mean that was to me, was a principle issue, I mean that's why I remember that but we spent a year with that young man and we had a lot of contact with his mother afterwards, but there were principles there that were at stake that influenced our practice. So I suppose that's why that was meaningful. (Anna, 2<sup>nd</sup>, 0, 313-392).*

The participants also 'carry' their backpack patients because they were examples of: making a difference for the patients/families; because they were difficult or complex cases or where there was a special connection with the nurse.

*I feel I do carry them. There are definitely patients I carry around because I have made a difference. Well I have felt that I have made a difference. Why are they in my backpack? Maybe for me they would also be difficult situations, not only the people that were in difficult situations or people that the nurses were struggling with at the time. And it would be about that connection, that relationship, people, complex cares and definitely learning the skills. And then as I have changed areas of practice there are other people who are complex in other ways, yeah maybe they have maybe complex needs. (Kirsten, 2<sup>nd</sup>, 0, 49-96).*

## Constructing a Knowledge Base – of Skills, Experiences and Patient Relationships

Backpack patient stories were built-up over a life time and placed in the ‘backpack’ in order to construct knowledge and also to illustrate the significance of relationships. The participants felt they grew with each story and they were used to become the best nurses they could be. These stories influenced their Being and Becoming, taught them lessons and skills and developed into reminders for the future.

The participants talked about growing with each story they placed in their backpack. They grew exponentially with each story they placed in the backpack and were able to practice those skills later once they were acquired and stored in their backpack.

*I suppose that some of those stories that I told you have influenced my being and becoming because I think throughout, I can see with each one perhaps I grew more. Or that I did things in each one of the stories that perhaps, I wouldn't have been able to do, back at story number one or you know story number two... (Chris, 2nd, 0, 228-237).*

The participants believed that in the beginning, practical skills were remembered and as their practice confidence grew they were able to learn from and remember the connections and personal relationships with patients.

*I think it's remembering the clinical/professional aspects that occurred. Where it was a crisis or just something interesting. But I think the other thing is a degree of connecting or I guess those earlier experiences are more than that, they are remembered more for the actual lessons learnt or the clinical experience part of it, more than the relating. I think the relating aspect has grown more in recent years, has become a greater part of why I remember people in more recent years. I guess when you first start, trying to get the practical things right and because you have to, in order to build the confidence of being competent enough as a practitioner. That would have been the early focus. And the sort of personal relating side of things, would be there. But how important that is has sort of grown more over the years. And still the bottom line is as a nurse is still being a safe practitioner, so the actual clinical skills side of things have to be maintained. And I mean I still can learn more skills but maybe what has happened is that has become, because of practice and experience that has become more familiar. Because of repetition and whatever you do learn skills, practical skills so that your focus is not so much on establishing them and I guess the natural progression is that those things become just part of the looking after the person... (Sharyn, 2nd, 0, 270-330).*

Backpack stories acted as a reminder when similar situations were about to occur. Often they cropped up out of the subconscious and alerted the nurse so she did not make the same mistake again.

*Sometimes people pop up and I think oh I wonder what it was, I wonder why that person keeps coming up or I wonder why, especially if it is somebody out of the blue, you know that you maybe cared for, well for me, 20 years ago...and I take it one step farther and instead of thinking oh did you do that, I think oh is there a reason why that happened? And maybe there is a connection. Maybe I am thinking about something that was similar to that situation?...Like woops! Oh, oh I have been here before and certainly learning from those previous mistakes ...so yes always be alert to the mistakes you have made in the past and try not to repeat them in the future. It certainly stays in your backpack. (Liz, 2nd, 1, 687- 670 & 0, 129-152).*

When the memory surfaces the nurse was able to consciously take on board the lessons they were learning from the current situation and file them in their backpack for use again in the future.

*I guess you process those sorts of things for whatever the need is at the time. And the memories serve as reminders. Or you remember them in the future, as well as consciously taking them on board the lessons you are learning from the situation. I guess what I do professionally in the way I learn, the way I process things, I take from certain situations I guess it reflects the same sort of processing. And maybe as you get older and hopefully more mature you do things more consciously. (Sharyn 2nd, 2, 330-337)*

The participants often talked about the particular patient's that 'taught' them about a specific skill or relationship. They can "close their eyes and remember the room and everything" (Liz, 2<sup>nd</sup>, 0, 224).

*I was thinking about what skills can I actually remember? And I remember knowing babies and the importance of developmental care. Knowing about that before it became sort of one of the foundations of practice. And I remember the baby who taught me it. I remember him well. He was a baby I'd cared for, for a long time and he had been very sick and finally he was off the ventilator and out of his oxygen and just sort of staying in an incubator feeding and growing and I remember thinking oh great! I've got this baby to play with! I'm going to have a good time with this baby, this morning! So I did everything for the baby, I did all of his cares and I bathed him and I weighed him and I talked to him and he cooed at me and we had a lovely time! And anyway, so I thought right, ok, we've been weighed and we've been bathed and fed and you've been put in a cute little outfit, now well have a bottle! And then I sort of looked at him and I thought, ohhh! I don't think you are enjoying this quite so much at all. And he sort of went quiet and pale and mottled and I thought, babies not going to have a bottle! And I was thinking - you did too much to that baby all at once Jayne! And you didn't take any notice when he stopped enjoying it! So I remember that boy who taught me that before we actually were taught that as part of neonatal nursing practice. Interesting isn't it? (Jayne, 2nd, 0, 298-319).*

The backpack patient experiences enabled the participants to have an 'intuitive' understanding of the next patient. They assisted the nurse to gain expertness and exemplary behaviours.

*You know how you go to the bedside and you just have a knowing about how you are going to be? I've always really liked thinking about me as an intuitive practitioner but much to my great sadness comes the realisation that intuition is built upon so much experience and so much that's gone before in your backpack of cases that you carry around. About how you are going to be next time or how you are 'not' going to be next time. (Kate, 2nd, 0, 76-80).*

The participants remembered their backpack stories with emotion. They were often incidences where the nurse had learnt a profound lesson from a particular patient situation.

*A lot of mine I think are emotional ones. I would say the majority of those of mine are emotional ones. But I've sort of learnt something from that. That guide me. Maybe about the things that you've done well. The things that you've learnt to do. Like I talked about learning to sit in a room with a baby and family, a baby who was dying - just sitting there. And just learning how to do that and just to be there. Be with them. So I think the ones that I carry around with me are more emotional. Ones where I have learnt a skill being with people or interacting with people. (Jayne, 2nd, 0, 331-362).*

The participants described that they could remember specific patients if they were given enough clues. However, the patients they carried in their 'backpacks' were different and were there because of special connections that had been formed.

*One of the other things is that sense of the impact that people have on me. There would be very few of the people that I've cared for that I couldn't remember and I meant that would be hundreds ...But I've met people and they've said to me "you were the nurse who came to mum" and when they say this I can remember. And I can remember the colour of the bedroom, the colour of her nightie, every single detail, but she isn't somebody that sits in my backpack. But if I get enough cues I can remember. In situations like that though I am not conscious of me being there. Maybe in those other situations where I carry them, I'm conscious of me being there as well? ...I think they are there because they demand it. Maybe the intensity of the input was greater from me? (Liz, 1st, 1, 208-222 & 2nd, 1, 259-266).*

## **Telling Stories to Talk the Talk**

Backpack patient stories were used when nurses attempt to communicate with others. During teaching situations they are often used to highlight examples of both good and bad practice.

Backpack patient stories are the way nurses articulate what nursing is all about – that it is not just a physical act, but a 'being with' and a 'making a difference'.

*I think it's about learning because you do, in reflecting and thinking and telling the story. Because there is a reason why you are telling the story...because nurses tell stories all the time, but what do we use them for? I mean it's that whole, it's gets back to the whole business that nurses say that we have been*

*well in our drive for professionalism but it's to do with being able to articulate what nursing is actually about. And it's not just the physical tasks; it's the being with the making the difference and what that means. (Anna, 2nd, 0, 414-439).*

Telling backpack patient stories was a way for nurses to connect with others nurses, to understand and share common meaning.

*Being able to tell the stories around patients and certainly a lot of the papers I've presented, I would tell stories around patients that I had cared for to highlight whatever theme I wanted to highlight. And people would come back to me and say I really enjoyed that paper you gave, because you talk the talk and we know that you know what we are talking about. So that was actually really affirming because it was based in practice which of course it should be, people could relate to it. The participants often used their 'backpack' stories and experiences to make connections with others. The stories stimulated their colleagues to reflect – to think about what they were doing and why they were doing it ...It's funny when I was sitting on the loo before I was just sort of thinking about the patients' stories. I have noticed in this job is that I don't have those stories anymore. And it's interesting how you talk as nurses and the story telling that nurses do is based on, usually patients' stuff. When I was at NZNO I used patients' stories all the time and it's like being with new grads I mean I spoke to the new grads the other week and you do that because you are trying to connect. I suppose it's that whole connection thing. And you are trying to get them to think about where they're at and what they're doing. So yeah I suppose it's about connecting and if you are talking to a group of nurses that is often how you connect. I mean we tell stories about what happened in practice. (Anna, 1<sup>st</sup>, 1.1., 579-583 & 2<sup>nd</sup>, 0, 392-419).*

The participants took what they needed from their stories to illustrate different facts, for different reasons and in different situations.

*You take from it, what side of the story you want to present...and they change. I think it's to do with the demonstrating of, but also connecting...If I was talking about a complex palliative care patient, how I would talk about that with an experienced palliative care nurses would be different to how I would talk about it with new graduates. But I might use the same themes because I want to highlight something within that story that I want them to get the message around. (Anna, 0, 452-521).*

Many of the participants backpack stories were about mistakes. They often used these as powerful teaching tools.

*One incident I always remember was a woman who had a gastroscopy and she came back to the ward and I was very new and I am so embarrassed to even tell you this story, it's awful! And she came back to the ward and you know how the nurses say things in report that they shouldn't say? I called her a dying swan! Awful!! Because I thought she shouldn't be in that much pain. And I came back the next day and she had perforated her bowel!! And I will never forget it. I will never do that again. I can't believe I ever did it. And I tell the students that, because it makes me feel absolutely sick to the core...I use them a lot, those stories and even ones that haven't worked. Absolutely. And I tell them to the students, absolutely and they will look at me as if to say Ohhh that's terrible! Half*

*of me thinks that's uncomfortable and the other half of me, if they remember that for the rest of their lives then they will be better off. Like I am remembering it for the rest of my life. (Kirsten, 2nd, 0, 120-143).*

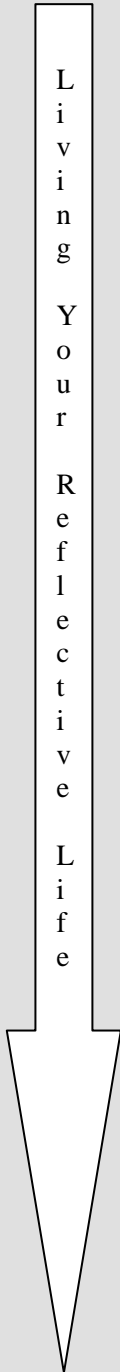
*I guess within those practice experiences it hasn't all been positive stories and if anything it's the negative ones that probably stay in my mind because they are the ones that I have learned from. And they are your reality checkers, you know? you haven't got it all sussed yet, it's not that simple... (Kate, 1<sup>st</sup>, 0, 101-103).*

Backpack patients were influential in all aspects of the participants' nursing lives. They illuminated the good stories - reaffirming their love of nursing; they reiterated reasons to be authentic; they encouraged the participants to continue making a difference in their patients' lives and they were used to walk the talk with their colleagues and communicate with their critical friends. The not-so-good stories were also profound and used as Ah Ha's to change practice in order to make a difference in another's life.

There were many different patient stories told and carried by the participants and all for a variety of reasons. Throughout this chapter, segments of these stories have been revealed. However, an important feature of understanding and 'knowing' these exemplary nurses is appreciating these stories in their 'wholeness'. Therefore selections of these backpack patient stories are included in Appendix 8.0.

## **THE UNFURLED KORU**

In this chapter I have unfurled the koru and described the participants' journeys of Being and Becoming. I have used their voices to tell the stories – to explicate the lived experiences and meaning of B/being and B/becoming an Exemplary Nurse. The pivotal construct within this journey - is being and becoming 'authentic'. This concept is reliant of living reflective lives and related to their love of nursing; making a difference; critical friends; walking the talk; and their use of backpack patients – in both a personal and social way. Each of these major constructs has categories and sub-categories as illustrated in Table 2.

PIVOTAL CONSTRUCT	MAJOR CONSTRUCTS	CATEGORIES	SUB- CATEGORIES
<p>AUTHENTIC BEING</p> <p>L i v i n g  Y o u r  R e f l e c t i v e  L i f e</p> 	A Combination Of Being Able To Be Yourself – Be Your Own Person And Be The Nurse	Knowing And Being Self	Joining the professional and the personal Impact on others – bit players in other peoples lives Moral courage - to act where others fear to tread
	A Love Of Nursing	It's A Privilege To Care For Others I Can Enjoy Someone But I Don't Need To Seek It Out	
	Critical Friends	Being Pushed Beyond Your Boundaries – Charge Nurse As Mentors Being Impressed By Another – Role Models Like Minded Friends	
	Making A Difference Sustains Me	Being The Best You Can Be  Having A Sense Of The Patients Experience Caring Communications And Connections With Another	Being a life long learner Being on top of things and in control Going the extra mile  Respecting another It's the patients journey
	Walking The Talk	Walking Alongside  Being A Leader	Being a team builder Creating environments that get the best out of people Being an innovator and agent of change Challenging colleagues
	Backpack Patients	Making Sense And Meaning From Experiences Constructing A Knowledge Base – Of Skills, Experiences, And Patient Relationships Telling Stories To Talk The Talk	

**TABLE 2: Constructs & Categories of Being and Becoming an Exemplary Nurse**

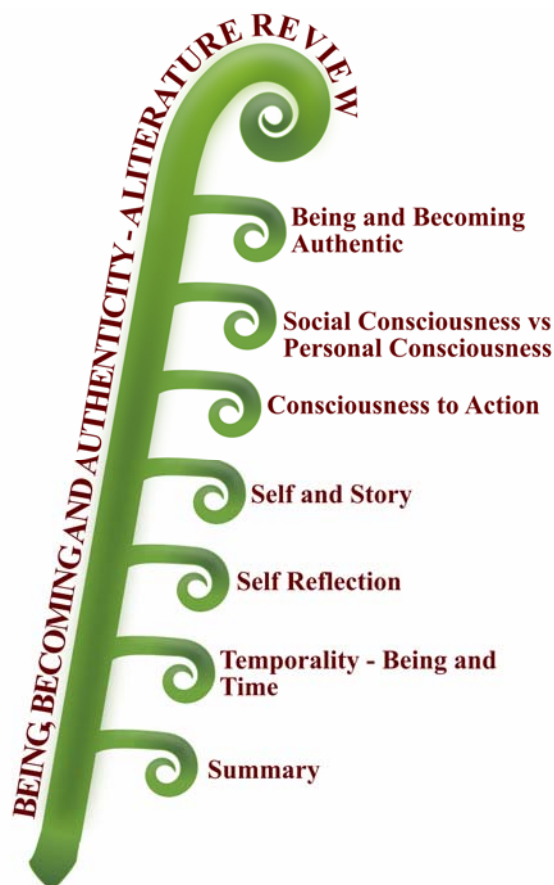


In the following chapter, a literature review of the philosophical constructs of Being, Becoming and Authenticity are presented. These are described and discussed in relation to the study participants' findings from Chapter 4. Further interrelationship of these assumptions, along with an understanding of 'exemplary nursing' (Chapter 6), will be the basis for the Discussion and Synthesis (Chapter 7) of this thesis.

## CHAPTER 5

### BEING, BECOMING AND AUTHENTICITY –A LITERATURE

#### REVIEW



An expansive literature review of the philosophical constructs of Being, Becoming and the notion of Authenticity was undertaken after the findings of the study were realised - as congruent with my design and methodology. During this phase I read extensively on the philosophical history of these constructs and realised the current understanding of these concepts had changed dramatically over time, with each epoch and its thinking having influenced succeeding philosophers.

After exploring the philosophy of these constructs and delving into how they

changed from the views of the Ancients, the influence of religion in the Middle Ages, the Renaissance and Reformation, the Enlightenment; Romanticism, through to the thinking of the modern Existential philosophers, I came to understand that many of the ‘current’ ideas which are taken for granted are actually deeply rooted in this history. My reading of this knowledge informed and clarified this thesis’s underpinnings and the study participants’ findings related to these ideas. A detailed review of this area initially spanned 20,000 words, which was beyond the scope of this thesis. Accordingly, this chapter presents a highly focused appraisal of these philosophical aspects as they relate to the study findings.

In this chapter I describe the dictionary definitions of these terms and discuss specific ideas that make up the constructions of Being and Becoming an Authentic Exemplary Nurse. These notions are: social consciousness versus personal consciousness;

consciousness to action; self and story; self-reflection; and temporality – being and time.

## **BEING AND BECOMING AUTHENTIC**

The New Shorter Oxford Dictionary on Historical Principles states that as a full verb ‘be’ is to:

*1. Have place in the realm of fact; exist, live. 2. Come into existence, come about; happen, occur, take place. 3. Have or occupy a given position; exist in a stated circumstance, condition, or relation; occupy oneself in a given way. (Brown, 1993, p. 195-196).*

‘Being’ as a noun is described as:

*1. Existence, material or immaterial; life. Existence in some specified condition, circumstance etc. 2. Condition; standing, position, livelihood. 3. Substance, constitution; nature, essence, person. 4. That which exists or is conceived as existing especially a person or other intelligent life. (Brown, 1993, p. 208).*

‘Become’ is written as the verb “*come into being*”; and as a noun or adjective, “*Come to be, begin to be*” (Brown, 1993, p. 202).

‘Becoming’ is stated as “*The action of coming to be something or passing into a state*” (Brown, 1993, p. 202).

These recent dictionary definitions state the verb ‘be’ as relating to existence – to ‘be’ or ‘become’ **something**. In this study to ‘be’ or ‘being’ was related to **being an exemplary nurse**, and to ‘become’ was to **become an exemplary nurse**. ‘Be’ or ‘Being’ as the noun described the ‘essence’ or ‘nature’ of the being and in this thesis is related to the **Being** of the **Exemplary Nurse**. The term ‘essence’ derives from the Greek ‘ousia’ which means the essential inner nature of a thing – the true Being of a being (Kahn, 1973). The Latin ‘essentia’ comes from the word ‘esse’ which means ‘to be’ and is that which makes a thing what it is rather than it being or becoming something else (van Manen, 1990). While these modern definitions are irrefutable, the views of these terms were modified throughout history from the early Greeks and their struggles to categorise the meanings of being through to the questions of what a true self was as discussed by the twentieth century existentialists. Furthermore, linkage of these ideas often occurred for example Edmund Husserl used both Plato’s (1961) ‘Eidos’ or

definition of an idea or form and Aristotle's (1941) notion of essence as the essential nature of a thing; to designate his own idea of essence as the 'what'ness of a thing opposed to their 'that'ness (Husserl, 1982).

The New Shorter Oxford English Dictionary on Historical Principles defines Authentic as:

*Entitled to belief as stating or according to the fact; reliable; trustworthy. Real, actual, genuine, original, first-hand, really proceeding from its stated source, author, painter etc.* (Brown, 1993, p. 150).

The New Shorter Oxford Dictionary states the word Authentic comes from the Greek word – "*authentikos*" meaning "*Principle, genuine*" (Brown 1993, p. 150). They quote R.D. Laing, a prominent psychiatrist, who said: "*To be 'authentic' is to be true to oneself, to be what one is, to be 'genuine'*" (Brown, 1993, p. 150). The Collins English Dictionary states further that the Greek word "*authenticus*" comes from the Greek word "*authentēs – one who acts independently*" from the composite of "*Auto + hentēs – a doer*" (Anderson et al., 2004, p. 99).

The New Shorter Oxford Dictionary defines the word 'Authenticity' as "*The Quality of being authentic*" (Brown, 1993, p. 150).

The notions of authenticity, as described by these dictionary definitions, such as 'being true to oneself', 'being what one is' and 'acting independently' are congruent to **Being an Authentic Exemplary Nurse** in relation to this thesis. However, the notions of authenticity that are defined by these modern dictionaries did not become relevant until the later half of the 18th century (Trilling, 1971). For example one of the earliest mentions of authenticity was made by the Greeks in 400 B.C. Here the adage "*Know thyself*" was inscribed on the temple of Apollo at Delphi (Anonymous, 1996, p. 221). Plato (429-347 B.C.) ascribed this saying to the seven wise men, but it seems he did not mean what we think of today as self-knowledge, for the Greeks used the term "*gnothi seaton – know thyself*" in a different contextual situation than we do today (Taylor, 1989, p. 113). For Socrates (384-322 B.C.) and his pupil Plato, what was important about self-knowledge was not 'being yourself' but instead projecting yourself as being what was particular and distinctive about yourself in order to be able to better match the ideal that determined your function (Guignon, 2004). Aristotle (384-322 B.C.), whose interest was theology, also believed in becoming what you were predestined to become (Fearn, 2001). He believed this was a person's aim throughout their lifetime and said:

*The good of man is the active exercise of his soul's faculties in conformity with excellence of virtue ...Moreover, this activity must occupy a complete lifetime, for one swallow does not make spring, nor does one fine day; and similarly one day or a brief period of happiness does not make a man supremely blessed and happy. (Aristotle, 1996, p. 25).*

Aristotle stated that the present could only be understood by reference to the future. The nature of a thing was inextricably linked to its telos, its goal or final end. He believed the final end of an object informs its nature, and that nature subsequently drives it towards its goal (Aristotle, 1991). For the study participants this notion has relevance only in part. The participants did want to 'become' exemplary nurses, but this goal was reliant on the knowledge of knowing themselves, their present Being and their past. Only with this knowledge could they 'know' how to act in the future – in order to 'Become'.

### **Social Consciousness Versus Personal Consciousness**

The participants in my study did not only know themselves, they were also aware of their impact on others, the social role of their being. It was during the Renaissance and Reformation that a newly emerging sense of society started to shape the modern understanding of self. This view incorporated a belief of society as manufactured and as a product of human decision making rather than something natural or preordained (Taylor, 1989). The experience of 'social' as 'other' to one's true self brought forth a split between the real me – the true inner self – and the 'persona' (from the Greek word mask) that people wore in the external world (Guignon, 2004).

Jean-Jacques Rousseau (1712-1778) believed that society itself was the cause of most of the miseries and corruption of the modern existence and the ultimate aim in life should be the voice of conscience (Rousseau, 1992). He believed in the idea of an inner 'true self' where one could make contact with nature. He said to:

*"leave those vain moralists, my friend, and return to the depth of your soul: that is where you will always rediscover the source of the sacred fire...that is where you will see the image of true beauty" (Rousseau, 1996, p. 549).*

This self-discovery, brought about by self-knowledge and self-realisation, was for Rousseau, not only similar to artistic creation but was instead, the ultimate form of artistic creation. From his perspective, everyone could become an artist, because he believed every person created their own life. To make this life artistic, a person did not need to undertake self-reflection, which Rousseau believed could cause a splitting apart.

Instead people should ‘unreflectively’ immerse themselves in their own life by fully participating and involving themselves as a feeling and acting whole (Guignon, 2004). Rousseau directed people to “*be yourself*” by living a life that was creative, truthful and genuine to all their feelings (Starobinski, 1988, p. 199). Here it was less important ‘what’ you did than ‘how’ you did it.

Georg Wilhelm Hegel (1770-1831) recognised the notion of historical change and believed that an idea was ‘true or correct’ dependent only on where you stood in time and place (Hegel, 1979). He also suggested an interactive relationship between man and nature, believing that when man worked he interacted with nature and transformed it and at the same time nature interacted with man and transformed his consciousness. Therefore, for Hegel, consciousness determined social being and what you thought conveyed what you did (Eagleton, 2000; Gaarder, 1996).

Karl Marx (1818-1883) also believed that material factors in society determined the way we thought and therefore the way we are – “*It is not the consciousness of men that determines their being, but, on the contrary, their social being that determines their consciousness*” (Marx, 1959, p. 84). Like Hegel, Marx believed that how we work affects our consciousness and our consciousness affects the way we work. Therefore the job we do is closely related to the way we think. However Marx inverted Hegel by claiming that ‘social being’ determines consciousness - what we say or do is ultimately determined by what we actually do (Eagleton, 2000; Gaarder, 1996). He claimed that the priorities of social being and consciousness are ontological ones concerned with the way we take human beings to be (Eagleton, 2000).

In congruence with both Hegel and Marx, the study participants’ social interactions and actions - both conscious and unconscious – enabled them to love and live nursing; relate and connect with critical friends; to enjoy and acknowledge that making a difference for another sustained their practice; and to work with others authentically. Of equal importance, their consciousness, – through the mechanism of living reflective lives and using backpack patient stories - enabled them to act authentically with others.

Mikhail Bakhtin (1895-1975), supported the view that humans exist as ‘polyphonic’ points of intersection within the social world – a world where people better understood themselves through social interactions, rather than through introspection or self-reflection (Bakhtin, 1981). This perspective was similar to the one put forward by

Martin Buber (1878-1965). He believed being a self was dependent on the relationship between the 'I' and the 'Thou'. For Buber, reality was 'being-in-between' which was characterised by mutuality and presentness. The 'I-Thou' focused on the whole being, which started from experience. Being a self was a very personal, individual, unique attribute, quality or spirit that made one human. Being was always experienced by being in relationship to and with others (Buber, 1965). This primacy of understanding the self through the social, was also articulated strongly by Hans-Georg Gadamer (1900- 2002). He believed people came to understand themselves through the 'we' long before the 'I'. He said:

*Long before we understand ourselves through the process of self-examination, we understand ourselves in a self-evident way in the family, society, and state in which we live. (For this reason) the focus of subjectivity is a distorting mirror. The self-awareness of the individual is only a flickering in the closed circuits of (social) historical life. (Gadamer, 1975, p. 276).*

For the participants in this study their social consciousness was shaped by their interactions with critical friends, their conversations with colleagues while walking the talk, and their critical reflection on memories carried in their backpacks. This was assimilated into their personal consciousness and used for 'action'.

## **Consciousness to Action**

For the participants in this study, their 'being' and their 'becoming' was a purposive 'action' where they endeavored to 'become' what they wished to 'be'. These 'actions' were always intentional and critically examined. The participants were aware that 'making a difference' in their patients' lives sustained them in their practice. One of the methods of achieving this was being the best they could be.

The idea of having a responsibility to act your best for self and society has been around since the times of pre-modern people. Despite believing that a 'God' or 'Spirits' were the cause of all actions in their lives, these early peoples also tried to alter the forces of nature by working on their own force of fate or destiny. While they had their own predefined place in life they also had a responsibility to act their best. They believed if they followed these ideas they would reach their full potential (Guignon, 2004).

Similarly, Soren Kierkegaard (1813-1855) believed that only when we act – and only when we make significant choices – do we relate to our own existence. He alleged that who you are depends on the stand you take on being a self and how you interpret

yourself is not a question of what you think but what you do (Kierkegaard 1962). This idea is an important feature for the study participants who not only thought about their ideas, and experiences but actually synthesised these with their past knowledge in order to take 'action'. This action was then reflected on for their future B/being and to make sense and meaning from their experiences.

Frederick Nietzsche (1844-1900) also saw life as a continual process of integrating one's character traits, habits, and patterns of interaction with the world. A person's goal was to make a unified character out of all they had done. At the same time, they could take responsibility for themselves and own up to what they were. Nietzsche did not believe that 'being' and 'becoming' were related. Instead he alleged that "*becoming must be explained without recourse to final intentions...Becoming does not aim at a final state, does not flow into 'being...one is just, what one becomes'*" (1968, p. 708). He believed everything one has ever done is essential to who one is and becomes. He wrote:

*The most recent history of an action relates to this action: but furthest back lies a prehistory which covers a wider field: the individual action is at the same time a part of a much more extensive, later fact. The briefer and the more extensive processes are not separated.* (Nietzsche 1968, p. 672).

For Nietzsche (1974), this belief, to own up to what one is, could be achieved by "giving style to one's character" (p. 290). This ability to give shape to oneself was a capacity by those who "survey all the strengths and weaknesses of their nature and then fit them into an artistic plan until everyone of them appears as art and reason and even weaknesses delight the eye" (Nietzsche, 1974, p. 290). This notion is very compatible with the participants' reflecting on and being aware of their own personality and character traits and placing themselves in positions that made use of these attributes for the best of their patients.

Jean-Paul Sartre (1905-1980) also understood that to act was everything (Centore, 1991). For Sartre, from their own nothing-ness a person – could by their own actions - create themselves to be the person they wanted to be. He understood humans as self-making, and people who defined their own identities in the course of living out their lives. He believed that "*a man is nothing else than a series of undertakings, ...he is the sum, the organisation, the ensemble of the relationships which make up these undertakings'*" (Sartre, 2001, p. 300). This is congruent with Adrian van Kaam's philosophy (1920- ) who said:



*As a man I am both “potentiality” and “emergence” ...I experience my potentiality as a dynamic tendency towards self emergence. I am not only what I actually am; I am also a constant movement towards self-emergence ...I am becoming. I am potentiality of dying to my life at any moment and to being born to what I am not yet.* (van Kaam, 1974, p. 109-110).

These philosophical ideas were realised in the study findings where the participants were both being and becoming at every moment in time.

Further, Alexander Nehamas (1946-) described the idea of becoming who you are, as similar to composing a literary work where the novelist's goal is “*a continual process of greater integration of one's character-traits, habits and patterns of interaction with the world*” (Nehamas, 1983, p. 404). He suggested that this self-formation included “*a willingness to accept responsibility for everything one has done, and to admit ... that everything that one has done actually constitutes who one is*” (Nehamas, 1983, p. 407). This notion is congruent with the study participant's critical reflection on their actions and interactions and their reliving of mistakes in practice through their retelling of backpack stories.

## **Self and Story**

As a way of integrating their experiences into their ongoing journeys, the participants used a ‘Backpack’ of patient stories to make meaning of and sense of their Being - to integrate their personal experiences with their social experiences. Backpack Patients Stories were used to construct a knowledge base of skills, experiences and relationships with their patients and to talk the talk with their colleagues. Each backpack patient and the story within it was significant for the participant and stayed with them, providing a moral imperative to continue providing exemplary care for the patients and family they cared for.

Alasdair MacIntyre (1929- ) supported the view of human life as an “*enacted narrative*” (MacIntyre, 1984, p. 211). He claimed that we all live out narratives in our lives and these are not just stories made up after the fact but something we perform in undertaking various actions. His view was that life could only be made sense of in terms of it being a collection of interlocking narratives that were unfolded within a wider context of cultural history (MacIntyre, 1984). Erik Erikson (1902-1994) and John Stuart Mill (1806-1873), also believed that stories enable an understanding of the continuity of life and an conception of self (Erikson, 1959; Mill, 1869). Mill wrote:

*The inexplicable tie ...which connects the present consciousness with the past one of which it reminds me, is as near as I think we can get to a positive conception of self.* (1869, p. 43).

Supporting these views in part, Charles Taylor (1931-) accentuated the embedded nature of life stories. He believed that to have or be a 'self', is to experience one's life as an unfolding story in terms of what one can grasp, what one has become and where one is going (Taylor, 1989). To accomplish this, people need to have an understanding of what is of crucial importance to their lives and therefore they must know where they stand and what is truly worth pursuing in their life. He stated:

*My identity is defined by the commitments and identifications which provide the frame of horizon within which I try to determine from case to case what is good, or valuable, or what ought to be done, or what I endorse or oppose. In other words, it is the horizon within which I am capable of taking a stand.* (Taylor, 1989, p. 27).

This idea of sense of self being defined by a set of strong defining, moral concerns and commitments was developed further by Harry Frankfurt (1929-). He believed that to be a person in the full sense of the word required a complete identification with certain foundational concerns and commitments that were unconditional - they were experienced as the definitive of 'who you are' (Frankfurt, 1988). This view was also supported by John Kekes, who believed they "*define our limits: what we feel we must not do no matter what ...They are fundamental conditions of being ourselves*" (Kekes, 2002, p. 21).

The study participants all verbalised a strong commitment to humanity and nursing in general. The commitment of 'who they were', along with their 'actions', based on critical reflection and knowledge carried in their backpacks, enabled them to 'be themselves'.

## **Self Reflection**

Henry Ey (1900-1977), stated that 'conscious being' was having experience of the world and having authority over it. He believed that the self obtained its substance from experience but transcends it - it "*flies over*" experience and breaks loose from it so as to become constituted as a "*rational*" being (Ey, 1978, p. 226). For Ey, the self is consciousness reflected upon itself and formed into a system of values, which is particular to an individual person. This reflection and formation conferred upon the self the existence of a person. The self is a being who advances itself in and through the

knowledge that it has of itself, in its self-consciousness. This self-knowledge is not speculative but rooted in the praxis of existence. It exists in and through this very important movement. A conscious being, is a being which is organised so as to have an experience at each moment of its history and to be the person that emerges through this history. An individual's personality, therefore, is a history constructed as a biography which links all the self's modes of being into a series of events. Ey, believed the being of the self was its becoming – because its ontology drove it back to its development. Therefore, through its individual character the self culminates in its historicity. This historicity of the self is not merely a manner of it encompassing itself in whatever is secret or private in its existence but also the events which enter into and follow each other in this existence - the sequence of being which constitutes the dramatic biography of the self (Ey, 1978).

Paulo Freire (1921-1997) also believed that as humans emerged through time, discovered temporality and freed themselves from 'today' – their relationships with the world became impregnated with consequence. He stated to be human was to engage in relationship with others and with the world. He alleged humans do this consciously and in a critical way by the use of reflection. This reflection or critical perception, allowed the human to:

*Discover their own temporality. Transcending a single dimension, they reach back to yesterday, recognise today, and come upon tomorrow...men exist in time. They are inside. They are outside. They inherit. They incorporate. They modify. Men are not imprisoned within a permanent 'today'; they emerge and become temporalized.* (Freire, 1987, p. 4-5).

Like these philosophies, in being and becoming authentic, the participants looked critically at themselves through the mechanism of 'personal' self-reflection. This was part of their authentic nature and the way they practiced both their nursing and their non-nursing lives. It was about knowing themselves and being themselves - joining the professional and the personal and being aware of their impact on other people. By doing this they were authentic practitioners and were able to go where others feared to tread. They acknowledged that being was a constantly revolving construct and that it was crucial to have balance in their lives. To achieve this balance, they often needed to move on to maintain equilibrium between their nursing being and their own being.

John Locke (1632-1704) stated that memory (personal recollections), were the keys that connected the collection of experiences or mental states into a continuous self. He

believed this was achieved by reflection – the thinking, reasoning and doubting of sense ideas in the mind (Locke, 1990). The study participants not only reflected on their actions and carried examples in their backpacks but actually went on to use these to be the best they could be. They consciously and unconsciously reflected, analysed and learnt from their behaviours - continuously integrating each experience into their journey of being and becoming an authentic exemplary nurse. This action then sustained their being and enabled them to make sense and meaning of their thoughts and actions.

## **Temporality - Being and Time**

Immanuel Kant (1724-1804) alleged that ideas could only be perceived as phenomena in time and space. These ‘ideas’ in our mind preceded every other experience and therefore what we saw may depend on where we were in time and space (Kant, 2001). He believed that time and space were modes of the human circumstance and that they were primarily modes of perception rather than attributes of the physical world. Similarly, the study participants’ lives were in the past, present and future all-at-once.

In my reading, the most significant philosopher regarding the relationships between Being, Time and Authenticity was Martin Heidegger (1889-1976). He related a person’s Being to ‘existence’, describing “*man’s Being*” as being-there’ or ‘Dasein’ (1962, p. 60). He stated, “*the ‘essence’ of Dasein lies in its existence*” (Heidegger, 1966, p. 67). In explaining this notion he believed there was no pre-given human nature that determined who we are. For Heidegger, ‘to exist’ - was to take a stand on what was essential about one’s own Being and to be defined by that stand - Dasein was (in its social activity) what it interprets itself to be (Heidegger, 1966). He alleged that each of us is what we pursue and what we care for. We could understand ourselves and our existence by the activities we pursued and the things we took care of. We were what we made of ourselves in the course of living out our active lives. He understood that what defines a person’s Being was not what they were doing in the present, or all the things they had done in the past but instead the way they went forward into the future. This ongoing happening never existed in isolation from the greater context and culture of the world they were in and a person’s ‘everyday’ activities were enmeshed in these concrete situations. In this way, there was no definitive distinction between the ‘self’ component and the ‘world’ component but instead there was an interwoven whole. Heidegger called this fundamental self-world unity – ‘Being-in-the-world’ (Heidegger, 1962).

Heidegger (1962) also alleged that human existence was a “*happening*” – a life story unfolding from “*birth to death*”, (p. 427), stating that the possibilities of self-interpretation and self-evaluation were taken from the social context into which people were “*thrown*” (1962, p. 64). He stated that people become more by being thrown outwards, - *thrown into my own individuality*” as they attempted to understand the world (1962, p. 64). Heidegger suggested that the ordinary preoccupations in the busyness of the world were actually forms of evasion or fleeing. People threw themselves into the turbulence of day-to-day chores in order to avoid facing up to the things they found threatening. He believed people were fleeing from their “*thrownness towards death*” (Heidegger, 1962, p. 310). And because they knew they were finite beings, they needed to make something of their lives. Here Heidegger stated that an experience, such as the confrontation of one’s own death, could transform a persons understanding of what life was all about. Heidegger saw this confrontation with death as an opportunity to an existence he called ‘authentic’.

The German word ‘*eigentlich*’, (translated as ‘authentic’ in Heidegger’s (1962) book ‘*Being and Time*’), comes from a stem meaning ‘*eigen*’ or ‘*own*’. He believed that authenticity did not detach a person from their social existence; instead, an authentic individual was deeply implicated in and obligated to the historical context in which they lived. Becoming authentic transformed the way a person lived in the world. Heidegger believed that being a self was an accomplishment rather than a given. Selfhood was something a person had to do rather than something that could be found - “*One is what one does*” (Heidegger, 1962, p. 239). To become an authentic individual is to be clear sighted, committed and determined – not by loosing “*itself in its object of concern*” - but instead being resolute with what was “*factically possible at the time*” (Heidegger, 1962, p. 442 & 345). This authentic presence is connected to the future and the past and provides a coherent continuity and “*constancy of the self*” that gives a person “*time for what the situation demands*” (Heidegger, 1962, p. 463).

Authentic self-focusing requires such traits as resoluteness; steadiness, courage, and clear-sightedness about one’s own life as finite. It calls for integrity and a lucid openness about what is relevant to one’s own actions. The authentic stance, according to Heidegger is facing up to the fact that we are building our own lives in all we do and we are answerable for all the choices we make – an authentic person “*chooses to choose*” (1962, p. 355). However, an authentic person also “*resolves to keep repeating itself*” or to keep reviewing its decisions and commitments by substantive moral reflection, in the

knowledge that it may need to change these over time (Heidegger, 1962, p. 355). This repetition imparts consistency and ensures in the end we are what we do (Heidegger, 1962).

Heidegger's philosophy has many congruencies and illuminations for this study's findings. The study participants were defined by their 'Being' and were always willing to take a stand on their 'Being'. They also realised that they were in the world with others and accepted that they were 'B/being-in-the-world'. Their lives were interrelated with 'being' at all points along the way. Here 'being' was a moment in time - an example of the practice of being the nurse. However, 'becoming' was not a whole collection of 'beings' but a linking of each experience into the existence of the person – into the journey that was 'Being and Becoming an Exemplary Nurse'. They were Authentic and used their past experiences of self-doubt, impostorship and reflection on mistakes to own up to what they were and what they were becoming. They used critical reflection to learn and make change and 'chose to choose'. In doing this they B/became what they wanted to B/become.

Charles Guignon (1944-) suggested the notion of 'human-lived-time' (C. Guignon, personal communication, June 20, 2005). Here the future is seen as an open realm of aims and ideals that guide people and gives their actions a reason (Guignon, 2004). It uses the past as a set of resources to be carried forward in order to achieve what they hope to accomplish and views the present as a point of intersection between past and future. The context of actions are understood through what is made accessible from the past. Human lived time is linear in that it had a forward moving projection but it also had *"a circular structure insofar as there was a constant back-and-forth between the meaningful possibilities of action opened by the past and the range of goals that open up in the future"* (Guignon 2004, p. 129).

This notion of human-lived-time was very congruent with the participants being and becoming exemplary nurses. They used their 'backpacks' to balance their memories of the past, integrated them into the present and projected themselves towards their becoming. For the participants, 'Being and Becoming an Exemplary Nurse' was a work in progress, a forward moving, revolving interweaving of past, present and future experiences.

## **SUMMARY**

In this literature review the ideas of several philosophers and their views on Being, Becoming and Authenticity were discussed in relation to specific notions related to the study findings.

For the study participants, their social consciousness and their personal consciousness was in balance – each relating and informing the other in synchronisation. By critically self-reflecting they used their experiences carried in their ‘backpack’ to ‘act’ purposively and to become what they wished to be. In the three dimensional time space of human-lived-time they amalgamated all their B/being, B/becoming and experiences to B/be-in-the-world.

In the following chapter, a specific literature review is described relating to the constructs of Being, Becoming, Authenticity and ‘Exemplary Nursing’. This literature review encompasses both a selection of nurse theorists’ views and literature purposely chosen in relation to the findings of this study. This knowledge is then discussed and synthesised with the findings of the study.

## **CHAPTER 6**

### **EXEMPLARY NURSING – A LITERATURE REVIEW**



In this chapter, I present a specific and extensive review of the literature related to Exemplary Nursing. I begin with a description of several nurse theorists ideas. These nurse theorists were chosen because of their philosophies having relevance with the key notions – B/being, B/becoming, Authenticity and Exemplariness. After describing their philosophical frameworks, I discuss how these views relate to my study findings.

My study results are then discussed in relationship to an article I wrote and published on the phenomenon of exemplary nurses in 2001. Following this I present an updated literature review that encompasses the succeeding years.

Subsequently, the findings from Chapter 4 – The Koru Unfurls, are discussed in relation to a comprehensive literature review of these constructs. Specific related concepts such as presence, expert nurses, ordinariness, good nurses, caring nurses, and story telling are also expounded in this section.

### **NURSING THEORIES**

In this section, I describe and discuss the relationship of several nurse theorists' works with the findings of my study. As will become apparent, these nurse theorists were also influenced by previous philosophers and their views. These general philosophical ideas were then integrated and aligned with the various nurse theorists' beliefs about nursing.



## Martha Rogers – The Theoretical Basis of Nursing

Martha Roger's nursing theory was based on many earlier researchers' works, including Ludwig von Bertalanffy, Teilhard de Chardin, Micheal Polanyi and Kurt Lewin (Rogers, 1970). While her theory changed over her life time, she believed, in congruence with my study findings, that "*The life process is a becoming*" (Rogers, 1970, p. 55). Her philosophy on becoming:

*Presupposes a belief in the irreversibility of time...the process of life evolves through time and is concomitantly bound in space-time. At any given point in time, man is the expression of the totality of events present at that point in time.* (1970, p.57).

Her earlier theoretical position acknowledged the unidirectionality of life. In Roger's view, life preceded rhythmically along a spiral and experiences, some considered repetitions, were in reality only similarities, as she believed life events did not repeat themselves. "*The future, like the past, is part of the evolutionary story of the universe. The irreversibility and unidirectional nature of the life process is bound inextricably with the unfolding of the physical world*" (Rogers, 1970, p. 59). Within this stance, pattern and organisation were seen as unifying concepts where continuous change was expressed by the emergence of new patterns in man and his environment. Her early belief of life as spiral is recognised in my study findings related to 'being is a constantly revolving thing'. However the notion of unidirectionality was not established in my study - where past, present and future for my study participants' was all at once situated in human-lived-time.

Rogers stated that humans possess the capacity to be consciously aware of themselves and the world around them – "*the rudiments of consciousness are transcended and find expression in man's rationality, his capacity for creation, his humanness. People are thinking, feeling beings*" (1970, p. 41). She believed that, "*Man's awareness is rooted in cognizance of his own mortality*" (Rogers, 1970, p. 68). She referenced Frankl and his proposition that the human's basic need is to find meaning in life and death. This notion has congruence with my study participants' use of 'backpack patients' to 'make sense and meaning from experiences'. She also alleged that human beings were amalgamations of the physical, biological, psychological, social, cultural and spiritual aspects that were part of an indivisible whole – "*Man is a unified whole possessing his own integrity and manifesting characteristics that are more than and different from the*

*sum of his parts*” (Rogers, 1970, p. 47). This idea has similarities with my study findings where the sub-constructs are part of the whole - and together the whole is greater than the various components.

Her theory of nursing developed into – ‘A Science of Unitary Man’, where she revealed three major principles - Helicy, Complementarity and Resonancy. These three principles and their associated concepts essentially said that people were co-created with their environment in a continuous, mutual, simultaneous, negentropic emergence (Rogers, 1986). Her conceptualisation eliminated the dichotomy between health and disease. She believed that health and illness could be viewed as expressions of the life process and that meanings of these phenomena were derived from an understanding of life in its totality. In 1983, she changed the wording of ‘unitary man’ to ‘unitary human beings’ in an attempt to describe the way she saw human beings as energy fields integral with environmental fields. From this 1983 paradigm, she postulated four concepts: energy field, a universe of open systems, pattern and four dimensionality (which was later changed to ‘pandimensionality’ in 1992 (Rogers 1986 & 1992). These concepts have similarities with the findings of my study in the acknowledgement that Being and Becoming an Exemplary Nurse is a spiralling journey where ‘being is a constantly revolving thing’ and the participants ‘live their reflective lives’ through the use of ‘backpack patients’ to ‘make sense and meaning from experiences’.

### **Margaret Newman - Health as Expanding Consciousness**

Margaret Newman, who explicated her theory in 1978, initially based her research on separation of concepts and control of the environment; then as she sought to understand the pattern, she moved towards a more hermeneutic dialectical approach. At this stage, she saw the “*pattern of the whole*”, with the focus of nursing on the unitary field that combined the person-family-community all at once (Newman, 1994, p. xix). This nursing focus, viewed health as a pattern of the evolving whole, with caring as the moral imperative. She believed that when a nurse concentrated on this belief, their practice and their patient’s lives would be transformed (Newman, 1994). She based her theory on her own experiences but was stimulated by the earlier works of Teilhard de Chardin, Itzhak Bentov, Bohm, Rogers, Young and Moss (Newman, 1994).

Teilhard de Chardin (1959) believed that a person’s consciousness continued to develop beyond the physical life and became part of the universal consciousness. This mirrored

Newman's Christian beliefs of life after death (Newman, 1994). Bentov (1978) viewed the evolution of consciousness as ranging from 'inanimate' objects such as rocks at the lower range, through to astral and spiritual 'beings' beyond the human level. He believed all creation was in constant and instantaneous contact and reality depended on where one fell within the spectrum of consciousness. He viewed absolute consciousness as a boundless deep sea that appeared calm but instead contained tremendous energy and creative potential below the surface (Bentov, 1978). These beliefs corresponded with Bohm's analogy of the implicate/explicate order where the creative potential embedded in absolute consciousness or implicate order had self-organising capabilities (Bohm, 1980). These processes of evolving to higher levels of consciousness were also consistent with Rogers (1970) assumptions on increasing complexity in living systems (Newman, 1994). In addition, Young's (1976) theory of human evolution through seven stages highlighted the crucial role of insight, pattern recognition and concomitant choice.

From these theorists' concepts, Newman integrated movement, time, space and time as manifestations of consciousness in nursing. For Newman, all experiences were significant and what was important was to be fully present in the moment and to understand that every experience was an expression of the process of evolving to a higher consciousness. She believed to be open was to be vulnerable and this often meant suffering. This suffering offered up the potential to transcend a particular situation and by letting go and embracing these experiences – the expansion of consciousness could unfold (Newman, 1994).

Finally, using Moss's experiences of love as the highest form of consciousness, Newman was provided with an understanding and affirmation of her own intuition regarding health and nursing. From this, she suggested that caring was not just something we do but something that transforms us and all that we do - "*It is a reflection of the whole of oneself*" (Newman, 1994, p. 141).

While my study participants did not mention the notion of an evolving consciousness, many of Newman's related concepts have similarities to the findings of 'Being and Becoming an Exemplary Nurse', as explicated in the sections; 'A Love of Nursing' and 'Making a Difference Sustains Me'. In having 'Caring Communication and Connections' with others, my study participants believed that being fully present in the moment allowed for a synergy between the patient and nurse – where true healing could

occur. Caring connections included aspects of respecting, knowing, being with and recognising it was the patient's journey and not their own. The participants also concurred with Newman, that caring was an implicit part of Being and Becoming an Exemplary Nurse and by acknowledging the 'privilege to care for others', accepted that this caring was reciprocal. In turn this sustained their 'love of nursing', which allowed them to be and become 'exemplary' nurses.

### **Paterson and Zderad – Humanistic Nursing**

Nurse theorists, Paterson and Zderad (1976) presented their work as "*an existential alternative approach for a professional nurse's knowing and becoming*" (1976, p. ix). They recognised the notions of being, becoming and authenticity in their theory and I believe it has many tenants that are similar to my own study findings. Paterson and Zderad, like my study participants, valued genuine humanism, and wrote:

*Nurses have the privilege of being with persons who are experiencing all the varied meanings of incarnate being ...in time and space. They not only have the opportunity to co-experience and cosearch with patients the meaning of life, suffering and death, but in the process they may become and help others become more – more human.* (Paterson & Zderad, 1976, p. xi).

Their theory defined nursing as "*an experience lived between human beings*" where each nursing situation reciprocally evokes and affects the other (Paterson & Zderad, 1976, p. 3). This is similar to my study construct of 'Making a Difference – Sustains Me'. They based this idea on the constructions of Martin Buber and stated that this relationship was founded on the nurse's existential awareness of self and others. Here each recognises the uniqueness of each other, while acknowledging that 'uniqueness' is a universal - so 'all-at-once', paradoxically each is like the other. They termed this 'uniqueness-otherness' and believed each becomes 'more', as they strive towards 'becoming' – a confirmation of their existence and an understanding of its meaning.

Congruent with my study findings, Paterson and Zderad also positioned 'authenticity' as a major tenant of their theory and entitled this concept 'authenticity-experiencing'. They believed that existential awareness calls for an authenticity with one's self, which they also called 'self-in-touchness'. This is more than intellectual awareness but an auditory, olfactory, oral, visual, tactile, kinesthetic and visceral response that conveys unique meaning in the nurse's consciousness. The in-touchness of these sensations and the nurses response informs them about the quality of being, the nurses thereness and

their presence with others. This allows for an “*unfolding becoming*” (Paterson & Zderad, 1976, p. 5).

Like my own study findings, they describe the interrelationship between being, becoming and authenticity and termed it ‘moreness-choice’. Here they believed nursing to be a chosen, deliberate life-long process. They alleged that being existentially and genuinely present with another was a human mode of being that was chosen and controlled by the self. They also believed that to be able to offer genuine presence to another, the nurse must believe in the value of this presence. They called this notion ‘value-nonvalue’ and referenced the works of; Plato, Rousseau, Goethe, Proust, Nietzsche, Whitehead, Jung, May, Frankl, Hesse, de Chardin, Bergson, Marcel and Buber in support. They wrote that essentially people are their own choices and they are their own history – they are what they have become and what they have not become. This knowledge was created through self-reflection, where there is an understanding of past choices in their relationship to becoming more and the potential to actualise choices for possibilities in the future. This feature was also a key concept in my study findings – ‘Being Authentic – Living reflective lives’.

These nurse theorists believe that humanistic nursing requires a “*deliberate, responsible, conscious, aware, nonjudgmental existence of the nurse in the nursing situation followed by disciplined authentic reflection*” (Paterson & Zderad, 1976, p. 8). Like my study participants, they stated that nursing is both being and doing, which is an expression of the nurse’s authentic commitment. They called for existential involvement and full presence of the nurses being – in both a personal and professional capacity. A central insight for these theorists was that nursing was a form of human dialogue. Here they believed that when nursing dialogue became genuinely inter-subjective, it had a kind of “*synchronicity that is evident in the nurse being with and doing with the patient*” (Paterson & Zderad, 1976, p. 37). Paterson and Zderad’s Humanistic Nursing Framework consisted of:

*Incarnate men (patients and nurse) meeting (being and becoming) in a goal-directed (nurturing well-being and more-being), intersubjective transaction (being with and doing with) occurring in time and space (as measured by the patients and nurse) in world of men and things. (1976, p. 23).*

This theory has numerous similarities and congruence with the findings of this study, especially the notions of exemplary nurses being and becoming in time, the synchronicity of self with other and its relationship with authenticity as both a personal and social concept that occurs through self-reflection.

## **Rosemary Parse - Human Becoming**

The nurse theorist Parse renamed her theory 'Man-Living-Health – A Theory of Nursing' to 'Human Becoming' and in it described the inter-relationship of 'being' to 'becoming' by using ideas from nurse-theorist Martha Rogers and the existential phenomenological theorists - Heidegger, Sartre and Merleau-Ponty (Parse, 1981 & 1998). The existential phenomenological tenets that Parse used were 'Intentionality' and 'Human subjectivity'. The concept of intentionality, was based on Heidegger's suggestion that people are always intentional in their actions – being open, willing to know and fully present to the world. Heidegger believed that people are fully involved with the world and in doing so creating a personal becoming. This creation was a makeup of the person's historicity and facticity. Their historicity reflects the connection of their predecessors and contemporaries in creating the who one was at a given moment, while facticity can be described as the immediate situation in which people find themselves (Heidegger, 1962).

For Parse, ideas from Heidegger and Merleau-Ponty gave rise to the concepts of 'Coexistence' and 'Situated Freedom'. Here, coexistence meant that people were not alone in any dimension of their becoming – they emerged through being with others (Merleau-Ponty, 1974). Situated freedom denoted that people reflectively and prereflectively choose the situations they find themselves in as well as their own attitude to that situation. Therefore, how that situation pans out is related to their facticity and earlier choices (Parse, 1992). By using notions from Sartre's (1956) work, she alleged people could remember past experiences as past events and could create personal remembrances by choosing the order and arrangement of reflections of these past events as they give meaning to each situation (Parse, 1992).

The second tenet Parse used was 'Human subjectivity' and was related to Heidegger's thought that people are by nature no-thing but rather both being and non-being – living what is and what is not-yet-all-at-once. He believed that people grow through their relationships and they give meaning to the projects that appear through the process of becoming by co-participating in this emergence and choosing to live certain values (Heidegger, 1962). This tenet produced Parse's (1992) concept of 'Co-constitution', which referred to the idea that situated meaning emerges through the particular constituents of that situation. Further, as Merleau-Ponty (1974) described, people interrelate with the various views of the world and others and actually co-create these

views by a personal choice. People by nature are present to the world all-at-once. They are open to all possibilities and so participate in the creation of the world (Heidegger, 1962). Parse believed the essence of these experiences originated in co-existence with others and the person's genuine presence with moment-to-moment emergence. This genuine presence called forth a risk taking that occurred through a revealing-concealing choice (Parse, 1998).

Many of Parse's ideas are similar to the findings in 'Being and Becoming an Exemplary Nurse'. Through 'Authentic Being' the participants created their own 'personal becoming' but there was also an acknowledgement of being-in-the-world with others and that they were not alone in their 'becoming'. They used their experiences - relationships with 'Critical Friends', and 'Backpack Patients' - to create their present lives and they 'Lived their Reflective Lives' in order to learn and check they were continuing to do so in an authentic manner. Reflection on all their experiences, (past and present) allowed them to make sense and meaning from these interactions. They were always present, open and willing to know more. They made sure they were able to 'Make a Difference' by 'being the best they could be' and were aware that to practice in this exemplary way – 'sustained' them.

### **Patricia Benner – From Novice to Expert**

Patricia Benner in her 1984 treatise, 'From Novice to Expert: Excellence and Power in Clinical Nursing Practice', described expert nursing by using the model of skill acquisition developed by Professors Hubert L. Dreyfus and Stuart E. Dreyfus. The Dreyfus Model of Skill Acquisition was based on their study of chess players and airline pilots (Dreyfus & Dreyfus, 1980). This model hypothesised that in the acquisition and development of a skill, a student passes through five levels of proficiency: Novice, Advanced Beginner, Competent, Proficient and Expert.

In applying this model to research nurses and nursing, Benner described six domains of nursing practice: the helping role, the teaching-coaching function, the diagnostic and patient-monitoring function, effective management of rapidly changing situations, administering and monitoring therapeutic regimes, monitoring and ensuring the quality of health care practices, and organizational and work-role competencies. Throughout these competencies she described many 'expert' attributes that could be portrayed as 'exemplary' and similar to this study's participants knowledge and skills as illustrated in

the subsections ‘Making a Difference Sustains Me’ and ‘Walking the Talk’ depicted in Chapter 4 of this thesis. Further-more, Benner’s experts were described as having a vast background of experiences, where they did not need to rely on analytic principles to guide their actions but instead had an intuitive grasp on each situation by using pattern recognition and the use of paradigm cases. They developed their expertise through the process of comparing similar and dissimilar clinical situations. My study participants were similar to Benner’s expert nurses, who practiced at the expert stage for all domains using “*past concrete situations as paradigms*” which has similarity to my participants’ use of ‘backpack patient stories’ (Benner, 1984, p. 3).

Benner used the definitions of Gadamer, Heidegger and Polanyi in explicating her meanings of experience and personal knowledge. She stated that a particular past experience or situation may be powerful enough to stand out as a paradigm case because these “*past situations stand out because they changed the nurse’s perception...guides the expert’s perceptions and actions and allows for a rapid perceptual grasp of the situation*” (Benner, 1984, p. 8).

*It is the particular interaction with the individuals learners prior knowledge that creates the “experience” – that is, the particular refinement or turning around of preconceptions and prior understandings.* (Benner, 1984, p. 9).

She believed that experienced nurses easily remember clinical situations that altered their approach to patient care and through systematic record and analysis of these paradigms, the knowledge embedded there could be understood. This is congruent with my study with exemplary nurses and their recollection of backpack patient’s stories and their use of critical reflection to compare and contrast experiences.

Benner believed in a “*central role of caring*” (1984, p. 170). She stated that “*excellence requires commitment and involvement, but it also requires power. Since caring is central to nursing, then power without excellence is an anathema*” (1984, p. 207). She described this power in caring as the empowerment of patients without domination, coercion or control. However, she acknowledged that this relationship was contextual and sometimes to empower, the nurse needed to coerce the patients to engage in painful tasks that they would not readily undertake on their own. The participants in my study also demonstrated this type of behaviour when they described themselves as ‘Being on top of things - and in control’. Benner (1984) additionally describes exemplars where courage or risk-taking occurred. She calls this ‘Transformative Power’ and it is



congruent with my findings of ‘Moral courage – acting where others fear to tread’. She is unclear what exactly makes a risky intervention work but she is adamant that almost no intervention will work unless the nurse-patient relationship is based on mutual trust and genuine caring. These attributes mirror my findings of ‘Caring Communications and Connections with others’ and ‘Respecting another’.

Benner also discussed the issues of meaningful work - in the sense of psychological fulfillment, which she described as “*not just pleasure seeking*” (1984, p. 195). This is similar to my findings of ‘A Love of Nursing’, where the participants described that they could ‘enjoy being with somebody but they didn’t need to seek it out’ and the findings of ‘Making a Difference – Sustains Me’. Using Yankelovich’s ‘Meaning of Work’, Benner (1984) reported three benefits nurses wanted to gain from their work: To be promoted within a structure that acknowledged their expertise, provided challenges and adequate remuneration; to be good at what they were doing; and to find self-fulfillment through meaningful work. These findings are comparable to my findings in ‘A Love of Nursing’, ‘it’s a privilege to care for others’, ‘being the best you can be’, ‘Walking the Talk’ and ‘making sense and meaning from experiences’.

Benner also described nurses who were ‘burnt out’, referencing one nurse saying:

*To keep my sanity and marriage, I left nursing... I now earn twice the salary, but I still think of going back. The emotional rewards in nursing are worth more than my present higher salary, but only if I am allowed time to meet my patients’ needs. (1984, p. 196).*

This excerpt has many comparisons with this stud’s findings of ‘being is a constantly revolving thing’ and its relationship with ‘creating a balance and moving on’. Benner stated that although nurses need to take care of themselves, controlling or distancing strategies were not the best protections against burnout. Labeling it Participative/Affirmative Power, she described ‘helping’ nurses as committed and involved. She reported nurses in her study describing relationships with their patients as ‘knowing each other really well’, that they ‘became friends’ and ‘cared about them’. Benner, in her own self-reflections also revealed that she remembered the warnings of not ‘becoming too involved’ during her own nursing career. Later she developed a hypothesis from questioning other nurses, believing that:

*By being involved, these nurses were more fully able to draw on their own coping resources and the resources offered by the patients, family, and the situation. I suspect that distancing techniques dimly protect nurses from the pain in the*

*situation, but they also prevent them from taking advantage of the resources and possibilities that come through engagement and participation in the patients' and families' meanings and ways of coping.* (Benner, 1984, p. 164).

She believed that a certain level of commitment and involvement was necessary for expert performance. These ideas are congruent with this study's findings of 'Authentic Being', 'going the extra mile' and acknowledging the 'privilege to care for others'.

In her chapter titled 'The Quest for a New Identity and New Entitlement in Nursing', Benner (1984) recommends that nurses are provided with meaningful incentives and reward systems; a clinical promotion system; increased collaborative relationships and increased recognition. Similarly to my study findings on becoming exemplary by 'Being Pushed Beyond Your Boundaries', she reports successful retention strategies are supported by "*a challenging first job – one that stretches his or her abilities* (Benner 1984, p. 201). She referenced research that supported the idea that that the more challenging the first year "*the more successful that person will be five or seven years later*" (1984, p. 201).

In contrast to my study, Benner only described exemplars where there was a positive outcome for the patients involved - these were '*outstanding clinical situations where the nurse learned something about her practice*' (1984, p. xvii-iii). She acknowledged this bias, by stating "*deficits were not the point of inquiry*" (1984, p. xxii) and admitted that "*in the real world, nurses and physicians alike have good and bad days*" (Benner, 1984, p. xxi). She went on to include examples where physicians behaved badly when collaborating with nurses but incorporated no such negative 'nursing' behaviours. In this way, Benner's method is divergent to my study, where this study's participants gave examples of negative care episodes – where there were often unsatisfactory outcomes for all involved (as described in Chapter 4). I believe that this study's participants learnt more about their practice by re-experiencing both positive and negative stories than Benner's experts. I consider that reflecting on these experiences was a significant factor for this study's participants, which enabled them to Be and Become Exemplary Nurses.

## Jean Watson – Nursing-Human Science and Human Care

Jean Watson recognised the integration of being, becoming and authenticity in her nursing theory – ‘Nursing – Human Science and Human Care’ (Watson, 1985). She believed to be human was an element of having an “*evolving consciousness*” (Watson, 1999, p. 128). Similarly, in her later work ‘Postmodern Nursing and Beyond’, she described a vision of ‘Transpersonal Nursing’, defining it as:

*An intersubjective, human-to-human relationship, which encompasses two individuals in a given moment, but simultaneously transcends the two, connecting to other dimensions of being and deeper/higher consciousness that accesses the universal field and planes of inner wisdom: the human spirit realm. (Watson, 1999, p. 115).*

She stated that when two individuals come together in a caring moment, they are “*both in a process of being and becoming*” (Watson, 1999, p. 115). Both bring a different life history and life world but “*both are influenced by the nature of the moment, for better or worse, depending upon the consciousness of the one-being-cared-for*” (Watson, 1999, p. 116). As the two come together the two separate individuals create a new field, both become part of the new whole, and each becomes part of the life history of the other. Watson described an actual transpersonal caring moment as involving both action and choice by both individuals, with both being given opportunities to decide how to ‘be’ in the relationship and what to do with the moment. The notion of being present in the moment was described as being present in the actuality, being transcendent and beyond the moment and being in both at the same time. Using this framework “*both the one-caring and the one-being-cared-for are co-participants in ‘becoming’ in the present and the future; both are part of some larger, deeper, complex pattern of life*” (Watson, 1999, p. 118). These ideas are fully congruent with the relationships with patients as described by the participants in my study concerning the findings of the ‘living reflective lives’, ‘privilege to care for others’, ‘Making a Difference – Sustains Me’ and ‘Backpack Patient Stories’, situated within the framework of a spiralling journey of being and becoming - integrating past, present and future – in human-lived-time.

Watson demonstrated notions of ‘being authentic’ when she suggested a methodology, through both aesthetics and art - of ‘being’ as well as ‘knowing’ and ‘doing’. She called forth practitioners that had an “*authentic presensing of being in the caring moment, carrying an intentional caring-healing consciousness*” (Watson, 1999, p. 10). She declared that to ‘transform’ one must start with the ‘self’ and referenced Maxine Greene

(1991) to support the notion of authentically engaging with the invisible world of texts and margins.

Similar to the findings in this study, she writes of a 'calling', believing that practitioners may have a *"so-called 'calling' into caring healing work"* (Watson, 1999, p. 7). She believed that, similar to the past, when nursing was considered a 'calling', there needs to be another call for compassion, commitment and involvement - a passion for nurses to recommit themselves to a calling to engage in reform based on basic human caring-healing and health values (Watson, 1999, p. 263). Watson stated that she wrote her 1999 book to find meaning and to hopefully provide herself and *'others with the courage to be true to one's 'calling' and all that conveys'* (Watson, 1999, p. 16). This knowing self was related to my study findings of 'Being Authentic' and the use of 'moral courage'. In describing this latter notion she quoted a professional nursing student stating, *"I have to remind myself every day that it is through care and courage that I get through the day...it is so hard and I feel all alone"* (Watson, 1999, p. 68). This notion is identical to that found in my study and is related to the notion suggested by Guignon (2004) that being authentic is often a lonely existence.

By referencing the work of Fox (1991), she used metaphors to describe the life-generating caring-healing perspective. She recounted Eros as the way of the authentic – a new cosmology containing the sacred feminine archetype – one of transformation, whereby all things were made new or whole (Fox 1991). Similar to this study findings of 'authentic being' and 'living reflective lives', she linked the personal with the social when she described caring requiring both theory and praxis to move beyond mere 'thinking' to 'actions' which could be accomplished through *"critical reflection"* (Watson, 1999, p. 11).

My study findings correlate with Watson's major assumptions of: Caring based on an ontology and ethic of relationship, connectedness and consciousness; Caring being demonstrated and practiced interpersonally and transpersonally; Caring consisting of 'caritas' consciousness, values and motives; Caring relationships that affect the one-caring and one-being-cared-for; Caring relationships conserving human dignity, wholeness and integrity and offers authentic presencing and choice; Caring that promotes self-growth, self-knowledge, self-control and self healing possibilities; Caring that accepts and provides a space for people to find the own wholeness of being and becoming; Authentic presencing providing the potential to change the 'field of caring' and potentiating wellness and wholeness; and Transpersonal caring-healing integrating

all the ways of knowing (Watson, 1999). These ideas are fully supported and described in my study findings in Chapter 4 and in Appendix 8.0.

Watson wrote that Nursing and Nurses need to move to an Era III/Paradigm III, Postmodern/transpersonal Era. Here she believed “*nurses within the postmodern/transpersonal frame will need to be ontological architects, creating healing space and providing ontologically based healing modalities of care*” (Watson, 1985, p. 257). This ontological architect will create, shape and ‘hold’ space for healing through a caring-healing consciousness. In acknowledging the transition to this transpersonal era, she stated that practitioners could fluctuate in the postmodern space – change the lens they were using to engage in their work and continue to make a difference as they moved towards this new level. While I can’t assert that the participants in this study are Watson’s ontological architects, I do believe that they have many of the qualities she hopes for and in their ‘Becoming’ they are authentically moving towards this type of ‘Being’.

### **Conclusions from the Nurse Theorists**

The participants in this study are reflected in many of the philosophies put forward by these theorists. In particular the concept of meaning making and life as a becoming as advocated by Rogers; Newman’s ideas of presence promoting synergy and transforming care; Paterson & Zderad’s concept of authentic being as a concept through time in relation to both the personal and the social; Parse’s phenomenological tenets of intentionality and human subjectivity; Benner’s expert nurse qualities and Watson’s transpersonal caring and becoming an ontological architect. These notions are congruent with this study’s findings: ‘Authentic Being’ ‘A Love of Nursing’, ‘Critical Friends’, ‘Making a Difference –Sustains Me’, ‘Walking the Talk’ and ‘Backpack Patients’.

### **EXEMPLARY NURSES IN THE LITERATURE**

In 1998, I coined the term ‘exemplary’ to describe nurses considered the finest in the profession (Noble-Adams, 2001). At this time a literature review did not highlight the term ‘exemplary’ in any other nursing related articles.

The New Sorter Oxford English Dictionary records the word ‘exemplary’ as coming from the Latin word “*exemplaris*” (Brown, 1993, p. 878). They define the word as:

*Adj Of a person, quality, etc.: fit for imitation. Of a thing: serving as a model or pattern; archetypal. 3. Of a kind liable to become an example; remarkable, signal extraordinary. Serving as a specimen or type; typical. Of or pertaining to an example; providing examples; illustrative.* (Brown, 1993, p. 878).

These dictionary definitions seemed accurate descriptions of exemplary nurses - so far as being an example, fit for imitation, serving as models, remarkable and extraordinary. However, I also believed that 'exemplary nurses' would somehow be more than the sum of their parts. I wondered if they had some special ingredients that made them continue in the face of adversity and continue giving exceptional care. I also wanted to know what these X Factors were – what did the examples pertain to and exactly what did they illustrate?

My initial literature review was carried out using the National Institute of Health, National Library of Medicine website [www.nih.nlm.gov](http://www.nih.nlm.gov) during 1998-2001. I subsequently published an article entitled: Exemplary Nurses – an examination of the phenomenon, in 2001. In this paper, I described several “*possible composite concepts*” that may conceptualise the phenomenon (Noble-Adams, 2001, p. 24). In reviewing this original paper to the findings of the current study, the concepts of altruism, natural caring, a calling, the nurse-patient relationship, commitment and authenticity are similarly described by the participants in this study. Also the characteristics of the nurses described in the articles on ‘Work Excitement’ (Simms et al. 1990; Lickman, Simms, & Green, 1993; Savage, Simms, William, & Erbin-Roesmann, 1993), ‘Positive Energy’ (Hover-Kramer, Mabbett, & Shames, 1996; Mabbett, 1987), and ‘Star Nurses’ (Kendall, 1999) have been portrayed by the participants in this study and remain congruent with this study’s findings with exemplary nurses. These concepts were typically mentioned under the headings of a ‘Love of Nursing’ and ‘Making a Difference’. The pivotal construction ‘Authentic Being’ was mentioned in this initial review as a “*fundamental attribute of exemplary nurses*” but was not fully conceptualised as – ‘a combination of being able to be yourself, be your own person and be the nurse’ as described in this study (Noble-Adams, 2001, p. 28). The associated concept of ‘Living your reflective life’ was also not portrayed. Additionally, the notions of ‘Critical Friends’, “Walking the Talk” and ‘Backpack Patients’ were not conceived as potential concepts in this original paper.

On reflection, this piece of writing worked well as a prerequisite literature review for a research project. It allowed me to see the nursing literature was scarce in this area and

that an emergently designed study interviewing ‘exemplary nurses’ and looking at ‘the big picture’ would give new insights into this area and advance nursing knowledge.

## **Review of the Literature - Related to Exemplary Nurses**

Recent literature searches found several uses of the term ‘exemplary’ in nursing articles. This later literature review was carried out using the Cumulative Index of Nursing and Allied Health Literature (CINAHL) and Te Puna, the National Library of New Zealand website, during 2001-2005. Most commonly, articles used the term to denote ‘exemplary’ institutions, strategies, standards or initiatives. Other papers used the term in their titles to acknowledge specific ‘exemplary’ nurses for awards, but none defined the specific characteristics or attributes of the nurses. One paper highlighted the term ‘exemplary’ in their title and stated that they asked nursing respondents in their first and fourth years of nursing training for their “*definition of the word ‘exemplary’*” (Llewellyn-Thomas, Sims-Jones, & Sutherland, 1989, p. 367). However despite listing seven main attributes that were congruent with this study’s findings such as: collaborative ability, empathy with patients, knowledgeable/skillful caregiving, leadership ability, ability to act as an advocate for the patients and for the profession and personal integrity - no actual definition of ‘exemplary’ was given.

Four further qualitative studies denoted ‘exemplary’ nurses in the fields of; School Nursing (Pulcini, Couillard, Harrigan, & Mole, 2002), Midwifery (Kennedy, 2000) Holistic Nursing Practice (Graber, 2004) and Oncology Nursing (Perry 1996a; 1996b; 1998). In all these studies, the nurses researched were suggested by peer nomination as comparable with my own study. Pulcini et al. (2002) used Benner’s novice to expert research to support their study. They used the Delphi technique and in the findings listed 43 personal and 57 professional characteristics that made “*the school nurse expert stand out*” (Pulcini et al. 2002, p. 38). While they placed these into a table of five overarching characteristics which would be useful to school nurses, this study did not illuminate ‘exemplary nursing’ in a comprehensive sense and they did not define the term ‘exemplary’ in a holistic sense. Similarly, the article on exemplary midwifery practice also referenced Benner’s experts and used the Delphi technique as method to find the characteristics of the exemplary midwife (Kennedy, 2000). Although it was a very high-quality research paper, it did not demonstrate the entire depiction of being exemplary either. Graber’s (2004) article interviewed 24 hospital clinicians, of whom 10 were nurses. They researched clinicians who specifically practiced caring and

compassion every day. They concluded that they achieved this through having close relationships with their patients where:

*The clinicians did not attempt to distance themselves, but developed warm, empathetic relationships with patients ...without sacrificing objectivity in providing compassionate care ...integrating mind and heart. (Graber, 2004, p. 87).*

This paper highlighted some concepts aligned with authenticity as described in my own study but was not specific to nurses, nor comprehensive in its findings. In contrast, Perry's (1996a, 1996b, 1998) qualitative study using observation, open-ended interviews and written narratives of eight exemplary oncology nurses, which was analysed multi-dimensionally by hermeneutic analysis and grounded theory analysis, was very methodologically similar to my own study. She wrote in her introduction that:

*Within most disciplines there are some professionals who are recognised by their colleagues as being exceptionally competent practitioners. These individuals are sometimes called "expert", "unusually competent" or "extraordinary". Their commonality is that they do their work in a remarkable way and their actions and interpersonal interactions are regarded by others as models. (Perry, 1996a, p. 6).*

Three major themes emerged from Perry's (1996) data analysis: dialogue in silence, mutual touch and sharing the lighter side of life. In particular, the findings related to valuing individuals with unique needs and perspectives and the importance of respect, compassion and dignity were comparable to 'Making a Difference – sustains me' and 'Authentic Being'. In emphasising these, Perry (1998) poetically wrote:

*Making a difference*  
*My small gesture, lovingly given, causes you to feel valued,  
 When you feel important, so do I  
 Satisfied that I do make a difference, I am motivated to continue to care for you,  
 and for others  
 A Journey Shared  
 Share your journey, you cannot sparkle alone.  
 Those that are drawn near to you reflect and magnify your spirit*

*Nurse Transformed*  
*Shaped and molded daily by a constant stream of challenges, I continue to  
 evolve.  
 Each time I confront death and disease all life becomes more treasured.  
 Now, as approach life with a sense of urgency, eagerly soaking up all of the  
 experiences it offers.  
 I want to nudge the world, to make a difference in the lives of those who need  
 me.  
 But all the while I recognize that I too must be sustained and I receive as openly  
 as I give.  
 With gratitude I accept and welcome these changes, and anticipate my continued  
 transformations. (Perry 1998, p. 99, 100)*



In congruence with this study's findings related to 'Authentic Being', Perry reports her participants saying:

*To be a good nurse you have to get really close to your patients, share part of yourself" and "I don't believe nurses who let themselves get involved in these satisfying nurse-patient relationships ever burn out. I get back much, even more than I give.* (Perry, 1998, p. 100).

The findings of this study, although specific to oncology nurses, were relevant to all nurses and were reflective of some of the findings in this study, such as 'Love of Nursing', 'Making a Difference – Sustains Me', and 'Authentic Being'. Despite these congruencies, this article did not mention this study findings of 'Critical Friends', 'Walking the Talk', nor the use of 'Backpack Patients', which the study participants and I found to be a necessary construct in Being and Becoming an Exemplary Nurse.

## **Authentic Being**

Several Nurse Theorists have described congruent phenomena to 'being authentic' in their philosophies (Benner, 1984; Benner & Wrubel, 1989; Parse, 1998; Paterson & Zderad, 1976; Watson, 1979, 1985, 1999) and many nurse researchers have described being authentic as a measure of nursing excellence (Aranda & Street, 1999; Bolton, 2000; Cumbie, 2001; Daniel 1998; Kleiman, 2004; Montgomery, 1994; Nelson, 1982; Swanson, 2000; Taylor, 1994, 1995).

In the previous sub-chapter, being authentic was described philosophically as the relationship between personal existence and social being. Montgomery has long maintained that *"caring is a unique expression of authenticity of each person in a relationship"* (Montgomery, 1994, p. 40). She coined the term 'authentic caring' and stated that expert nurses become deeply involved and committed to their nurse/patient relationships, which satisfies them without becoming co-dependence or over-involvement. She termed this being - 'spiritual transcendence' and believed that to maintain authentic caring, nurses need to transcend their own ego – find greater meaning and significance in their involvement with patients – and move beyond their superficial self to the core of their being or spirit. (Montgomery, 1994). These beliefs are similar to the ideas found in this study's findings. Nelson (1982) also believed that authenticity was the *"fabric of ethical nursing practice"* (p. 1). While Nelson's article was essentially a literature review she believed that authentic nurses were committed, willing to take the risk of being an individual and decision makers who were willing to

answer for their decisions. Congruent with this study's findings, she conveyed being authentic as relating to both self and others and stated that self-reflection was an important component. She discussed the notion of 'being' – striving towards full personhood, self-realisation and self-actualisation and like the participants in my own study, believed that this process was never finished as one could never reach a truly perfect 'state of being' (Nelson, 1982).

Bolton (2000) stated, "*that it is authentic caring behaviours that distinguishes nursing from other professions*" (p. 583). The nurses in her study believed that nursing was a vocation involving altruism and that the emotional involvement with their patients gave them the greatest potential for job satisfaction. They offered something extra as a gift for their patients, and they did so with no expectation of return except the satisfaction they derived from being able to "*make a difference*" (Bolton, 2000, p. 584). This notion is similar to this study's findings of 'making a difference - sustains me' and 'going the extra mile'. B. Taylor (1994) also described a similar phenomenon to authenticity – that of 'ordinariness'- being human. Using phenomenology as her PhD methodology, she described eight aspects of the phenomenon: facilitation-allowingness, fair play-straightforwardness, familiarity-self-likeness, family-homeliness, favouring-favourableness, feeling-intuneness, fun-lightheadedness and friendship-connectedness (Taylor, 1994). She wrote that nursing is a people-orientated vocation and involves all the usual complexities of inter-human relationships, which are intensified when patients require nursing care and:

*As a human relationship, nursing is made therapeutic by the humanness of the interpersonal encounters...nurses who are able to acknowledge and value their own humanness in their professional lives bring a special gift to people...because they bring themselves as knowledgeable and skilful humans who are able to transcend the professional inhibitions of their roles to be 'just themselves'.* (Taylor, 1994, p. 4).

She stated that patients recognise and respect nurses who are competent but also that they are human, just like they are – "*ordinariness is sophisticated in its simplicity*" (Taylor, 1994, p. 241). This aspect mirrored many of this study's findings related to 'Being Authentic'. Additionally, a distinctive discovery, which mirrored my own findings of 'moral courage – to act where others fear to tread', was the notion she called fair play and its relationship with straight talking, risk taking and tolerating another's humanness. She stated:

*The phenomenon of ordinariness in nursing revealed ways in which people negotiated impasses in communication, through being honest, if not somewhat blunt, yet at the same time tolerating some of the annoying features in the other person, appreciating that they too, were only human. (Taylor, 1994, p. 197).*

She alleged that when nurses and patients know each other well enough to share straight talking, they know each other well enough to risk a relationship worth keeping (Taylor, 1993). Similarly, Cumbie (2001) stated that the essential element of therapeutic participation was nurses bringing their authentic selves into the nurse/patient relationship. She believed nurses come into this “*authentic state of being in the world*” through a full participation in life and by the use of reflection (Cumbie, 2001, p. 59). In congruence with my study findings, she also found that commitment and the courage to ‘be’ were “*necessary to make ‘being’ and ‘becoming’ possible*” (p. 60). Equally, Kleiman (2004) found “*an authentic attending to health-related concerns*” occurred in her study of six Nurse Practitioners (NPs) when they made connections with their patients (p. 263). Eight further essential meanings for interacting with patients, such as openness, connection, concern, respect, reciprocity, competence, time and professional identity, were identified through dialogues that showed that “*both the NPs and patients became more as persons*” (Kleiman, 2004, p. 268). While the notion of authenticity was not defined per se in this phenomenological study, it was implied in statements relating to NPs gaining opportunities for personal and professional growth. Kleiman’s study had similarities to my study, such as the use of a qualitative methodology and the use of NP’s who were expert practitioners.

Despite the majority of articles supporting authenticity as an important feature of being a nurse, there has been critique of authenticity as the “*dominant view in the nursing literature of the nurse-patient relationship, incorporating the value of being genuine*” and a statement that it is “*only a partial and inadequate framework*” to understand this relationship (Aranda & Street, 1999, p. 75). Aranda and Street’s article reported selected findings from a critical praxis study where two contradictory expressions were used to describe the nurse-patient relationship – ‘being authentic’ and ‘being a chameleon’. They described the emergence of the nurse-patient relationship through time as a:

*Theoretical repositioning of what constitutes a ‘good nurse’”, where “a distant and impersonal nurse wearing a face mask and seemingly unaffected by the suffering of those around her was replaced by ‘a nurse who is self-aware, able to cope with self-disclosure and with highly developed interpersonal skills. (Aranda & Street, 1999, p. 77).*

They reported their study nurses acknowledging caring and authenticity as dominant values in their work but also expressing confusion and guilt as they struggled to align authenticity with the way they chose to reveal or conceal aspects of themselves depending on the nursing situation. They used several examples to typify this type of behaviour, including changing one's accent to be more favourable with a 'working class family'. On questioning the nurses further, they established that they had no qualms with self-authenticity but they did have issues regarding authenticity with their patients – the social vs. the personal. The authors proposed that an understanding of the nurse-patient relationship through the notion of 'intersubjectivity' could assist the nurse to reconcile their tensions. They referenced Crossley's (1996) work on 'Social Becoming' to explain that the way nurses 'shift' their position to gain access into the patient's world or to give care should not be seen as an abuse of power or a failing to be authentic. Crossley's findings related to 'being authentic' do not concur with my own study. While I can understand that some nurses feel the need to change their 'countenance' to have better relationships with their patients, my study findings suggest that nurses who are being and becoming exemplary are self-assured enough to 'be themselves' in any patient situation. By being 'natural' and genuine, they do not have to resort to being a chameleon.

### **Living your Reflective Life**

'Living your reflective life' was a major component of this study's finding related to 'Being Authentic'. Reflection and 'reflective practice' were commonly used terms that describe this notion in modern nursing and this literature review highlighted numerous articles related to this topic. In this section, I will discuss only those that incorporate a critical link between the being-doing of nursing and a full reflection in/on practice as relevant to this study's findings.

There is no doubt that reflection facilitates the integration of theory into practice and is an accepted element of nursing practice (Agyris & Schon, 1974; Bailey, 1995; Davies, 1995; Duke & Appleton, 2000; Emden, 1991; McCougherty, 1991; Palmer, Burns, Palmer, & Bulman, 1994; Rolfe, 1997; Scanlon, Care, & Udod, 2002; Wong, Loke, Wong, Tse, Kan & Kember, 1997). Internationally, nursing schools of education include reflective practice as part of the syllabus and Nursing Councils advocate the development of 'reflective nurse practitioners' (Gilbert, 2001; Glaze 2001; Liimatainen, Poskiparta, Karhila, & Sjogren, 2001; Teekman 2000). In New Zealand, the Nursing

Council of New Zealand lists it as Competency 2.8, in their Competencies for the registered nurse scope of practice (Nursing Council of New Zealand, 2005).

Despite its acceptance in nursing, there have been various ways in which reflection has been described, such as: An everyday activity that can be developed for learning from experience; A continuum with technical rationality; A hierarchy of levels between technical ability and ethical and moral rationalisation of practice; A process of emancipation; The artistry of combining a professional repertoire with current clinical problems to invent unique responses; and The incorporation of calculative and contemplative thinking, with the transformation of thinking into learning (Agyris & Schon, 1974; Atkins & Murphy, 1993; Boyd & Fales, 1983; Dewey, 1933; Duke & Appleton, 2000; Habermas, 1987; Jarvis, 1992; Kuiper & Pursut, 2004; Mezirow, 1990; Pierson, 1998; Saylor, 1990; Taylor, 1998; Williams & Lowes, 2001). Despite these differences, there is agreement that it is an ongoing process that links an experience with relevant knowledge; that it is triggered by feeling evoked by a particular situation; it can occur before, during or after an event; and can integrate past and future practice in action (Dewey, 1933; Glen, Clark, & Nichol, 1995; Greenwood, 1993; Schon, 1983; Teekman, 2000). These notions are fully supported in my study findings – ‘living your reflective life’ and its relationship with learning from ‘backpack patients’.

There were many studies that assessed various learning strategies to develop reflection, and the results varied (Duke & Appleton, 2000; Glaze, 2001; Liimatainen et al. 2001; McCougherty, 1991; Powell, 1989; Richardson & Maltby, 1995; Wong et al. 1997). Most stated that reflective learning strategies did not assist student nurses to reach the higher levels of critical reflection, while education with experienced nurses produced higher levels of critical reflexivity and consequent transformation in the learning process.

The participants in my study did not reveal any formalised reflective education, other than an awareness of the theory taught in undergraduate nursing programmes. My study findings affirmed that they lived their reflective lives primarily through innate and unconscious reflection, which became more conscious as they recognised it as the mechanism by which they continued to have a ‘love of nursing’ and in order to ‘make a difference’ in the patient’s lives. This critical reflection was supported by their relationships with critical friends. This was acknowledged by Duke and Appleton (2000), who stated that “..other factors such as the quality of mentorship or critical

*dialogue influence critical reflection*” (p. 1566). This sentiment was also described by Conway (1998), who in studying nursing experts, found that expertise developed through response to the nurses’ worldview and Teekman (2000) who stated that collegial support helped his study respondents make sense of situations.

Mentors were also acknowledged by Kuiper and Pesut (2004) as influencing reflection and learning. Their excellent article acknowledged the benefits of reflective practice but also maintained that single-minded attention to metacognition or reflection, without attention to the influence of critical thinking did not promote effective learning. They stated that these two elements were the key ingredients in a commitment to life long learning. They described a Self-regulated Learning in Nursing Model that incorporated three important aspects: behavioural self-regulation or self-monitoring; metacognition or self-regulation, and environmental or self-regulation (Kuiper & Pursut, 2004). This model related well to my study findings that assimilated authenticity and reflection as both personal and social factors.

A further excellent study described 10 registered nurses having ‘discourse-with-self’; where self-questioning assisted them to structure their thought processes in order to be able to think ahead, clarify issues and make meaning (Teekman, 2000). In examining the types of questions his respondents asked themselves, Teekman suggested three levels of reflective thinking at successive levels: reflective thinking-for-action, reflective-thinking-for-evaluation and reflective thinking-for-critical inquiry. Similar to my own study findings, thinking-for-action occurred prior to, during and after the action while reflection-for-evaluation occurred after the action and after the practitioner has created meaning from the situation. At this stage, analysis took place to clarify the experience including the aspects of “*knowing myself, how I respond, how I behave...the vulnerability of me as a human...and that I don’t have all the answers*” (Teekman, 2000, p. 1131). While these ‘knowing self’ notions were found in my own study, Teekman states that his respondents did not consciously review and update their existing propositional knowledge base but rather “*respondents evaluated their gains in terms of the practical...whether they would do the same thing again under similar, but not necessarily identical, circumstances*” (2000, p. 1132). In his opinion, his respondents did not reflectively think at a critical level.

Mezirow (1990) also distinguished three types of reflection. Content and Process reflection occurred as the practitioner asks what and how a problem occurs, while

Premise reflection or Critical reflection usually involves asking why? When practitioners engage in Premise questioning, their meaning perspective may be changed. Similarly, Argyris and Schon (1974) described two levels of reflection. The first level (single-loop learning) is self limiting while the second level (double-loop learning) permits progressive testing of assumptions and increasingly greater learning effectiveness (Argyris & Schon, 1974). Greenwood (1998) also identified that reflective practice in nursing differed between single-loop learning in the United Kingdom and double-loop learning in Australia. Greenwood said it:

*Involves reflection on values and norms and, by implication, the social structures which were instrumental in their development and which render them meaningful.*  
(1998, p. 1049).

C. Taylor (2003) also put forward some concerns regarding the unreflective and uncritical way reflective practice is used. In stating her reservations, she said, *“there is a tendency to regard the subjective turn of reflection as giving access to an authentic self and a more real account of practice...than the technical-rational accounts of biomedicine”* (Taylor, 2003, p. 250). While Taylor acknowledged the good of reflective practice, she believed we should work on enhancing its quality by considering ‘how’ things are said, rather than just simply focusing on ‘what’ is said. She stated that nurses needed to acknowledge that reflective practice accounts were not just personal but also constructed the world of practice for the whole of nursing as well (Taylor, 2003).

The participants in my own study also acknowledged the critical nature of their reflections - revealing powers structures, history and context being important as well as the consequences of their decisions and actions. They used others to assist their reflections and looked beyond the here-and-now to use the knowledge for the future as well. In agreement, Teekman (2000) stated that self-questioning was an effective strategy, but it was not wholly sufficient to make sense of situations, as it couldn’t compensate for or replace, dialogue with colleagues, lack of information, information overload, unrecognised pattern recognition or lack of experience. In concluding, Teekman (2000) stated that thinking based on clinical reasoning using previous experiences, moved a practitioner towards being an expert. This expert is not just a nurse with experience but a practitioner who uses all levels of reflection and is able to move between the types of information and select and transform knowledge appropriate to the situation (Benner, 1984; Schon, 1983; Teekman, 2000). Experts who are critically reflective, are ‘humanistic existentialists’, and are passionate about nursing practice,

confident and assertive and able to challenge themselves and colleagues authentically (Conway, 1998; Glaze, 1998, 2002). Like Swanson (2000), the participants in my study believed that being authentic in both a professional and personal way was the solution to an integrated mind, body and spirit harmony and “*reflection is the key to developing all the other characteristics*” (Swanson, 2000, p. 32).

There were also articles renouncing the use of reflective practice in nursing as a form of domination (Cotton, 2001; Gilbert, 2001). Both these articles used a broad Foucauldian perspective to challenge the hegemonic discourse of reflection in nursing and were very thought provoking. However, as they related more to written reflection or the use of clinical supervision, they were not relevant to my thesis findings.

## **Presence**

The concept of presence is closely aligned with my study findings of ‘Authentic Being’ and is related to ‘Making a Difference’, as it relates to both the social and the personal aspects of being. Definitions of presence differ from a simple ‘physical presence’ – a being there/‘psychological presence’ or a being with; to a more comprehensive definition of ‘therapeutic presence’ – “*a conscious act of being fully present – body, mind, emotions and spirit – to another person*” (McKivergin & Daubernmire, 1994, p. 69). This later definition is comparable with Watson’s (1985) concept of transpersonal caring, Paterson and Zderad’s (1976) transactional interaction, Parse’s (1992) transcendent and transforming notions, Newman’s (1994) expansion of consciousness and Dossey, Keegan, Guzzetta, & Kolkmeier’s, (1988) concept of healing as:

*The process of being parts of oneself (physical, mental, emotional, spiritual, relational and choices) together at a deeper levels of inner knowing, leading to an interaction and balance, with each part having equal importance and value. (p. xv).*

Paterson and Zderad (1976) first introduced the notion of presence, and described it as “*a mode of being available or open in a situation with the wholeness of one’s unique individual being; a gift of self which can only be given freely*” (Paterson & Zderad, 1976, p. 122), and Parse (1992) described therapeutic presence as a “*primary mode of practicing nursing*” (p. 36). Gardner (1985) also described presence as the core of the nurse-patient relationship and suggested that the antecedents of presence include caring; self-awareness; abilities of listening and touch; commitment to helping others and expertise and knowledge, which are all aspects found in my own study. He described



presence in nursing as the physical ‘being there’ and the psychological ‘being with’ patients. The psychological component is abstract and refers to the intuitive knowing where the nurse senses the patient’s experience (Gardner, 1985).

As similarly described by participants in my study, when nurses allow themselves to become one with their patient’s experiences, they can subliminally receive messages from their patients - it is as if their consciousness acts as a conductor (Montgomery, 1992). This is a kind of understanding Noddings (1984) calls ‘receptivity’. Similarly Newman (1994) understood presence as a relational paradigm that encompassed consciousness and was characterised by a pattern of person-environment-interaction, which was acausal, intuitive and problemistic (Newman, 1994).

Hines (1992) described presence as time with another, where the nurse has an unconditional positive regard for the patient – a connectedness that includes a transactional communication with, being with, doing with - an encounter that is valued by both and sustained in their memories. Benner and Wrubel (1989) stated: *“The ability to presence oneself, to be with the patients in a way that acknowledges your shared humanity, is the base of much of nursing as a caring practice”* (Benner & Wrubel, 1989). B. Taylor (1994) concurred, stating that nurses ‘do’ clinical work and through this work, their quality of ‘being-with’ is expressed. Congruent with my own study findings, she believed that doing is related to being, in that nurses and patients both convey their being together through the medium of *“doing for”* and *“being done to, and with”* (Taylor, 1994, p. 22).

Integral to this nursing presence, for my study participants was the inclusion of a reflective state of consciousness. Here, valuing being and knowing became essential elements for understanding the concept and being able to apply it in action. This understanding embraced the contextual aspects of being which occurs in relationship with others (Gilje, 1992). Through ‘presence’, nurses are able to experience ethical, aesthetic, empirical and personal ways of knowing (Carper, 1978). Only through valuing ‘presence’ can the nurse be concerned with ‘more being’ and ‘becoming’ as well as with ‘well being’ (Gilje, 1992). When expert nurses are present, energetic, in-tune and have presence, ‘Flow’ is experienced which is characterised by a deep absorption in the task at hand and performance at an optimum level that joins the nurses’ intuitive and analytical knowledge (Benner 1984; Buber, 1965; Csikszentmihalyi, 1990; Karl, 1992).

Encompassing essential elements of my study findings related to being authentic, McKivergin and Daubenmire (1994) presented a 'Model of Self', which described people *"in terms of an external and internal environment"* (p. 75). Similar concepts to the social and personal, included 'Input' from family, friends and life experiences; 'Inside Me' – memories, genetics, physiology and self-esteem; 'Output' – emotions, behaviours and creativity and 'Perceptual Filters' – attitudes, beliefs and values; social norms, peer pressures and laws. They used this model to teach nurses to *"become more mindful about the dimensions of their lives and ways to become more intentional about their level of presence towards themselves...and being present to others...incorporating presence into practice"* (McKivergin & Daubermire, 1994, p. 75). Like my study findings related to 'Being Authentic', this model brings the nurse together – joining their personal and social being.

### **Being Is a Constantly Revolving Thing**

In my study 'being as a constantly revolving thing' and 'creating a balance and moving on' were important facets of 'being authentic'. In acknowledging this, Larson (1986) stated *"adulthood is not a plateau, rather, it is a dynamic changing time...there are patterns and rhythms to the life cycle"* (p. 54). Being and Becoming an Exemplary Nurse is an ongoing journey and Teekman (2000), Glaze (2002) and Mezirow (1990) all acknowledged that life and nursing were transitional processes. Anderson (1997) also illustrated this notion with its relationship to authenticity, when she said:

*Each of us is taking a professional journey. We use our scholarship and our relationship building skills to lean and mentor, experience and contribute, and lead and follow. Our creativity, flexibility, and adaptability provide us with a "centering" that enhances our success, but our only reason to pursue the journey with vigor is to create a better environment for professionals to practice and for patients to receive care. Let us know ourselves so we can ground the journey with integrity.* (p. 8).

Like the findings of my study demonstrate, Reeder (1992) also suggested that a balance of perspective and action can be achieved through the use of self-reflection.

There were many factors that caused my study participants to move on and Valliant (1977) identified four major variables that could influence life: opportunities or obstacles one encounters; the amount of effort one makes on their own behalf; the sources of support and guidance one receives to assist them to become adjusted and to cope with life; and their own personal resources. These factors were all relevant and

mentioned by my study participants but the major reason for the move was to regain balance of their personal and social being - in order to give 100% and make a difference in another's life.

In supporting this notion of authenticity as both the personal and the social and its relationship to balance, Karl (1992), stated that life and situations always involve a 'who' an 'is' and a 'there'. He described these as being abstract notions of individual consciousness (who), environmental shaping (there) and the relationships between them (is). He believed that the ability to 'be there' fluctuates and – *“one has ‘good’ days and ‘not so good’ days”* and the capacity differs due to different demands from work, home, family, friendships and self (Karl, 1992, p. 3). One area affected the other and how a person ordered their life affects their capacity to 'be there'. He stated that it was important for people to be embedded in sources that could animate their 'being', and this in turn allows for a greater capacity to 'be there'. He believed people could achieve this when the mind, spirit and relationships were balanced – *“when in ‘balance’ I am more present everywhere”* (1992, p. 5).

The literature related to being authentic supports the study findings that Being and Becoming an Exemplary Nurse is both a constantly revolving journey and a balance between the personal and social aspects of being. The mechanism, which maintains the equilibrium, is critical reflection.

## **A Love of Nursing and Making a Difference**

Through having a 'love of nursing' and wanting to 'make a difference', the participants in my study were able to be and become exemplary nurses. They accomplished this by having 'caring communications and connections with others' and by being and becoming expert nurses in order to 'be the best they could be'. In this section, the notions of caring, expert and good nurses will also be discussed as related to these study findings.

### **A Love of Nursing**

The participants in my study loved nursing. In Montgomery's (1992) study of spiritual transcendence, she also identified her study nurses describing a love of nursing. They also talked about the privilege of caring for patients. Nursing was described as a calling by some of my study participants and others have also described this phenomenon

(Karl, 1992; Newman, 1994; Raatikainen, 1997; Watson, 1999). Newman (1994) described her calling as: *“I had been feeling a call to nursing as a career for a number of years...I knew, after only a few classes, that nursing was right for me”* (p. xxiii).

Although my study participants loved nursing, they looked at this through a critical lens. Because of their authentic being they were able to live with the paradox of caring deeply about their patients but also not getting too involved (Montgomery, 1992). Benner and Wrubel (1989) described this notion as the narrow path nurses walk between ‘enmeshment’ on one hand and ‘inappropriate distance’ on the other. In older literature sources, nurses were advised to not have deep personal involvements with their patients and the use of the term ‘co-dependency’ began to cast suspicion on the motives of nurses wanting to take care of people (Flaskerud, Halloran, Janken, Lund, & Zetterlund, 1979; Griffen 1983; Montgomery 1992). However, nurse scholars such as Benner (1984), Gadow (1980), Montgomery (1994), Newman (1994), Parse (1981 & 1998), Peplau (1956), Rogers (1970, 1986 & 1992) and Watson (1985 & 1999) have acknowledged the depth of personal involvement required to care. They, like Montgomery (1992) have found that expert nurses know how to become deeply involved without succumbing to destructive forms of over involvement and have the ability to care in a way that reinforces their own professional satisfaction and commitment. These notions are completely congruent with my study findings.

### **Expert Nurses**

The existence, acceptance and importance of ‘expert’ nursing practices are evident in the nursing literature, for example, Adams et al. (1997); Benner, (1984); Bonner (2003); Brown & Tiavale, (1996); Conway (1998); Edwards (1998); Glaze (1998); and Jasper, (1994). Since Benner’s (1984) work on ‘Novice to Expert’, interest in nursing expertise has increased, however, there is still discrepancy over exactly what expertise means. While most studies agree that experts are skillful and have a profound knowledge base and are competent to use this knowledge, they do not agree whether it is the personal qualities of the nurse made evident in practice or practice within a specific clinical setting (Adams et al. 1997; Bonner 2003; Edwards 1998; Frank 2002; Jasper 1994). Additionally, questions have been raised over nurses with expert skills in one area and merely competent or proficient in others and whether all nurses have the potential to become expert (Farrington, 1993).

In my study, all the participants had been experts in their specific field of nursing, yet many had gone onto other areas and utilised this expertise at another level. Benner (1984) believes that experts can only function within their own framework of pattern recognition when they are in their own specialist area and that not every nurse can become expert. In my study, personal characteristics (such as being authentic) revealed through practice, were the most important factors in being an expert. This notion was also confirmed by Edwards (1998) who studied seven Accident and Emergency (A&E) nurses' constructs on the nature of nursing expertise. He said that despite wishing to acquire expert criteria for A&E nurses, he found that:

*What was surprising was that much of the material elicited could equally have applied to nurses in other clinical areas, indeed to expert practice in almost any field. This implies that the attributes of expertise are more transferable than the original work of Benner (1984) would suggest.* (Edwards, 1998, p. 22).

In order to clarify exactly what an expert was, Jasper (1994) sought an operational definition using Walker and Avant's (1988) notion of concept analysis. Through this method, she suggested the defining attributes of an expert were: *"possession of a specialized body of knowledge and skill; extensive experience in a field of practice; highly developed levels of pattern recognition, and acknowledgment by others"* (Jasper, 1994, p. 771). While Jasper believed this latter concept may be contentious, she believed a definition needed some externally validated criterion.

This concept was also described by Bonner (2003) in her results of a grounded theory study with 17 renal nurses. She found that being recognised as an expert was necessary for the exercise and maintenance of expert nursing skills – *"in order to practice as an expert, nephrology nurses must first be recognized as one"* (Bonner, 2003, p. 125-6). Expert nurses can be recognised and designated by patients, nurses and doctors, however similarly to my own study where peer nomination was the method of participant selection, Bonner (2003) said that nurses were in the best position to judge another nurses' practice because they frequently witnessed it in action or had to manage the consequences of that practice. When these nurses were asked who were the 'most expert' nurses in their unit, the qualities used to recognise these nurses were described as: a wealth of up-to-date knowledge; extensive clinical skills; ability to teach other nurses; the ability to move into a renal area and succeed without faltering; an enquiring mind; the capacity to put more effort into their work than other nurses; and the ability to take on more responsibility than other nurses (Bonner, 2003). In addition, Bonner

described three sub-categories recognising expertise: 'Being Trusted', 'Being a Role Model' and 'Teaching Others'. While some of these aspects are specific to renal nursing, many of these notions are similar to the findings of 'Walking the Talk' – 'walking alongside' and 'being a team builder' where this study's participants described acknowledging and using their own reputations to be role models and exemplars to others. Jasper also highlighted this when she stated:

*The label of 'expert' becomes self-reinforcing, in that colleagues will draw on expertise once it is established. This in turn builds reputations as experts become more visible when they are consulted by others and are used as role models for students and other practitioners. If the expertise is not reinforced then the label will become extinct with loss of credibility and loss of reputation in the field.* (1994, p. 774).

There were also other smaller studies, which partially described components of expertise. In a small single case study with one 'expert' nurse, communication was found to be a priority for 'expert' practice and one they "*considered exemplary*" (Brown, 1994). Another paper, highlighted six narratives on expert practice - advocacy; assertiveness; communication; expert clinical knowledge; advanced assessment skills; creative problem solving and respecting human dignity (Fallas et al., 1991). These hallmarks of 'expert' nurses were similar to my own study findings, but were not a comprehensive description.

A small interpretive study, looking at expertise from another perspective, asked 17 patients their perceptions of an 'expert' nurse (Walker, 1996). They described nurses who were "*interested, friendly, available, and knowledgeable and who signaled, however briefly, an authentic and distinctive, caring, nursing presence*" (Walker, 1996, p. 43). While this article came from the patient's perspective, it did have congruence with my study findings that highlighted being authentic, but was additionally insubstantial for other constructs.

The notion of 'expertness' has also been critiqued, for example, from English (1993) and Farrington (1993). English (1993) had methodological difficulties with Benner's (1984) 'expert' subjects being identified by peer assessment and suggested that since Benner had placed such importance on the role of the expert nurse, surely it would have been worthwhile clarifying exactly what was entailed in gaining it! He believed it was essential to define and make explicit the criteria used to define excellence in practice and considered that nursing needed to be founded on scientific knowledge, based on

empirical research rather than “‘*hunches*’ provided by Benner’s experts” (English, 1993, p. 393). He rightfully highlights that negative incidents were not used in Benner’s study and non-experts were not asked if they also made ‘intuitive’ inferences. These shortcomings were answered in my own study, where the participants were both ‘being’ and ‘becoming’ exemplary and related previous ‘negative’ experiences as learning examples. While I cannot fully answer English’s critique of requiring a full definition of ‘intuition’ in practice, I can state that intuition is only part of the picture of ‘making a difference’ that sustains practice and is in-turn, part of being an authentic exemplary nurse.

A further interesting philosophical critique argued that the emergence of the ‘expert’ nurse as a moral and ethical category was the result of neo-Thomist discourses from such nurse theorists as Benner. Central to this development was the notion of “*the good*” and its relationship to knowledge, skill and practice (Nelson, 2004, p. 12). Nelson stated that nurses should move away from looking at exemplary situations, which moralises all practice and professional activities, and instead look to those situated in the “*everyday collective practice*” where “*we may be able to bring into focus the more modest, but no less powerful ethical capacities through which nurses habitually enact their practice*” (2004, p. 21). Again, this critique is partly answered in my study where ‘exemplary nurses’ were in a state of ‘becoming’ and therefore recounted many experiences of positive and negative ‘everyday’ nursing practices.

### **‘Good’ Nurses**

A literature search for ‘good’ nurses highlighted an extensive body of literature. I have described only the most relevant ones as examples of the literature related to ‘good’ nurses. Of the many articles found, most focused on subjects as; whether good nurses were ‘natural’, Allen (1997) and Brown (1998); a relatives experiences of good and exemplary care, Bradley (1998); Christian compassion, Shelly (1997); education tips, Krishfield (1997); nurses acting as assistants or replacements for physicians or complementary to other health professionals providing care (Allen, Frasure-Smith, & Gottlieb, 1982), or debates over prioritising clinical or educational skills, Evans (1991); Masson (1990) and Shepherd and Bassett (2000). There were also several letters to the editor on the topic as to ‘what makes a good nurse?’, Anonymous (2003); Gorsky, Roberts, Lim, Marty-Meyerson, & Brewing, (2002); Preece (2004) and Zoreta (1993). These articles were all anecdotal and were not research based or referenced. While they

described attributes such as natural feminine traits, Christian compassion, and having good educational and clinical skills they were not useful as comparisons with my study on exemplary nurses.

An interesting article looking at the construction of the nursing subject through history, argued that the range of speaking positions available to the nurse was limited by gender, class and education (Alavi & Cattoni, 1995). While the issues raised may have importance concerning nursing education, it did not make any definitive conclusions and while my reading of it highlighted the need for exemplary role models and the usefulness of reflective practice – the paper itself did not have relevance to the findings of my study. Another article described the visions and values of the good ‘Irish’ nurse, through using a framework of discourse analysis within the method of historical (Fealy, 2004). The conclusion that *“the image of the nurse is both culture-specific and changes to reflect the underlying sociocultural context, and prevailing system of power and influence”* is accurate but again did not enhance the understanding of the phenomena of ‘exemplary nurses’ (Fealy, 2004, p. 649). Further articles highlighted discrepancies over nursing students and staff nurses’ notions of ‘the good nurse’, but were also not relevant to Being and Becoming an Exemplary Nurse, for example, Wilson and Startup (1991) and Kiger (1993).

In a small article emphasising the need to search for ‘very good nurses’ rather than ‘really bad nurses’, Pool (1987) listed ten qualities of a good nurse - competent, knowledgeable, energetic, articulate, courageous, intelligent, a positive thinker, a visionary, no need to please others and a risk taker. Like my study finding - ‘moral courage’ she believed that risk takers are important and stated:

*They know to improve themselves and to improve the world chances must be taken and mistakes must be made. They accept this as a simple fact of life. They allow themselves to make errors and they assume others will also. They view errors as a means by which we learn and grow.* (Pool, 1987, p. 3).

An article that was comparable to my study findings, described ‘good nursing practice’ as *“being as well as doing”* (Smith & Godfrey, 2002, p. 301). Their qualitative study of 53 nurses’ perceptions of being a good nurse, highlighted seven categories - personal and professional characteristics, patient centeredness, advocacy, competence, critical thinking and patient care. These categories were in congruence with my study findings and it was interesting that their participants prioritised the *“intuitive and analytical personal attributes that nurses bring into to nursing by virtue of the persons they are”*



(Smith & Godfrey, 2002, p. 301). This construct is similar to my study finding - 'Being Authentic – joining the professional with the personal'. Similar sentiments regarding personal characteristics, were described by Charge Nurses describing good nurses (Wilson & Startup, 1991). While these two papers described characteristics similar to those found in my own study, they did not depict the full phenomena of Being and Becoming an Exemplary Nurse.

### **Caring Nurses**

Caring is regarded by many as an essential dimension of nursing practice (Benner & Wrubel, 1989; Mayeroff, 1971; Noddings 1988; Roach 1987; Watson 1979, 1985). It has been used as a noun, an adjective, a verb and an adverb but there is no consensus regarding its definitions; its components; or its processes. While it has been identified into five major conceptualisations: caring as a human trait; caring as moral imperative; caring as an affect; caring as an interpersonal interaction and caring as a therapeutic intervention (Morse, Solberg, Neander, Bottorff, & Johnson, 1990), there have been questions raised as to whether caring is the 'essence' of nursing due to the difficulties in identifying, conceptualising and measuring the concept and disagreement over its uniqueness to nursing practice (Dunlop 1986; Komorita, Doehring, & Hirschert, 1991; Williams 1997).

Historically, caring was seen as giving physical care to another person (Williams, 1997). Florence Nightingale used the term primarily to indicate environmental and physical care (Nightingale, 1969). Later into the 20<sup>th</sup> century, the idea evolved into a concept that had both an affective and task dimension that incorporated a humanistic approach, including aspects of existentialism and humanism. Some believe these adaptations may have occurred through the incorporation of information from other disciplines into the realm of nursing (Howard, 1975; Williams, 1997). For example; Freud (1966) determined care as an essential component for survival of the species, Maslow (1975) defined care as a biological phenomenon that requires awareness of the need of humans for caring and Erickson (1968) and Rogers (1957) each identified caring or concern as essential in a helping or loving relationship.

Over the last 20 years, a number of nursing theorists have discussed this phenomenon from different perspectives. Bevis (1981), Gaut (1983), Leininger (1981), Paterson and Zderad (1976) and Watson (1985) have all understood caring to be essential for growth and healing of the patient and an experience lived between human beings. It is more

than being technically competent or a benevolent one-way nurse-patient interaction. Caring is now viewed by these theorists, as the central concept of nursing - indeed the essence of nursing and is seen to be as beneficial to the nurse as it is to the patient (Benner & Wrubel, 1989; Leininger, 1981; Montgomery 1992, 1994; Roach, 1987; Noddings, 1988; Watson, 1985).

Caring has been depicted as a positive nursing attribute by both patients and by nurses but in general, they disagree on their perceptions of caring behaviours. Nurses tend to stress the importance of emotional caring, whereas patients seem to stress the importance of task orientated caring aspects (Gooding, Sloan, & Gagnon, 1993; Larson, 1986, 1987; Mayer, 1986; Reimen, 1986; von Essen & Sjoden, 1995; Wolf 1986). While some studies reported congruence between patients and nurses this was most often due to the way the question was presented to the participants or the research technique used not prioritising caring attributes but only listing them as themes (Appleton, 1993; Redfern & Norman, 1999).

### **Patient Perspectives on Caring Nurses**

There are various studies published on the patients' perspectives of 'caring nurses' and the results are varied. Patients describe caring nurses as competent in physical/technical caring through to emotional/spiritual and interpersonal caring. Disparities from the patients regarding the priority of these caring behaviours were dependent on the patient's age, gender, context of care, length of stay, diagnosis, prognosis or the type of study methodology – quantitative or qualitative (Brown 1981; Cronin & Harrison, 1988; Gardner & Wheeler, 1988; Mayer, 1986; Ray, 1989; Reimen, 1986; Weiss, 1984; White, 1972; Wilde, Starrin, G. Larsson, & M. Larsson, 1993; Williams 1997).

Quantitative studies regarding patients' perspectives on caring nurses, demonstrated that patients place more emphasis on the task dimensions such as clinical competence and attention to physical care, knowing how to give shots, how to handle equipment and when to call the doctor (Larson, 1986 & 1987). On the contrary, most qualitative studies demonstrated caring behaviours such as the development and maintenance of confidence, interpersonal competence, comforting, reassurance, trust, self-reliance, assurance, holistic understanding, connectedness/shared humanness, presence, anticipating and monitoring beyond the mechanical, being indicative of 'good' nursing care (Fareed, 1996; Fosbinder, 1994; Kirk, 1992; Milburn, Baker, Gardner, Horsby, & L. Rogers, 1995; Miller, Haber, & Byrne, 1992; Walker, 1996). However, interestingly

and contrastingly, several qualitative studies based in the Nordic countries found their patients did emphasise the primacy of skill based competencies over more affective ones (Bjork, 1995; Fagerstrom, K. Eriksson, & Engberg, 1998; Halldorsdottir & Hamrin, 1997; Lovgren, Engstrom, & Norberg, 1996; Wilde et al. 1993).

### **Nurses Perspectives on Caring Behaviours**

Most nursing literature supports the opinion that nurses generally believe that the interpersonal aspects of caring are most indicative of a caring nurse, for e.g. Barr and Bush (1998); Clarke and Wheeler (1992); Ford (1990); Forrest (1989); Larson (1986 & 1987, and Milburn et al. (1995). However, some studies have contradicted this assumption, believing that nurses should be re-focusing on skill and competence (Astrom, Norberg, Hallberg, & Jansson, 1993); Bjork, 1995; Greenhalgh, Vanhanen, & Kyngas, 1998). These studies do not permit any conclusions regarding the relative importance of one caring dimension over the other. One dimension may be of prime importance in one care context while another may dominate in another. This was demonstrated in my own study where the nurses illustrated times where it was important to 'Be on top of things and in control' by 'acting' 'evaluating' and 'assessing'. At other times, it was more appropriate to 'have a sense of the patient's experiences', to 'respect another' and understand it was 'their journey'.

Like other authors I believe it is the patient's perceptions of caring that is the most important and nurses need to be aware that this often changes as the patient's needs change (Astrom et al. 1993; Campbell, 1984; Dunlop, 1986; Fagerstrom et al. 1998; Fleming, Scanlon, & D'Agostino, 1987; Fosbinder, 1994; Milburn et al. 1995; Wilde et al. 1993; Williams 1997). As one of Astrom et al's (1993) study participants said, "*how I act depends on the situation*" and the skill to find that right level of involvement is very important (p. 183). The exemplary nurses in my study were acutely aware of this and were able to 'care' appropriately depending on their patient's needs.

This literature review supported my study findings that to be and become an exemplary nurse you must first love nursing. From this position exemplary nurses are able to make a difference and in turn sustain their professional and personal being.

## Critical Friends - Role Models and Mentors

Critical friends were found to have an important influence on the participants being and becoming exemplary in my study. This literature review found many papers regarding the role of mentors to trainee or newly graduated nurses, for example, Cameron-Jones and O'Hara (1996); Darling (1986); Ellis (1993); Gould (2001); Hayes (2001); Krozek (2002); and Spouse (1996 & 2001). While these papers highlighted useful criteria for matching mentors to students and some characteristics that could be accorded with the findings of my own study, they were not relevant to discuss in the context of exemplary nurses.

However, numerous articles were found during the literature review search that acknowledged mentors or role models as being significant to nurses becoming the caliber of nurse they are today, for example, Barker (2002); Davidhizar (1988); Dilworth (2002); Fitzpatrick (2003); Fontaine (1998); Heitschel (2001); Hill (1998); Jacobson (1998); Kay (2002); Knodel (2004); Larson (1986); Madison (1994); Malone (2002); Moser (1998); and Murdaugh (1998). In these articles, mentors were defined as protectors, supporters, teachers, facilitators, counsellors, preceptors, exemplars, guides, mother surrogates, role models or best friends. They described relationships that were formally based, prearranged or assigned - through to more casual, spontaneous, voluntary and informal relationships. These types of critical friends and the different relationships were also described by my study participants.

Also similar to that found in my study, many articles described the crucial role that 'charge nurses' have in mentoring others, for example, Andrews and Wallis (1999) and Fox (1991). Despite discrepancies over titles in these articles, the relationships were congruent with my study, where their associations with critical friends was based on common interests and goals, high expectations, constructive critique, inspiration, intellectual stimulation, motivation, guidance and support. They were described as invaluable in assisting the nurses becoming the calibre that they were today and supporting them towards the future. Like the participants in my own study described, often many different role models and mentors were used by nurses throughout their careers. In addition, Anderson (1997) believed that most of them never knew they were a role model, teacher or inspiration, declaring that:

*All were leaders in their fields and seemed to have a consistent set of values on which they based their practices decisions and career moves. Some of them I*

*viewed from afar and never worked with directly. Some I worked with side by side and had the advantage of discussing how and why they influenced a situation or made a decision. I was always encouraged by their personal confidence, their sense of adventure, and their willingness to continuously learn something new. (p. 8).*

As described my study participants, often mentors and role models became good friends. This was paraphrased by Knodel (2004) who said *“I find such divine power in the fact that my first supervisor and mentor became one of my very best teachers and friends”* (p. 52) and in sharing what her mentor’s greatest gift was, she stated:

*“She is committed to her personal and professional growth. Her desire for life long learning is an inspiration to all. What I witnessed early in my career was a woman whose leadership characteristics and behaviours included honesty, respect, vision, flexibility, integrity, professionalism, empathy, sense of humour, listening, trustworthiness, understanding and a team player attitude”* (Knodel, 2004, p. 52).

Teekman (2000) noted the importance of collegial support when he carried out 22 interviews with 10 registered nurses about their experiences of one self-selected non-routine clinical situation. He used the qualitative methodology of ‘Sense Making’ to illuminate reflective thinking in nursing practice. This sense making approach rested on the metaphor of a ‘journey without a destination’ and the *“‘constructings’ that humans create in order to bridge the gaps of existence from self to others, to situations, and to events across time-space”* (Teekman, 2000, p. 1128). This notion had many similarities with my study participants’ journey of being and becoming exemplary and his findings showed that collegial support and previous experience were the most important factors in making sense of situations. These results were congruent with my study participants’ use of ‘critical friends’.

Balance between personal and professional responsibilities was found to be an important feature for the participants in my study, and was also confirmed by other authors, for example, Campbell and Rudisill (2005); Fontaine (1998); Knodel (2004) and Murdaugh (1998). They believed prioritising and balance was *“how happy, productive people integrate work and family”* (Fontaine, 1998, p. 31). Knodel (2004) in acknowledgement, wrote of her mentor:

*During the course of her career, while raising seven beautiful children, her ability to balance family and career was truly admired by the nursing staff...Balance is not a new science. The best illustration of it is Laurel’s 50-year journey to authenticity, the gift of self. (p. 52).*

Critical friends were also important in assisting my study participants to maintain authenticity – through ‘creating a balance and moving on’. This notion was reiterated by other authors who described critical friends supporting, encouraging and guiding others through career changes (Larson 1986; Vance, Davidhizar, et al. 1997; White, 1988). As highlighted in my study – Being and Becoming an Exemplary Nurse is an ongoing journey of meeting and being challenged by others. Anderson (1997) in support, stated:

*Throughout my journey, many professional friends inspired me and contributed to my learning...Significant challenges over the years have become an opportunity to reexamine my knowledge base and path of my journey. My Journey is not complete. (p. 14).*

The literature supports the notions found in my study findings, that critical friends are invaluable in stimulating, supporting, encouraging, directing and guiding exemplary nurses on their journey of being and becoming. They are also important in assisting the nurses to make sense of experiences and to maintain the balance between their personal and professional being.

### **Walking the Talk - Leadership**

The nurse theorist Parse (1997) believed that leadership was not a ‘function of a position’ but a ‘quality’ present in a person who guides by blazing a path for others to follow. In her opinion, leaders walk the talk by “*sharing a dream that is explicitly shared through the living of values and beliefs*” (p. 109). She stated that there are at least three essentials inherent in leading: commitment to a vision, willingness to risk and reverence for others (Parse, 1997). These aspects correlate completely with my study findings of ‘walking the talk’, especially the characteristics of ‘walking alongside’, ‘being a leader’, ‘challenging colleagues’ and ‘being an innovator and an agent of change’. Similarly, Swanson (2000) described aspects of “*walking the talk*”, stating that there are more “*‘being’ characteristics than ‘action or doing’ characteristics*” in being a leader (p. 30). She presented the transformational characteristics of a leader who has the traits of: courage, belief in people, being value driven, a life long learner and teacher, an expert dealing with complexity, ambiguity and uncertainty and a visionary leader. These skills were related to developing relationships through teamwork, collaboration, mentoring, networking and the ability to foster a healthy relationship with oneself (Swanson, 2000). Similarly, Frank (2002), in her study with 500 nurses, described the formation of a Leadership Education Model (LEM) composed of six

major leadership components: being a visionary, an expert, an achiever, a critical thinker, a communicator and a mentor.

A common thread in many leadership articles was the notion of 'transformational leadership', for example, Burns (1978; Campbell and Rudisill (2005); De Groot (2005); Dunham and Klafehn (1990; Girvin 1998; and Gurka (1995). These leaders "*set aside their own self-interests for the greater organizational good*" (De Groot, 2005, p. 38). They had a profound and extraordinary effect on their colleagues because they engaged in the joint pursuit of goals in a reciprocally stimulating manner, which inspired all involved (Burns, 1978). They embraced innovation and commitment to the professional and personal growth of self and others (Gurka, 1995).

Authentic leadership means that in order to lead, leaders must be true to themselves. This allows them to lead with credibility and integrity (Duignan & Bhindi, 1997). These features are congruent with my study findings related to 'Authentic Being' and its connection with 'Walking the Talk'. Burns (1978) stated that there were two important factors of transformational leaders - vision and empowerment. He believed creating vision required introspection, reflection and a willingness to change. These attributes are paired with Parse (1997) and Swanson's (2000) beliefs as well as my own study findings, and support the notion of 'living reflective lives' and 'being an innovator and agent of change'. Self-empowerment turns this vision into reality and is both a course of action and a philosophy within each person, being based upon the belief that each individual has an intrinsic worth that is illuminated through the process of self-discovery (Hotter, 1992). The empowered person "*takes risks, makes conscious choices, and behaves in an authentic manner*" (Koerner & Bunkers, 1992, p. 8).

Having courage and taking risk, whilst also learning from mistakes was also found to be an important feature of my participants and was acknowledged by others as an important feature of an authentic leader (Frank 2002; Gurka 1995; Parse 1997).

'Walking alongside' by 'being a team builder' and 'creating environments that get the best out of people' was a major aspect in my findings related to 'walking the talk'. This was mirrored by several authors who described good leaders who: create appealing organisational cultures where leadership is shared by participatory decision-making and the empowerment of colleagues, for example, Davidhizar and Shearer (2002); De Groot

(2005); Dunham and Klafehn (1990); Gunden and Crissman (1992); and Shiparski (2005).

Good leaders provide environments of ‘intellectual stimulation’ where questioning is encouraged, learning is valued and creativity is nourished (Dunham and Klafehn 1990). This required a shift from acting as a traditional educator to one of being a coach and mentor (Gunden & Crissman, 1992). This ability to look for the potential in people and to communicate to their colleagues their worth, so that they can see it in themselves was described in my study and also by other authors, for example, Covey (2004); Dunham and Klafehn (1990); Gurka 1995; and Hill (1998). Covey (2004), stated this could be achieved by a leader who utilised: role modeling and setting a good example, path finding by jointly determining goals, aligning and managing the system to stay on course and empowering by focusing talents on the results. Hill (1998) mirrored my study findings when she stated *“In mentoring others I focus on developing their potential and try to reinforce a job being done while providing opportunities for growth and leadership”* (p. 10). Anderson (1997) in agreement, stated that leaders have an obligation to encourage growth and maximise others’ potentials.

A further article, describing a feminine model of leadership, suggested the good leader needed to maintain a balanced lifestyle that included areas outside of work (Helgesen, 1992). This notion of work/life balance was found in my study and was also highlighted in the literature review of critical friends. It is an important feature to role model and to encourage and support in others. In order to create this balance, my study participants often moved on. Anderson (1997) also describes her need to be challenged by writing:

*Moving on was something I needed to do. I needed to grow and develop in a new environment. I wanted to use what I had learned...to give leadership to a department...mentor others and contribute to the profession.* (p. 11).

The literature supports my study findings that leadership is about being authentic, walking alongside and transforming others to be the best they can be as well.

## **Backpack Patients**

The construct of ‘backpack patients’ was a novel and important element found in B/being and B/becoming an Exemplary Nurse. Backpack patients were experiences and situations that were placed in the study participant’s memories. The literature regarding memory is vast and a full explanation is beyond the scope of this sub-section. However



it is important to note that memory is related to both metacognition (reflection) and critical thinking (Paivio, 1975). Knowledge is stored in the memory through primary/short term memory and secondary/long term memory. Knowledge is filtered and encoded through the short term memory in the brain before, ideally, it is entered into the long term memory or in this case, my study participant's 'backpacks' (Atkinson & Shiffrin, 1968; Waugh & Norman, 1965). Metacognitive strategies such as reflective and critical thinking, accelerate this storage process and promote optimal encoding for long term retention ( Craik & Lockhart, 1975).

The use of 'schemata' (coherent knowledge storied in the memory) assists in conceptualising this knowledge. Schemata arise from, and mentally represent, experiences and situations that have profoundly affected the possessor. These schemata influence all aspects of leaning including reasoning, decision making, perception, comprehension memory and problem solving (Cust, 1995). These skills also enhance the retrieval of information and nurses who were found to be able to manipulate instantly available information quickly, were better able to use these critical thinking processes (Case, 1994; Beitz, 1996; Schank, 1990). This use of knowledge and prior understanding has been shown to play a crucial role in learning and is a trade mark of being an expert (Benner,1984; Cust 1995). Experts have excellent short term and long term memory functions and they know how to use their knowledge. Therefore they are able to perform mental and physical tasks quickly and effortlessly with little conscious control. Difficult problems are carefully analysed and they monitor their performance by testing for understanding (reflection) and checking for errors (Cust, 1995; Glaser & Chi, 1988). This notion is similar to Benners' (1984) description of the expert nurse, where she stated:

*With an enormous amount of background experience, now has an intuitive grasp of each situation and zeros in on the accurate region of the problem without wasteful consideration of a large range of un-fruitful, alternative diagnosis and solutions. (p. 32).*

Therefore it can be proposed that 'exemplary nurses' use reflection-in-action and critical thinking to produce and aid the retention of knowledge (situations and experiences) which are stored in their memories (backpacks). They then make it available to be used again by using schemata, reflection-on-action and critical thinking, when a similar situation occurs. They then assimilate the new knowledge with the previous knowledge, by using critical thinking and reflection-on- action-evaluation, and store it in their 'backpacks', for use in the future.

The participants in my study recounted these memories and ‘told stories’ during our interviews – to reveal to ‘me’ - their life experiences. In the majority, these stories had only ever been re-told to themselves - as a means to learn and to ‘make sense of and meaning’ of their own individual sacred moments in practice. In explaining the value of this type of previous experience for sense making, Teekman (2000) used the image of a ‘storeroom’ – “*with a stock of practical knowing...full of memorised situations, which could be accessed to evaluate the current situation*” (p. 1130). This metaphor could be used interchangeably with my own study use of the ‘backpack’. The notion of ‘framing’ was also used as a strategy by Teekmans’ (2000) respondents to ‘put things together in their minds’ in order to “*continue their journey*” (p.1130).

Arndt (1992) has stated that stories help focus attention on the taken-for-grantedness of practice and through turning to everyday practice, caring can be revealed. Many other nurse researchers also believe that caring which is often hidden and undisclosed to the public and other nurses, can be revealed through storytelling and narrative expression, for example, Benner (1984 & 1991); Benner and Wrubel (1989); Bowles (1995); Boykin and Darbyshire (1994); Gadow (1999); Parker (1992); Parker, Gardner, & Wiltshire, (1992); Pamphilon (1997 & 1999); Sandelowski (1991 & 1994); Schoenhofer (1989); and Wiltshire (1995). These nurse researchers believe that nursing situations are revealing of nursing knowledge and practice and through sharing stories and narratives, knowledge and the creation of meaning, can be communicated. My study participants not only used their ‘Backpack Patient Stories’ to ‘make sense and meaning from experiences’, but also to ‘construct a knowledge base of skills, experiences and patient relationships’ and to ‘talk the talk’ – to communicate with colleagues and to teach others. These stories were an integral facet of linking, reflecting and learning from experiences throughout the participants nursing lives in order for them to be and become authentic and exemplary nurses.

Again, this literature review supported the constructs put forward my study participants using their backpacks to make sense and meaning from experiences; to construct a knowledge base of these situations and to tell stories to talk the talk with others. Implicit in this process was the use of critical reflection to place the experience into the long-term memory or participants backpack.

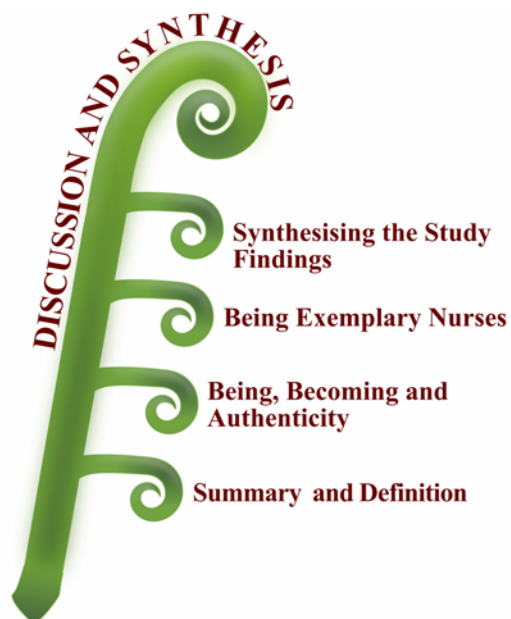
## **SUMMARY**

In this literature review the philosophies of several nurse theorists and the many different constructs that could be used to define ‘exemplary nursing’ were described and discussed in relation to this study’s findings.

This purposeful review illustrated and clarified that this study’s participants had attributes comparable to those described and called for by nursing theorists and other studies that depicted ‘exemplary’ characteristics and skills. Furthermore this study’s participants often went further and demonstrated and exemplified a holistic ‘Being’ – that they were more than the sum of their parts and integrated all aspects of themselves in order to B/be and B/become.

## **CHAPTER 7**

### **DISCUSSION AND SYNTHESIS**



In this chapter, I synthesise all the preceding knowledge gained through the study findings and their relationships with the philosophical constructs of Being, Becoming, Authenticity and Exemplary Nursing. I state my own views and theorising on the relationship of these constructs and present my definition of B/being and B/becoming an Exemplary Nurse.

### **SYNTHESISING THE STUDY FINDINGS**

In this study, the pivotal construct to B/be and B/become an Exemplary Nurse was being authentic through living reflective lives. This was related to their Love of Nursing, Making a Difference, Critical Friends, Walking the Talk and the use of Backpack Patient Stories.

Being (ontology) and knowing (epistemology) are concerned with being human, being a nurse and being with others. Drawing on the work of Heidegger (1962), the nature of 'B/being' in this thesis was multifocal. The study participants were 'being' exemplary nurses as they practiced the caring of nursing. They also were fully aware of their own 'Being' and how they sustained this, balanced their lives, and how they impacted others. There was a spiralling interconnectedness between their 'being' and their 'Being'. This was realised through reflection in/on their actions and a balance between their 'self' and 'others' – an authentic presencing – an embodying – a B/being-in-the-world.

## **A Love of Nursing**

The participants Love of **Nursing** was a prerequisite construct to being and becoming an exemplary nurse. This was a complete amalgamation between their personal love of nursing and the social 'privilege' to be part of their patient's lives. Through critical reflection they acknowledged their enjoyment and recognised that it was a reciprocal caring that was sustaining and nurturing rather than destructive and co-dependent.

## **Critical Friends**

Critical Friends, such as mentors, role models and like minded friends were influential for the participant's social and personal being and becoming. These people were moral arbitrators and supporters of the participant's own Being and their nursing being, and encouraged them to B/become. They often 'saw' the participant's attributes before they themselves had this recognition. In particular Charge Nurses had a huge influence on all of the participant's nursing lives, often being the ones that pushed them into their specialty areas, encouraged them to take up further studies in these areas and to apply for more senior nursing positions.

The participants used the good traits of other nurses around them to integrate into their own B/being and communicated with like-minded friends to critically examine and reflect on their practice. Critical friends supported the participant's confidence in being able to B/be, B/become and practice in a fully authentic way.

## **Making a Difference**

Making a Difference in their patient's lives sustained the participant's in their own practice. By being the best they could be; through continuous learning, being on top of things and in control, and always going the extra mile, they were able to have a sense of the patient's experience. This enabled them to have caring communications and connections, while respecting and recognising that these experiences belonged to the patients. This interrelationship between the internal personal sustaining and the external social dimension of being the best nurse they could be epitomised the authentic nature of the participants.

## **Walking the Talk**

Walking the Talk was a combination of the participant's personal and social B/being – practicing what they preached. Because they were confident in their own Being, they were able to be authentic when communicating with their colleagues. This enabled them to be firm when dealing with conflict, while also 'seeing' and supporting the 'B/being' of their colleagues. They were aware of their own exemplary skills and used them to encourage others to be the best nurses they could be. This was an ongoing characteristic and they were leaders who not only changed and implemented innovative practice, created environments and teams that got the best out of people, but also kept abreast of, became involved with, and integrated politics into practice. They nurtured their colleagues and supported them to B/be and B/become Authentic Exemplary Nurses as well.

## **Backpack Patient Stories**

A full integration of the participant's personal and social B/being occurred during the construction and consequent remembering of their Backpack Patient Stories. These significant stories were used to construct a knowledge base of skills, experiences and relationships with their patients and to talk the talk with their colleagues. Each backpack story was important for the participant who carried it and stayed with them, providing a moral imperative to continue providing exemplary care for the patients and families they cared for. These sacred moments in practice were memories that linked together the continuity of their lives. As a way of incorporating their experiences into their ongoing journey, they used these stories to make sense of and meaning of their B/being.

## **BEING EXEMPLARY NURSES**

The participants had multiple skills and attributes that made them be able to practice as exemplary nurses. These included many characteristics that prominent nurse theorist described such as demonstrating: Roger's continuous, mutual simultaneous negentropic emergence; Newman's evolving consciousness; Paterson and Zderad's unfolding becoming through authentic reflection; Parse's Intentionality and Human Subjectivity; Benner's expert nurse qualities and Watson's major assumptions of transpersonal caring and their becoming nursing's ontological architects.

Additionally the study participants portrayed and described many other qualities that were reported in the nursing literature related to expert nurses, presence, ordinariness, goodness, caring and story telling in nursing.

### **BEING, BECOMING AND AUTHENTICITY**

The participants in this study were authentic in all senses of the word - it was a joining of their social consciousness and their personal consciousness. They looked critically at themselves through both personal self-reflection and social discussion with critical friends. This was part of their authentic nature and the way they practiced both their nursing and non-nursing lives. They understood themselves – they knew what sustained them and they practiced from their ‘wholeness’. It was about knowing themselves and being themselves – joining the professional with the personal and being aware of their impact on others. By doing this they were authentic practitioners and were able to go where others feared to tread. They used critical self-reflection following significant relationships with others and placed these in a ‘backpack’ to make sense and meaning from them, to construct a knowledge base, and to use them for the future. They were aware that their inner feelings and decisions were important but they were also aware that they lived in a world with others and that their actions would always ‘speak louder’ than the words in their heads. Reflection was focused on themselves and their relationships and impact on others – they constantly balanced their personal aims along with the social gains for others. They described times of doubt, impostorship and lack of confidence in their own Being. These self-reflections were used to evaluate their B/being and to check they were being the best nurses they could be and to never take themselves for granted. As they stated, they were conscious that to B/be and B/become an Authentic Exemplary Nurse was a “Combination of being able to be yourself – be your own person – and be the nurse”. In this way they were able to fully B/be-in-the-world.

They were also aware that to B/be and B/become was a constantly revolving journey. It was important to have balance in their lives and to achieve this they often needed to make changes or move on in order to maintain equilibrium between their nursing being and their own Being. Additionally, being exemplary, was an ambition that would take a life time to realise - if it was achievable at all. For the participants this was an aspiration. They were conscious of the fact that they could be exemplary in the moment or during a particular situation but they could never be fully exemplary as this would

mean that the journey was finished, that all knowing had been reached and there were no more challenges ahead. They concurred with Freire, who stated “...*men as beings are in the process of becoming – as unfinished, uncomplicated beings in and with a likewise unfinished reality*” (1987, p. 57). Despite knowing this, they acted purposively towards ‘becoming’. As Guignon (2004) said “*the self is something we ‘do’ not something we find. We are self-fashioning beings*” (p. 127). Heidegger (1962) also believed that being a self was an achievement rather than a prearranged outcome and was something people needed to ‘do’ rather than be found and John Macquarrie (1982) alleged that people should not concentrate solely on a “*human being*” but a “*human becoming*” (p. 2). In this study, being exemplary was also not something the participants could automatically ‘become’ – it was something they had to try to ‘B/be’. Their journey was about ‘doing’ something, not just ‘being’ something – it was about putting their consciousness into action.

Despite consciously working towards ‘trying to be’ exemplary nurses, the participants did make mistakes and errors in practice. While the participants always recounted these stories with discomfit, they were also aware that nobody is faultless. They recognised, as Gaut (1992) stated, that “*Being human is not perfect*” (1992, p. xv). Therefore, these mistakes, like all their experiences, were reflected on and learnt from. They were placed in their backpacks to provide an ongoing reminder of their learning, as a moral imperative not to make the same mistake again and to teach others.

Being and becoming is also related to time and place. The participants were able to B/be and B/become in a three dimensional time-space connection of past, present and future. Guignon (2004) called this human-lived-time. In the present, the experience of a situation existed not only in the current time but also as a point of intersection between future and the past. In this vortex, the contexts and actions of the participants were made comprehensible. Past experiences were carried in a ‘backpack’ as a set of resources to be taken forward to assist them in achieving purposeful actions, hopes and dreams and the future was understood as an open realm of aims and ideals that guided the participants, gave their actions a point, and let the past come alive to provide meaning.



## **SUMMARY AND DEFINITION**

Exemplary Nurses are an amalgam of many attributes, skills, experiences, and knowledge. They are not perfect but continually learn from their experiences to improve both their own lives and also the lives of those they care for. They are able to B/be and B/become through the thinking and understanding that occurred as they reflected on each personal meaning and the social interactions they had with those around them. As they balanced these experiences from the past and their encounters in the present they projected themselves towards their future.

### **B/being and B/becoming an Exemplary Nurse – A Definition**

*Exemplary nurses authentically embody being themselves with being with others – they are 'B/being-in-the-world.' Situated in human-lived-time they use experiences carried in their backpacks to actively be who they want to become. At the spiralling intersection between past and future they use their love of nursing and critical friends – to make a difference for those they care and to walk the talk with their colleagues.*

In the following chapter I present my concluding comments, including reflections on the research journey, my beliefs, reservations and limitations of this study. I also note the implications of the findings for nurses and the nursing profession and offer ideas for further research.

## **CHAPTER 8**

### **CONCLUSIONS**



In this concluding chapter I offer some reflections of the research journey and reiterate the key aspects. I recap the significant findings that emerged from the participants' stories and their assimilation and integration with the relevant and associated literature. Following this, I discuss the uncertainties and limitations of the research project. Finally, I identify some implications of the findings for

nurses and the nursing profession and offer ideas for further research. In writing this conclusion, I bring this study to a close, but like its inherent spiralling nature, it is only part of a journey for me, the participants and the nursing profession itself – an ongoing never-ending journey of discovery, reflection and becoming.

### **REFLECTIONS ON THE RESEARCH JOURNEY**

I commenced this study with the aims of illuminating the 'X Factors' of Being and Becoming an Exemplary Nurse and the lived experiences of being and becoming one. I wanted the participants to elucidate the phenomena through using a qualitative and participatory methodology, where negotiation would be a key aspect. In choosing to develop my own method based on the Constructivist Approach and Human Science Approaches, underpinned by Glaser's Emergent Philosophy, I used a method that was congruent with these aims.

I recruited ten exemplary nurses, through personal knowledge and the 'snowball' selection technique. In volunteering to participate, these nurses recognised their own 'exemplary' attributes. However despite this, some felt uncomfortable with the 'exemplary' label at the beginning of the research process. At this stage, we had no

precise definition of 'exemplary nurses', except the information that had been gathered by myself in an earlier literature review entitled 'Exemplary' Nurses – an exploration of the phenomenon'. However, as the research process continued and the participant findings were used to direct and consequently explore the associated literature sources - a comprehensive conceptualisation emerged. Here the major assumption inherent in the label – exemplary, was the notion of 'becoming'. This involved the integration of knowledge and experiences through 'reflection' on the day to day 'being a nurse'. Being exemplary was not about being perfect but learning from every experience and integrating it into 'becoming'. This notion was affirmed and favoured by the participants. In addition, by appending stories where mistakes were made and learnt from and including several participant 'backpack stories' in full, kept away from placing these participants on pedestals and also avoided the view that there is only one way to B/be and B/become exemplary.

The participants were interviewed three times and also provided additional information. As a result, data in this study consisted of nearly one thousand pages of transcribed interview text and the associated participant information such as poetry, writing and photographs. Additionally memos and notes were written by myself and recorded in Interview, Research Process or Ah Ha Journals. Further information accrued once the relevant literature sources were used. Management of this data occurred through utilising the computer package QSR NVivo. The use of this programme was invaluable. It allowed for storage and management of the raw data and then facilitated coding and categorising - while remaining 'grounded' in the whole text and its meanings. Once the coding and categorising had been completed, analysis and synthesis occurred through the use of writing as method. Writing became a way of knowing - assisting me to both discover and analyse. It allowed me to reflect on what was happening in the data and I was able to connect the various categories and themes together into a coherent and workable whole.

An important factor in the assimilation of the categories and themes into the whole was the issue of negotiation and voice. I strongly believed that these findings should be in the participants' voices with only some linking, clarification, and illustrative points made by myself. I wanted the findings and the final integration and synthesis with the literature to be fully 'grounded' in the participants stories. It was important that the reader should be able to track through this process - from the choice of an appropriate methodology and method that supported participant-researcher co-operation; through

the emerging and grounding of the findings; to these findings directing the review of relevant literature sources and the subsequent synthesis, discussion and integration.

Review of the relevant literature sources and their synthesis was a circuitous process by which the study findings fully directed the literature search – which were then described and discussed in relation with them. They were not used to expand or enlarge these findings but to enlighten, illuminate and clarify. Important ideas found in these literature searches were: the notion of being and becoming through time – specifically human-lived-time; that being exemplary was an authentic embodiment of being self with being with others – a true B/being-in-the-world; that there were specific and fundamental interrelationships with the study findings, several nurse theorists own philosophies; and notably - the major constructs – authentic being through living reflective lives, love of nursing, critical friends, making a difference, walking the talk and the use of backpack patients were significant elements in both the nursing literature and for B/being and B/becoming an Exemplary Nurse.

Once the research project was complete, it was then important that I re-presented this text in a way that was accessible to the readers – including the participants and the lay public. I wanted the participants to feel happy to recognise their B/being and B/becoming and the notion that it was a forward moving spiralling journey related to past, present and future in the moment. For the lay person, I wanted them to understand the privileged world nurses share with their patients and to appreciate the ongoing nature of B/being and B/becoming exemplary. And while this thesis has yet to be shared with the wider public, critical friends have read, acceded and celebrated these thesis findings.

## **LIMITATIONS**

Despite a general accedence of the research, there are number of limitations that occurred throughout this project. These included the ethical issues of using the participant's real names or pseudonyms and managing emotion when the participant's recounted stories of significance. There was also the question of temporality and its effect on the participant's stories over time and the acknowledgement that context played a smaller part than I had imagined. Finally there was the issue of where to put the struggles of being an exemplary nurse. These issues and concerns were continually

highlighted and recognised by me throughout the research process and addressed when appropriate.

## **Ethical Issues**

An interesting ethical dilemma to come out of this research project was the use of real names or pseudonyms when presenting the research. It was an important aim of this research that it gave something back to the participants themselves and that they recognised and celebrated their exemplariness. Therefore I believed it was imperative that they could choose to use their own first names or not for this thesis publication. This was stated in my Ethics application and was approved by the HEC of VUW. To this end, some of the participants have used their real names and some have not. Due to a condition of sampling – that of initial selection of personally known exemplary nurses and the consequent use of ‘snowball participants’ - there is the potential for participants to be identified. This is also exemplified by the study taking place in the South Island of New Zealand with its population of approximately one million people. Taking this into consideration, each participant was regularly asked about the use of names or pseudonyms and changes were made accordingly. I also excluded most personal and identifiable information and removed or amended material at their request, after they had reviewed their quotes in text at the various thesis stages.

Another ethical issue was the evocation of painful memories that surfaced for the participants during the telling of significant stories. Sometimes these stories were concerned about the participant’s family such as the death of a family member, relationships with partners or becoming a mother or grandmother and how these had impacted on the participants own being. Other significant and emotive stories included the sudden realisation that specific colleagues had been a powerful influence on them and their being and becoming. A common retelling was stories of patient’s deaths and the significance of their first cardiac arrest. These stories were noticeably emotive for all the participants when they shared them with me during the interviews. Unexpectedly and unpredictably to both myself and the participants was the re-telling of mistakes in practice. This feature was acknowledged by the participants when they reviewed their first interview transcripts, with many stating how unusual it was that in an interview aiming at finding and illustrating exemplary behaviour, many of the stories were negative and about errors in practice. While a first response was to feel uncomfortable and some declared that they weren’t exemplary nurses and shouldn’t continue the

interview, it soon became obvious that the mistake was not the actual reason they were carrying it in the backpacks. Instead, these stories were retold because of what the participant's did after the mistake – how the incident had affected them and changed their practice. These sacred moments in practice had transformed the participants into being and becoming who they are today. When the participants showed emotion during the interviews I acknowledged their feelings and asked if they wanted the tape stopped. Often I went ahead and stopped the tapes and we would have drink break. We then talked about the issue and resumed the interview when they were ready. After these types of episodes I would check that they felt ok and always re-checked with them about it before the next interview.

## **Temporality**

The issue of temporality or the context of time was an interesting issue both through the length of time taken to undertake the project and then as depicted in human-lived-time and its relationship with the participants past experiences and memories. This concept of reality was an inherent notion in the research methodology and is an important point to restate.

Time was a context to the participants' joint constructions as it may have affected remembering, recalling and the telling of stories. As the research project took over five years to complete, new experiences were continually occurring for the participants that could have affected their memories of past events as well as changing the stories already told. Participants chose the stories to tell and which aspects they wanted to talk about. This re-calling relied on both their conscious choice of content and the actual facts that they 'could' remember. This study was acceptant of the fact these were subjective and individual. Each of participant's stories had been constructed by various influences over time and none was 'better' or 'more true' than another. It recognised that the participants may not hold the same construction forever and that this research will remain 'true' only for a 'time'. However, despite these limitations and the fact that the realities may have been different for each participant, similarities and joint constructions were possible, with one pivotal construct and five major constructs emerging as consensus constructions. The participants were asked their feelings on these and concurrence was reached and recorded as issues of trustworthiness.

## Limitations of Context and Lack of Nursing Action

An unexpected limitation that surfaced during the participants final interviews was the issue of context and nursing action. An axiom of this study was the use of a natural setting and the acknowledgment that physical context would play a limited role in the study. However several of the participants were surprised that many physical nursing actions, such as touch were not illuminated, nor was there much about political awareness and action for change. While emergence was a priority which allowed the findings to emerge from the ground up - the negative side was that some of the ordinariness of nursing was lost. As Janet stated *"It's like breathing. You're not going to ask people how they were breathing – it just happens!"* (Janet, 3<sup>rd</sup>, 1, 3-4).

Sharyn noted that touch was missing from her stories, stating:

*Rubbing a hand up and down a patient's back who is breathless or placing a hand on their shoulder has become a more natural part of my relating and caring for patients.* (Sharyn, 3<sup>rd</sup>, 2, 1-2).

Liz also noted that her physical being was not portrayed in her stories, stating:

*For the first many, many deaths that I experienced I would hold my breath when they died. I was conscious of doing it and I would think Oh!, I am holding my breath.* (Liz, 3<sup>rd</sup>, 2, 1).

In discussing this issue further with Janet, she stated that questioning the participants on the physical actions they were doing, may have illuminated it more:

*I suppose in a way you form a picture in your mind when you are listening to us talk and sometimes the behaviours of the nurse and the actions they are talking and how they are seated – what they are actually doing might be missed. You could find out if you asked them some questions like "Tell me what you look like or what you are actually doing when while you are doing this?". And they might say "Well, I always sit here and I do this". So they would then have to describe what they are actually doing or what they looked like in that story. I don't know – you may have pulled some things out but I don't think it's a failing I think its something about retrospect – if you knew what you knew now – you know?* (Janet, 3<sup>rd</sup>, 2, 1-4).

Ellen also noted at her third interview that many significant aspects related to action were not addressed in the findings. In particular those aspects of political awareness and action for change. In accepting this limitation I also believe that in deciding to use both an emergent and Constructivist Approach there will be both consensus and disparity in the participants constructions. Also when using qualitative approaches the sample is small and generalisation of multiple meanings was not the aim. Instead the goal was to

understand and illuminate Being and Becoming an Exemplary Nurse through the emergence of consensus core constructs.

## **The Struggle of Being an Exemplary Nurse**

As noted in Chapter 2, questions related to the struggles of being an exemplary nurse were not formally asked in the second interviews, despite being highlighted in the letter of information. In spite of this, many of the participants mentioned their struggles throughout the first two rounds of interviews. Primarily they struggled with the system and its impingement on being able to make a difference and its connection with balancing their personal and professional lives. If issues around struggles were mentioned in the interviews they were typically coded and categorised under the heading Authentic Being – Being is a Constantly Revolving Thing and Creating a Balance and Moving On. Despite these struggles being coded and categorised here, several participants mentioned this aspect again at their third interviews and Ellen stated that this issue was not fully integrated into the thesis findings. She noted several times during this final interview that being an exemplary nurse was a struggle. She often used the words *“frustrating”, “discomfort”, “challenging and pushing”*. She stated that *“strength comes from a sense of what’s not right”*, and she believed that she had become *“tough – really tough –which makes exemplary nurses what they really are”* (Ellen, 3rd, 11, 12-17). Despite these limitations she acceded that the findings were congruent and she also acknowledged the issue of ‘ordinariness’ – where the everydayness of nursing could have been assumed, stating *“it may be that people are too familiar with it so that it doesn’t come up”* (Ellen, 3rd, 11, 23). While this is true, many of the situations described by the participants were identifiable for people and place and therefore I did not use these quotes to exemplify the concept. I also realised that their personal lives were an important feature to this balance and I believed it was unethical to share these personal stories. While this could be construed as being paternalistic and as Ellen (3<sup>rd</sup>, 11, 31) stated, *“romanticising exemplary nurses”*, I accept this critique and place it as a limitation in this research.



## **SIGNIFICANT FINDINGS, IMPLICATIONS FOR NURSES AND THE NURSING PROFESSION**

There were several significant findings that emerged from this research. First was the notion of Authentic B/being – the balancing between the personal and social which was achieved through critical reflection, enabling a true B/being-in-the-world. Secondly was the actions taken by exemplary nurses such as their love of nursing, using critical friends, making a difference, walking the talk and using a backpack of patients' experiences – where they assimilated every influence on their lives to be and become exemplary. These two concepts were situated in the realm of human-lived-time, where the actions of the present were integrated with past experiences (carried in a 'backpack') and reliant on prospective goals and ambitions of the future to be and become. These findings are significant and novel. They are important for the nurses and the nursing profession and advance nursing knowledge.

### **Implications for Nursing and the Nursing Profession**

Authentic Being was the mechanism by which exemplary nurses balance their personal and social selves and subsequently move through their lives – reflecting, learning and adding more experiences as they 'become'. While the nursing literature and many nursing theorists agree that authenticity is an essential aspect of nursing practice I believe this study highlights and illuminates this notion in far greater depth than previously reported. Most importantly it relates this notion to the actual actions of everyday nursing – balancing these with the nurses own personal and social knowledge gained through critical reflection, interactions with critical friends and colleagues, and past experiences carried in backpacks. This knowledge allows exemplary nurses to recognise their love of nursing and to acknowledge that making a difference sustains them in their practice. An important feature for nurses and the nursing profession is this reflection and the need to ensure that nurses are supported, educated and encouraged to reflect **critically** on all aspects of their practice. Within this framework nurses and the profession need to be respectful of individualism and supportive of those nurses who live their reflective lives in order to be authentic. Nurses are not all alike and there are many paths to Being and Becoming an Exemplary Nurse. This notion needs to be paid attention to by nursing educational institutions, hospitals and those that accept and assess nursing students and registered nurses alike – there is not one way to become an

exemplary nurse. What is important is that these nurses are supported to be authentic. Moving on from this idea, all nurses need to be made aware of the importance of balance in their lives and the profession needs to support nurses to achieve this. This is especially important for assisting nurses to continue giving exemplary care while child rearing or caring for family. Nursing positions need to be more flexible and accommodating of the spiralling nature of life's journey and accept that these ups and downs are a natural part of the order of life. If institutions and hospitals accept this notion they will be rewarded by nurses who are sustained in their practice, enjoy making a difference and act as role models for others. If they do not 'exemplary' nurses will continue to move on in order to find the balance they require.

The five key constructs of love of nursing, critical friends, making a difference, walking the talk and backpack patients are all important notions for nurses and the nursing profession to recognise. Together these constructs make up more than the sum of their parts, especially when they are linked with being and becoming authentic. Using these constructs as building blocks for knowledge and learning, would be a novel and innovative way to teach and assess nurses and nursing. Within Love of Nursing such issues as the importance of feeling comfortable nursing and the privilege of caring did not occur until the nurses were out in practice areas. Therefore, it is important that nurses are given the chance to work in different practice areas and to reflect on the area that suits their personality and characteristics before they choose their specialty area.

Critical Friends such as mentors have long been identified as important for nurturing nurses. Notably the profession needs to be aware of the significant effect of **Charge Nurses** on nurses and their careers and the notion of pushing colleagues and mentees beyond their boundaries in supportive ways. Encouraging nurses to have critical friends with like minded attitudes is also an important issue for 'becoming'. Making a Difference was a crucial feature for exemplary nurses. The knowledge that doing their best sustains nurses in their practice is an important notion for the profession to be aware of. Ongoing education and learning was a vital part of making a difference and explicating the practice phenomenon with the theory may encourage more nurses to undertake continuing education in the knowledge that it affects both their practice and their own being. Walking the Talk by being a good leader is well known in the nursing literature and this study reiterated its importance. Of significance was to lead by example by being authentic at all times. Authenticity in leadership enables nurses to challenge and teach colleagues in both a meaningful and effective way. Finally, the

unique idea of backpack patients is a useful mechanism for nursing to adopt. Promoting useful reflection on practice, meaning making, construction of knowledge and teaching others are all important issues for nurses and nursing.

Of equal importance is the idea that all nurses have the potential to 'become' more and to strive to be exemplary. While the term 'exemplary' is an oxymoron – only able to be achieved in the moment - by using the notion of human-lived-time, nurses can aim to 'become' more. Here, the future is seen as an open realm of aims and ideals that guide and give actions a reason. It uses the past as a set of resources to be carried forward in order to achieve these goals and views the present as a point of intersection between past and future. The context of all actions are understood through reflection - what is made accessible from the past and carried in the memory or 'backpack'. Human lived time is both linear - in that it has a forward moving projection - but it is also circular and spiralling as it goes back and forth between the meaningful possibilities of action opened from the past and the range of goals that are exposed in the future. This spiralling action is the being and becoming of an exemplary nurse. Of course all nurses do not become exemplary, but I believe that if nurses are able to have balance in their lives and are supported and encouraged to maintain authenticity – their lives will be fulfilled, their practice will be sustained and consequently their nursing will be valued.

## **FURTHER RESEARCH**

Following on from both the limitations addressed and the implications for nurses and the nursing profession, there are several further research areas that could be explored to answer both the critique and the questions.

Primarily, a different method would shed light on different aspects of Being and Becoming an Exemplary Nurse. As an emergent project, this research gives a great base from which to ask precise questions about any area of interest identified. A larger study could illuminate and explore the effect of upbringing and childhood on being and becoming nurses. The issues of context and the struggles of being an exemplary nurse could also be addressed and clarified in this way. Specific inclusion of Maori or Male nurses may also illuminate further data.

Another important area (which was beyond the scope of this project), was the notion of the backpack. A study examining this phenomenon and its relationship with memory

and critical reflection would be very interesting and a useful tool to describe and use for nurses and the profession.

Finally, illuminated by the in-between of being and becoming, is the issue of non-exemplary nurses. Is there a place for the nurse who does an adequate and safe job but does not wish to expand their horizons or move forward? This is an important question for the profession to answer, and was asked of me by many audiences when presenting my preliminary findings from this research.

## **FINAL COMMENTS**

This research project has been a significant part of my life for over five years. By using a qualitative methodology which emphasised emergence I needed to ‘trust the process’ and feel confident that the findings would unfurl. In holding this philosophy to the fore throughout this journey, I believe the phenomenon of B/being and B/becoming an Exemplary Nurse has been illuminated. This process required ongoing commitment by both myself and the ten exemplary nurse participants, as our lives were also spiralling as we participated in the project. The willingness of Chris, Jayne, Liz, Kirsten, Joc, Janet, Kate, Sharyn, Anna and Ellen to share their stories and lives with me has been a true gift. I feel privileged to have heard their stories and used them to uncover and illuminate Being and Becoming an Exemplary Nurse. And while these nurses are part of a joint construction I wish to reiterate that they are individuals, albeit on a similar journey. As de Lint (1994) aptly said:

*Everything in between is a journey...a journey that can be documented and even held for a time, but never truly owned. Truth lies only in the vision that called up the creation and the memory of it that one takes away after it has been experienced, coloured by each person's individual life experience. No two people are the same, so no two people can remember it the same way. Art is reborn each time a new individual experiences it.(p. 579).*

Like de Lint's art, this thesis – depicted as the symbol of a fern - will be also be unfurled and reborn each time a different person reads it and experiences it. I realise that while this particular project draws to a close, it is only part of a bigger journey. Like the koru that illustrates the spiralling shape of this thesis, it is also reflective of an ongoing, never ending project – that of ‘B/becoming’ ~ for you, for me, the participants, other nurses and the nursing profession itself.



In conclusion I leave you with a photograph taken in the garden of The Graduate School of Nursing and Midwifery, Victoria University of Wellington – the image of a curled koru on a background of the unfurled and beautiful New Zealand Silver Fern.



## **APPENDICES**

### **APPENDIX 1.0: Personal Philosophy of Nursing Practice**

In this paper I make a statement about my personal philosophy, values and beliefs of my nursing practice, culminating in the distillation of the aesthetics of my practice – a poem and painting.

*(The text in this type script and italics was written before I commenced a literature search and depicts my innate and intrinsic ideas about my philosophy).*

*“What is central to my nursing philosophy? To me caring is the central tenet. Caring describes the way in which I use my knowledge to provide physical, emotional, spiritual and cultural care. This ‘doing’ of caring is based on my experience and knowledge. How I know what I am doing is right is based on both my own intuition/personal ‘just knowing’ and guiding ethical guidelines and how this is all put together is the art of my nursing practice. It encompasses such traits as respecting, commitment, sharing, connecting, valuing, being there, guiding and working as a team/partnership (the patient/family and I) towards a goal. In my practice this goal is not always cure or even wellness but to a dignified and/or peaceful death, in whatever guise that takes for the patient and family”.*

Many of these epistemological beliefs are based on the ways of knowing in nursing as described by Carper (1978), Munhall (1993) and White (1995).

*“To be able to care requires knowledge and skill”.* This is my empirical knowing (Carper 1988). *“It is important to me that the physical aspects of care are performed with skill and competence”.* I do not fully concur with Watson (1988) that the truly caring nurse only forms unions by transcending the physical aspects. In describing the processes involved in caring she emphasises the emotional, psychological and spiritual dimensions of care almost to the exclusion of the every day physical tasks of nursing (Morse, Solberg, Neander, Bottorff, & Johnson, 1990). While I believe that reducing patients to objects or their separate physical parts is not viable, I cannot fully concur with the view of the patient as a disembodied energy field, as I believe that physical care and the embodiment of the patient is extremely important (Benner & Wrubel 1989; Thorne, Cannam, Dahinten, Hall, Henderson, & Kirkham, 1998). While I understand where nurse theorists are coming from in their existential theories on the

nurse-patient relationship (Parse, 1992; Paterson & Zderad, 1988; Rogers 1970, cited in: Meleis, 1997; Watson, 1988;), I believe that they over-emphasise the psychologisation of the nurse patient relationship of nursing (Webb, 1996). Like Dunlop (1986), Phillips (1993) and Thorne et al. (1998), I believe that this tendency towards ‘disembodied caring’, which many nurses are using to distinguish their practice from medicine, goes against the very holistic caring practice that they are pursuing. Holistic care is important for my practice and encompasses physical, psychological, emotional, spiritual and cultural aspects (Pusari, 1998).

I also believe that the initial nursing focus - on the mind-spirit or the body (Watson, 1988), is dependent on the care setting (Benner & Wrubel, 1989; Webb, 1996) or the reason for the patient’s admission into the setting (Thorne et al. 1998). In my practice, most patients have a physical reason for being in hospital and their immediate concern is for relief from that problem rather than to instigate a meaningful relationship with the nurse (Salvage, 1990). This has been confirmed by patients in several studies when they were asked to rate nurse caring behaviours. Patients consistently ranked the clinical/physical/technical aspects of care as the most important (Gooding, Sloan, & Gagnon, 1993; Halldorsdottir & Hamrin, 1997; Larson, 1984; Mayer, 1987). Therefore, in my practice, being very confident and competent in my technical or physical care performance is extremely important. Like Roach (1984) and Pusari (1998), I believe that competence is having the knowledge, skill, energy, motivation, judgment and experience needed to respond to a patients need. Like them, I believe that a nurse must have competence and confidence to enter nursing situations in a meaningful way. This is both the embodiment of function and the ethic of nursing.

My personal knowing encompasses knowing the self and others and being willing to know more about the self and others (Carper, 1978; Paterson & Zderad 1988; Roach 1987). For me, ‘being there’, ‘connecting’ or ‘presensing’ (Benner & Wrubel 1989; Heidegger, 1962; O’Berle & Davis, 1992) is an important caring behaviour.

*“I feel when I stand at the nurses station that I have all these pieces of string attached to my hands, that have come from up through my heart from my brain, that are attached to all my patients (not necessarily in-patients) and a lot of the time I sense or just know when they need me. I go to their room or I ring them and - they needed me”.*

Simons (1987, cited in: Benner & Wrubel, 1989) describes the presence of the nurse as not only mere physical presence but also reflects being ‘in tune’ with another, an awareness of the others uniqueness that is perceived by patients as caring.



*"When I have had a particular close and caring relationship I feel these patients when I am at home, I always know if they have died. How do I know this? I think it is because I care".*

This 'feeling' relates to Watson's (1985) theory of human care where the mystery of being in the world acknowledges the three spheres of being – mind-body-soul which are not defined by time or space. This 'intuition', 'sensing' or personal knowing (Benner, 1984; Miller, 1995; Morse, Miles, Clark, & Doberneck, 1994) is an important part of my practice.

I also respect that I do not always know or understand something about another (Munhall, 1993). I 'value' the differences and individual beliefs of my patients (O'Berle & Davis, 1992). Each nurse-patient-family relationship takes time, concern and dedication on both behalves. Each experience is new and unique and understanding this is critical to the establishment of a meaningful nurse-patient relationship (Boykin & Schoenhofer 1989, Munhall, 1993).

Understanding the context of the particular nursing situation is also important, as is the cultural identity of the client (Benner & Wrubel, 1989; Leineger, 1988; Pusari, 1998; Ramsden, 1994; White, 1995). This is especially so in my practice of nursing in Aotearoa, New Zealand. Heidegger (1962) states that background meaning, is what culture gives a person from birth and is a way of understanding the world. Therefore I believe that in an attempt to know another it is important to understand their cultural background.

Like Noddings (1988) I believe that commitment is an essential ethical element for caring. This commitment has been described by Roach (1984) as being the ability to realise and assess another's being in the world and to feel a union with another. Heidegger (1962) calls this way of being 'concern' (Benner & Wrubel, 1989). He believes that concern is a key characteristic that allows the embodied understanding and background meanings for the patient to be known by the nurse.

*"...concern is a way of caring about patients that enables taking care of patients. Concern situates the nurse so that what is salient about the patient and about the patients' situation is apparent. Concern determines salience and is the basis for gaining knowledge...A nurses' concern can make both the patient and the patients' medical situation interpretable. A nurse's concern can make medical interventions possible for and understandable to a patient. And a nurse's concern can lead her or him to understand a patient's concern and champion that patient when further interventions are known to be painful and useless. Concern is caring... ". (Benner & Wrubel, 1989, p. 96).*

I am a dedicated nurse, both in that I am dedicated to being the best nurse I can be and providing the best care that I can. Similarly to commitment, dedication is considered an aspect



of caring that motivates nursing actions (Bevis, 1981, cited in: Morse et al. 1990). The primary response of dedication is centered on increasing intimacy between the nurse and patient, without which caring does not occur (Bevis, 1981). Like commitment, respect is very important in my practice. I concur with Noddings (1988) that the nurse must respect the patient's right to self-determination. Like Gadow (1985) and Watson (1988) I also believe that dignity is important and I demonstrate this through a commitment and respect for human life by expressing non-paternalistic values related to human autonomy and freedom of choice.

Guiding, teaching or 'coaching' (Benner, 1984; Benner & Wrubel, 1989) is an important part of my relationship with the patient and family. It is about using my expert knowledge and skills and my personal knowing of the patients' background and understanding of their particular situation to facilitate the patient and their family through their experience (Benner & Wrubel, 1989). It is about respecting their goals and wishes and working together in a partnership (Christensen, 1990). In this way nurses act as cultural mediators and serve as coaches for patients, making the strange and unfamiliar, approachable and understandable (Benner, 1984).

*"I also believe that this caring is often reciprocal. I am not sure the word to use in this case is care. But these patients give of themselves to this relationship, they trust, they share they communicate about some of the most painful and sacred things. This makes me feel privileged. As I care, they care, as they care, I care, it is like a circle".*

In this instance I concur with Peplau (1952), and Watson (1988) who believe that caring affects both the patient and the nurse. Watson (1988) believes that nursing within a transpersonal caring perspective attends to the human centre of both the one caring and the one being cared for, embracing a spiritual, even metaphysical dimension of the caring process. She believes there is a reciprocity between persons that allows for unique and authentic presence in the world of another. Like Buber (1970) and Paterson and Zderad (1988), this togetherness in the caring I-Thou encounter, facilitates growth, creates meaning for the experience and potentiates transcendence. According to Parse (1992) through being with another, connectedness occurs and moments of joy are experienced by the one being cared for and the carer. The ontological 'being' of caring espoused theorists such as Paterson and Zderad (1988), Watson (1988) and Parse (1992) have the common elements of the importance of authentic presence and connectedness between carer and cared for. They believe that caring in nursing is viewed as a mutual human process (Boykin & Schoenhofer, 1989).

*"But what makes me care? What makes me say, listen, do the things that are taken by the patient as caring? That is difficult to answer right now. I know I have always cared, I have always known what to say and when to say it and when to laugh and when to cry and when to hug and when to listen and when to be silent. I have known these things since I was a probationary nurse. This is the first time I have verbalised these things. I remember being in London, doing my BSc (Hons) and first reading 'From novice to expert' (Benner 1984) on the tube to and from work. Yes it was amazing, amazing because I knew those scenarios, those exemplars; I had been there and done that. Imagine here at last was 'intuition' being recognised as legitimate practice. But it was recognised as expert practice. Yes I agree these attributes can be paired with expert but some, like me, felt and acted like this when they were new nurses. I had been 17 1/2 years old when I started nursing so I didn't bring worldly experience with me. Where did it come from?"*

Roach (1987) would answer that by stating that the capacity to care is innately human, the human mode of being. She believes that *"caring is the human mode of manifestation of being"* (p. 45) and *"entails the capacity or power to care, a capacity linked with and inseparable from our nature as human beings"* (p. 47). Leininger (1988) and Benner and Wrubel (1989) concur and believe that caring is the motivator of nursing actions and is a basic way of being in the world. Roach (1987) and Benner and Wrubel (1989) also believe that one's ability to care is based on the acquisition of knowledge and skills. This is true and on reflection I am sure my intuitive abilities and caring ability has increased with experience but, for me, there was always this ability from the start of my nursing career. I like what Carl Marx (Cited in: Gaarder, 1995) says about this. *"Tell me what you do and I'll tell you who you are"* (p. 329). Marx believed that how we work affects our consciousness and in turn our consciousness affects the way we work. Therefore, the way we think is closely related to the job we do (Gaarder 1995). I concur with Larson (1992) who believes that *"the nature of your work acts as a powerful screening device, a filter that selects humanitarian, empathetic individuals who want to work with people .."* (p. 857). He states that words like 'dedicated', 'committed' and 'concerned for others' comes to mind when thinking about these types of nurses. For people like me, we feel a strong sense of purpose in our work, and we believe that caring for others expresses our deep values and personal goals that in turn direct us towards making a positive difference in the world (Larson, 1992).

Through the integration and synthesis of these patterns of knowing in relation to a particular situation, the aesthetic of my practice has been distilled (Boykin & Schoenhofer, 1989, Carper, 1978; White, 1995). As Boykin and Schoenhofer aptly state: *“Through the richness of knowledge gleaned, the nurse as artist creates the caring moment”* (1989, p. 152).

*“How I practice the aesthetics of my nursing can be described as having all this knowledge in my brain (knowledge-empirical knowing; knowing what is good and right-ethical knowing, and just knowing-personal knowing) this travels through my heart, and out through my hands to give both physical, emotional, spiritual and cultural care”.*

*This is my poem:*

*I stand within a circle of light  
The lamp of Nightingale a metaphor of myself  
It is not necessary to see the light  
Only that which it illuminates  
-the essence of my nursing self  
the kaleidoscope that is caring  
all extending from my being  
as spokes from a wheel, light from a lamp  
at all times connected to those I nurse  
-those for whom I care*

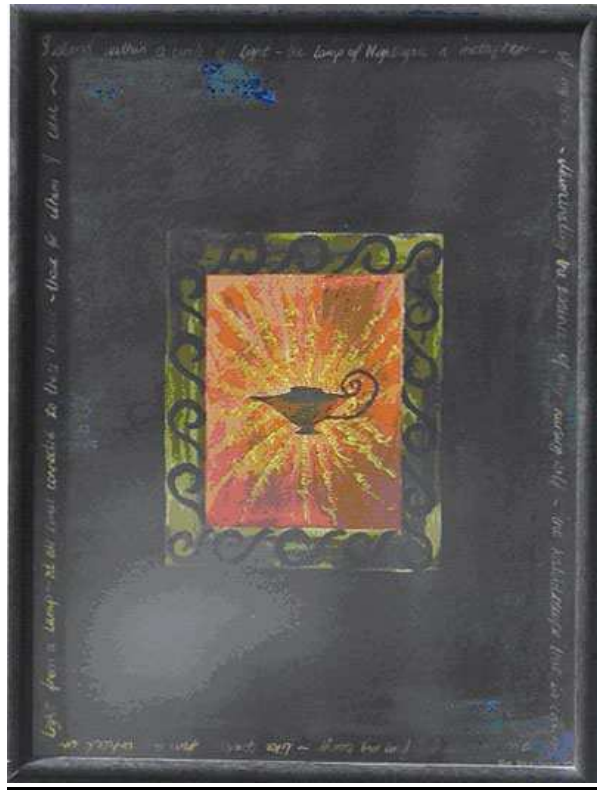
*Rae Noble-Adams (May 1999)*

I believe that art is important however, I consider that nursing is far more significant and as Henry David Thoreau said:

*“It is something to be able to paint a picture, or to carve a statue, and so make a few objects beautiful. But it is far more glorious to carve and paint the atmosphere in which we work, to affect the quality of the day – This is the highest of the arts”*

(Henry David Thoreau, cited in: Donahue, 1985, p. 1).

*This is my Painting:*



*The initial conceptual map for the painting was the belief that when I nurse I stand central to the patients for whom I am caring and that they are attached to me with pieces of 'metaphorical' string. Therefore I am depicted as Florence Nightingale's lamp, with the essence of my caring-being extending from the lamp as light beams, (which spell out the different words I use as caring) reaching out to my patients. The green surround has the koru (a symbol sacred to the Maori [indigenous people of New Zealand], which symbolises new birth/growth) depicted on it and this is reference to the fact that I live and nurse in Aotearoa New Zealand and practice in a culturally sensitive manner. The blackness, which surrounds this, represents the darkness of a world without caring, the bleakness of a patient lost in the dark without those who care. Finally the painting is circumscribed with part of my original poem.*

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## APPENDIX 2.0: Ethical Approval –Subject To...from HEC of VUW

VICTORIA UNIVERSITY OF WELLINGTON  
*Tē Whare Wānanga o te Upoko o te Ika a Maui*



### MEMORANDUM

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**TO:** Rae Noble-Adams  
Nursing & Midwifery

**FROM:** Graeme Kennedy  
Convener, Human Ethics Committee

**DATE:** 1 December 2000


**SUBJECT:** APPLICATION FOR ETHICAL APPROVAL: BEING AND BECOMING AN EXEMPLARY NURSE

---

Your application for human ethics approval has been considered by the Standing Committee of the Human Ethics Committee. The application is approved, subject to the following:

- 1 Please correct or amend the parts of the information sheets and consent forms as indicated.
- 2 The committee also found itself somewhat puzzled by the use of the term "exemplary". Some definition is needed so that participants know why they were chosen and who to recommend as further interviewees. But such definition presumably pre-empts the research. What happens if you do not agree with the basis which others use to select participants? This is not entirely an ethics issue (although it is relevant to informed consent), but the committee is aware of apparent circularity in the fundamental premise of your project.

Please send your amendments as indicated to the Secretary of the Human Ethics Committee for approval before beginning the data collection.

  
 G. Kennedy  
 Convener, Human Ethics Committee



## APPENDIX 2.1: REVISED ETHICS DOCUMENTS

### Appendix 2.1.1 Letter to HEC of VUW with required changes

16 Glenbrae Place  
Loburn  
2RD Rangiora

07.01.2001

Dear Mr Kennedy,

Thankyou for your letter of 1 December, approving my application for human ethics approval, subject to the requested changes to the study: Being and becoming an exemplary nurse.

1. I have corrected and amended the parts of the information sheets and consent forms as indicated.
2. I have also added the following paragraphs into the information sheet (Appendix A):

*"At this stage of the study it is difficult to exactly define the term 'exemplary', however the attributes you possess include: being a 'caring' nurse in the most holistic way possible; being altruistic, committed and dedicated to your profession; valuing the nurse-patient relationship and instilling others with your vitality and enthusiasm. In short you are a role model for your profession."*

*"I would also like you to share any other material that you think may help describe your way of being. These materials may be exemplars of you practice written as a 'reflective practice paper', letters about you and your experiences in nursing, or journal entries. These written materials will also be used in the data analysis."*

I thank you for your perception and understanding regarding the dilemma of defining the term 'exemplary' at the beginning of the study as indeed this will hopefully be discovered in the process. I hope the above paragraph is acceptable.

Regarding the query about what if I do not agree with the basis which others use to select participants, this should be minimised by the use of the constant comparative method of analysis. This method distills out the commonalties of the data, therefore if a participant depicts characteristics that are not shared with the other participants their data will not become part of the constituent theory/shared reality of the exemplary nurse.

I look forward to your reply

Yours sincerely



Rae Noble-Adams

## Appendix 2.1.2 Application for Ethics (Revised)

VICTORIA UNIVERSITY OF WELLINGTON  
*Tē Whare Wānanga o te Upoko o te Ika a Maui*



### HUMAN ETHICS COMMITTEE Application for Approval of Research Projects \*

#### Nature of Proposed Research:-

- (a) Staff Research    N
- (b) Student Research Y    Degree PhD (nursing)    Course Code NURS 691

#### Project Title: - (working title)

The X-factors - being and becoming an exemplary nurse

#### Investigators: -

- (a) Principal Investigator

Name    Rae Noble-Adams

School/Dept/Group

PhD Student, Department of Nursing and Midwifery, Victoria University of Wellington.

Any Professional Code of Ethics to be followed

(Name) .....

- (b) Other Researchers    NO
- (c) Supervisor (in the case of student research projects)

Dr. Alison Dixon, Head of School, Otago Polytechnic, Dunedin.  
 Honorary Research Fellow of Victoria University of Wellington.

Dr Margi Martin, Senior Lecturer, Nursing and Midwifery, Victoria University of Wellington.

Proposed Starting Date    February 2001

Proposed Date of completion of interviewing  
 February 2003

Proposed Source of Funding    Self funding

## Appendix 2.1.2 cont.

### Briefly Outline:

#### (a) The Objectives of the Project

The purpose of this qualitative research project is to explore 'being' an exemplary nurse and identify the processes that have occurred for nurses 'becoming' exemplary.

I will explore with the participants how they have become exemplary and how they perceive themselves as exemplary nurses. This is in order to explore, describe and conceptualise this phenomenon into a theoretical framework.

The research objectives in this study are:

- To develop a substantive theory on exemplary nurses
- To describe being an exemplary nurse
- To explore the relationships and processes that occur as these nurses are 'becoming' exemplary.

#### (b) Method of Data Collection

This research relies on the accounts of nurses who are 'exemplary' and the data they generate in order to develop a substantive theory. The research method will be informed by the qualitative interpretive methodologies of Life Story Narrative and Glaserian Grounded Theory.

##### b.i.) Design

- Nurses will initially be selected through the researcher's personal knowledge (i.e. previous experience working with these nurses) which has highlighted their 'exemplary' attributes as suggested by the literature relating to 'work excitement' (Simms, Erbin-Roesmann, Darga, & Coeling, 1990), 'positive energy' (Mabbett, 1987), and/or 'star quality' (Kendall, 1999).
  - I will make contact with the possible participants to ask if they would be interested in receiving information about the research project. If they express interest they will be contacted in writing to formally invite them to participate in the research project. A letter will explain that they have been selected to participate in the research project and will detail the proposed research and process (Appendix A). Participants who wish to co-operate will be asked to contact the researcher by phone. At this stage any questions can be answered and the researcher can gain verbal consent to continue.
  - Following verbal consent to participate, they will be sent a letter confirming their agreement to participate in the research (Appendix B.1), a biographical data sheet (Appendix B.2) and consent form (Appendix C).
  - They will then contact the researcher, or vice versa, regarding a suitable time and place for the interview.
  - The interview will take place after signing of the consent form.
  - Following the interview, participants will be asked to invite a colleague they know is exemplary to be part of the study.
  - Constant comparative analyses will commence after the first interview and will dictate further theoretical sampling and data collection.
  - Constant comparative analyses will continue until a core category and the associated conceptual links are created.
  - Sampling will stop after data saturation occurs.
  - Writing up of the thesis will take place.
-

## Appendix 2.1.2 cont.

At the beginning of a grounded theory study the researcher cannot cite the actual number of potential participants who will be required to reach saturation of the data. This is due to the nature of theoretical sampling (Glaser & Strauss, 1967; Glaser, 1978 & 1992). However it is likely that up to 12 participants may be interviewed and that each participant is likely to be interviewed up to three times. Sampling and re-interviewing will stop when theoretical saturation has occurred, that is, no additional data is found to develop categories or their properties (Glaser & Strauss, 1967).

Data collection will occur primarily through the elicitation of the participants life story narrative as viewed through being and becoming an exemplary nurse. Prompt questions will be used as needed during the interviews and will be listed on a semi-structured interview guide for the researcher (Appendix D). Before the participants arrive to be interviewed they will have read the study information guide and will have been asked to think about or 'jot down' some factors that may have attributed to them becoming an exemplary nurse. Subsequent interviewing guides will be directed by the previous data and will allow the researcher to ask direct questions relating to the categories (Glaser & Strauss, 1967). They will also be relatively unstructured in order to allow the elicitation of the participants personal viewpoints, preserving the flexibility required to follow themes and clear up any inconsistencies that may have arisen from the data (Stern, 1980). These interviews will be recorded and transcribed verbatim. A professional transcriber may be used to help transcription. The interviews will be transcribed as soon as possible after the interview and data analysis will commence immediately in order to facilitate simultaneous collection, coding and analysis and to provide further guidance for subsequent data collection (Glaser & Strauss, 1967; Glaser, 1978 & 1992). The participants transcribed interview will be copied for the participants who will be rung to validate the transcription.

Biographical data will be collected relating to the nurse's age, gender, ethnicity, years of nursing experience and speciality choices (See Appendix B.2). While they are necessary properties of the process under study, this data will not be assumed to be relevant until it emerges through the data as relevant (Glaser, 1978 & 1992). Each interview will last approximately one to two hours. Each participant may be re-interviewed more than once depending on the emerging theory and consent will include up to three interviews. If further interviews are required, this will be discussed and an agreement made between both parties.

### **b.ii.) Data analysis**

Each participant's audiotape will be listened in full by the researcher and transcribed verbatim.

- Initially the text will be looked at as a whole – at a Macro-zoom level (Pamphilon, 1999) analysing the dominant discourses, narrative form and cohort effect of the text.
  - This will be followed by Meso-zoom level - analysing the narrative process, narrative themes and key phrases of the participants; Micro-zoom analysis of pauses and emotions and Interactional-zoom where transaction and reaction are analysed (Pamphilon, 1999).
  - Working with the whole text and more in-depth 'zooming' in and out, will reflect the patterns and meanings of the narratives and identify interpretive categories that may be used to construct a substantive theory.
  - Theory will be generated by substantive coding. Substantive codes such as actions, reasoning and feelings will be derived from the language of the participant's transcripts using the Zoom model (Pamphilon, 1999) and informed by Glaserian Grounded theory (Glaser, 1978 & 1992). This process requires examination of the data line by line, coding words to describe these experiences, revising and re-coding, developing categories from the codes, constantly comparing the clusters to ensure they are mutually exclusive and comprehensive and linking categories and their properties to form tentative conceptual frameworks.
  - Categories are the consolidation of the first level codes. During category formation the researcher will hypothesise as to which coded data may be subsumed by an emergent category. Comparison of the emerging categories and their properties will allow for the development of higher order
-

## Appendix 2.1.2 cont.

categories that will be mutually exclusive and which will explain the other categories. During this stage the literature will be regularly reviewed in order to identify information that substantiates the emergent fit of categories and leads to the development of a conceptual framework (Stern, 1980).

- Theoretical constructs will then be developed which conceptualise the relationships between the three levels of coding.
- Constant comparative analysis will be employed throughout this process (Glaser & Strauss, 1967; Glaser, 1978 & 1992). This involves starting data analysis as soon as the data is at hand and comparing it continually with all new data emerging. This will allow for identification of similarities in coding and categories and facilitates conceptualisation of higher order categories by the comparison of coding, and their categories (Roberts & Taylor, 1998). Interpretation of the coding will be clarified during interview or at a later time and will be substantiated during subsequent interviews. This process continues by reduction, selective sampling of the literature and further theoretical sampling until no new codes or categories (saturation) emerges from the data (Baker, Wuest & Stern, 1992).
- The maintenance of a reflective journal will be used by the researcher during the research process and her own story will be written before participant interviews take place. Written memos will also be produced by the researcher as hunches and ideas related to patterns, themes and relationships are identified throughout the study and recorded immediately. In this way the researcher's intuition and insight will help to explain what is happening in the data. Memoing is intrinsic to the researcher role and may provide an additional focus for further sorting of codes and categories. The memos are always linked with others (which are grounded in the data) and then used as data themselves to be added to the rich conceptual scheme of the emerging theory (Glaser, 1978 & 1992).
- The computer software package NUD\*IST Vivo may be utilised during the phases of the research process for coding, analysis and memoing.

### **Validity and Rigor**

The validity of the findings of this study will be supported through verification of the transcripts by the participants during the research process (Roberts & Taylor, 1998). Participants will be given a copy of their transcribed interview for verification of their interview material. Accuracy will be established through checking out hypotheses and making successive comparisons, which will correct the inaccuracies of data (Glaser & Strauss, 1967; Glaser, 1978 & 1992). Rigor will be addressed by clearly describing each stage of the research process and providing enough data so that the conceptual links are made explicit throughout the study (Roberts & Taylor, 1998).

### **(b) The Benefits and Scientific Value of the Project**

Exploring the process that culminates in nurses becoming 'exemplary' is an important project for the nursing profession. These nurses are few and far between and we need to identify them, support them, describe them, and utilise them in order to stimulate others around them and potentially develop more of them. Their core characteristics and skills can be used for clinical appraisal or career recognition and we can begin to explore the clinical care of these nurses in terms of patient outcomes. Identification and portrayal of the associated concepts that may begin to explain these nurses will allow for the process they have gone through in 'becoming' 'exemplary' to be understood and developed further. We need to be able to describe their unique features in order to continue our journey of the professionalisation of nursing. Being able to identify and describe the archetype of our finest nurses is an important step in describing what Nurses are and do.

## Appendix 2.1.2 cont.

### **(c) Characteristics of the Participants**

Theoretical sampling will be used to select participants who are considered to know about the phenomenon under study. Any nurse that is known to be 'exemplary' as determined by the possible descriptors already identified through the literature will be eligible to be participate in the early part of the study. These nurses will be registered nurses, working in New Zealand health care related areas, such as hospitals, community based organisations, private establishments or Institutions of higher learning.

### **(e) Method of Recruitment**

The initial participants will be identified from personal awareness (in relation to the above attributes), in turn, these nurses will then be asked to invite colleagues they know are exemplary to join the study. This method known as the snowball sample (van Meter, 1990; Faugier & Sargent, 1997; Roberts & Taylor, 1998), is one in which members of a group identify other possible members, and those members in turn identify yet more members, thus the sample grows like a snowball (Roberts & Taylor 1998). If further participants are required notices, calling for exemplary nurses to join the study, will be posted in the appropriate areas following permission from the relevant gatekeepers. Concurrent collection and coding of the data will determine what data (theoretical sampling) needs to be collected next in order to develop the theory as it emerges (Glaser & Strauss, 1967; Glaser, 1978 & 1992). Sampling will be modified according to the advancing theory and will continue until no additional data is found to develop a category further.

### **(f) Payments that are to be made/expenses to be reimbursed to participants**

No payments will be made to the participants. Interviews will be held at a place mutually agreeable to both parties.

### **(g) Other assistance (e.g. meals, transport) that is to be given to participants**

The researcher will provide light refreshments during the interviews.

### **(h) Special hazards and/or inconvenience (including deception) that participants will encounter**

The participants have the right to be protected from discomfort and harm while maximising the potential benefits of participating in the study (Burns & Grove, 1993). It will be made known to the participants that they may feel emotional discomfort while recounting experiences or scenarios relating to being 'exemplary'. If this occurs the researcher will allow them time to work through these feelings and provide emotional support, before continuing the interview. If the distress is severe, the participants will be asked if they wish to continue the interview at another time and whether they require any other support.

This researcher will make a strong commitment to equalising potential power relationships during the interviews. This will be done by encouraging openness, and trust, especially during times of the participants verbalising sensitive and private feelings about the phenomenon.

### **(i) How informed consent is to be obtained (Include a copy of the consent form and information sheet that is to be used.) (See paragraphs 4.3.1(g), 5.2, 5.5 and 5.6.1 of the guidelines). If written consent is not to be obtained, please explain why**

All participants will receive a detailed explanation, verbally and in writing of what the research involves for the participant, including the aims and steps of the research (Appendix A). They will be offered the right to refuse to continue at any time. They will be informed that they may withdraw their data up until the time that their data enters the level two categorising stage. At the stage when transcripts from their interviews are returned for verification, the participants will have the opportunity to identify any quotes or vignettes they would not wish to be used in the final thesis or subsequent publications or

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## Appendix 2.1.2 cont.

presentations. They will have the opportunity to ask questions, make comments and voice concerns that they may have concerning this study at any stage.

Participants will be informed that they may be asked to re-iterate points from their initial interviews and may be re-interviewed at further times throughout the research process. Initial consent will include up to three interviews with subsequent interviews only being performed following discussion and consensus with the participants.

All participants will give their verbal and written consent before their interview begins. Participants will sign the consent form to signify they have read the information and are satisfied with the research design (See Appendix C). The consent form is set out in accordance with the guidelines suggested by the Health Research Council (HRC 1999a).

**(j) State whether the consent is for the collection of data, attribution of opinions or information, release of data to others, or use for particular purposes**

Consent is chiefly for the collection of data, but also 'vignettes' or direct quotes from the participants may be used in the thesis document and possible articles for publication and presentation.

**(k) Whether the research will be conducted on an anonymous basis. If not, state how issues of confidentiality of participants are to be ensured if this is intended. (See paragraph 4.3.1(e) of the guidelines) (e.g. who will listen to tapes, see questionnaires or have access to data)**

The researcher throughout the length of the study will ensure privacy and confidentiality for the participants as they wish. Names of nurses and their health care settings will not be used in the final conceptualisation, as a grounded theory contains a matrix of the core categories and their properties that have come through theoretical saturation of the data (Glaser & Strauss, 1967).

Participants will be informed that, as a courtesy gesture, the 'Director of Nursing' or 'Nursing Advisor' of each potential institution where prospective nurses may be selected for participation in this research, will be contacted via a letter (See Appendix E). This letter will outline the research and the potential for nurses within their employ to be approached for participation. Names of nurses, who agree to participate, will not be divulged to the Directors unless the participants wish this to be so.

A professional transcriber may be used to transcribe the participants' interview data. The professional transcriber will sign a Transcriber Confidentiality form before transcription begins (See Appendix F). Participants will be informed that 'vignettes' or 'raw quotations' from their transcripts may be used to illustrate themes throughout the report, subsequent publication and possible presentation. However, only the participant and the researcher will know where the vignettes come from. If it seems justifiable to use names in this process, they will be asked as to whether they wish to use their 'real' names or whether they wish to use pseudonyms (of which they can choose). This detail can be changed at any time throughout the length of the research project and will be documented on their initial consent form.

**(l) Procedure for the storage of, access to and disposal of data, both during and at the conclusion of the research. (See section 7 of the guidelines)**

All raw data collected during the research will be stored in a locked filing cabinet at the researcher's home. Analysed data will be stored in the researchers computer and security access maintained through password entry. The responsibility for the safety and security of the data will be the sole responsibility of the researcher.

A logbook will contain the code for each participant and the time, date and place where each interview was held. This will also be kept in a locked filing cabinet.

**Appendix 2.1.2 cont.****(m) Feedback Procedures (See section 8 of the guidelines)**

Copies of the participants' interview transcripts will be given to each participant to verify and to identify quotes they would not wish to be used as vignettes. Once verified, verbatim transcriptions of each participant's data will be copied, ring-bound and given to each nurse for their own use.

The participants may receive an abbreviated or full report of the completed research if they wish.

**(n) Reporting and Publication of Results**

A copy of the finished thesis, once accepted by the Victoria University of Wellington, will be placed in the Victoria University Library and all other libraries connected with the different institutions associated with the participants. Softbound copies will also be available to be lent out from the researcher. It is also proposed that parts of the thesis be written up for publication and presentation through peer-reviewed nursing journals and at nursing conferences to disseminate the findings amongst other nurses.

A copy of the finished thesis will also be made available for the participants to read.



## Appendix 2.1.2 cont.

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Appendix 2.1.2 cont.

Signature of Investigators as listed on page 1 (including Supervisors)

Rae Noble-Adams      Theodor W.      .

.....

.....

Date:

7/01/2001.

## Appendix 2.1.3: Letter to Prospective Participants

### APPENDIX A.

#### LETTER AND INFORMATION FOR PARTICIPANTS ENTERING INTO THE RESEARCH STUDY –

“The X-Factors’ – Being and becoming an “exemplary nurse”

(Pages 1-5)

16 Glenbrae Place

Loburn

2RD Rangiora

03 312 8144

Date

Dear \_\_\_\_\_

I am writing to you regarding the study “Being and becoming an exemplary nurse”. I have identified you as an exemplary nurse and I would like to invite you to be a participant in my study. After you have read this document outlining information and the process for participating in this study, could you please contact me by phone to let me know if you are interested in joining me. At this time I can also answer any outstanding questions you may have.

I look forward to hearing from you. Thank you for your time reading this document.

Yours Sincerely

Rae Noble-Adams

## Appendix 2.1.4: Study Information Sheet for Participants

### STUDY INFORMATION

The principal investigator in this study is Rae Noble-Adams. I am a nurse, (RGON), BSc (Hons), and I am currently a doctoral student in the Nursing and Midwifery Department of Victoria University of Wellington.

This study is being undertaken as a part-time project (5 yrs) for the Degree of Doctor of Philosophy (PhD) in Nursing. This study has approval from the Human Ethics committee of Victoria University of Wellington.

I can be contacted via;      phone: 03 312 8144  
    Fax: 03 312 8145  
    Mobile: 025 216 4730  
    e-mail: [rae.nobleadams@xtra.co.nz](mailto:rae.nobleadams@xtra.co.nz)

### THE STUDY

This study is about the process of being and becoming an “exemplary” nurse. I believe that “exemplary” nurses are uncommon in the nursing profession and that they are the epitome of all nurses. Their characteristics and skills are looked upon by patients/clients and colleagues alike as ‘what nurses should be’. The nursing literature has excellently described the attributes of the expert nurse, yet there has been no conceptualisation of how this ‘expert’ came about. I also believe that being an expert is just one of the many qualities that the ‘exemplary’ nurse exhibits. At this stage of the study it is difficult to exactly define the term ‘exemplary’, however the attributes you possess include: being a ‘caring’ nurse in the most holistic way possible; being altruistic, committed and dedicated to your profession; valuing the nurse-patient relationship and instilling others with your vitality and enthusiasm. In short you are a role model for your profession.

Part of this study is to look further into these and other qualities to find out when, where and how they came to be. The way I am going to do this is through the application two research methods called Narrative Life History and Grounded Theory. This entails collecting data from those nurses who are identified as ‘exemplary’, then coding the data for various themes. This is then compared with more and more data from other interviews, until eventually a theory of the phenomenon of the exemplary nurse is apparent. The nursing literature will be used in the development of the theory to substantiate or

## Appendix 2.1.4 cont.

support the findings. My own thoughts and feelings about the phenomenon will also be documented and used for insights.

### THE RESEARCH PROCESS

Once you have rung me and informed me of your wish to participate in this study, I will send you a letter confirming your agreement to participate, a biographical data sheet and consent form. The biographical data is completely voluntary and you can choose to share what you wish. The consent form will need to be signed before our first interview begins.

Before the interview, it may be helpful to you to think about and/or jot down some of the factors and influences on your life that may have helped you become an exemplary nurse. It may also be helpful to think about any circumstances or scenarios in your nursing practice where you first realised that you were an exemplary nurse. I would also like you to share any other material that you think may help describe your way of being. These materials may be exemplars of your practice written as a 'reflective practice paper', letters about you and your experiences in nursing, or journal entries. These written materials will also be used in the data analysis.

During our first interview you will be asked to relate your 'life story' through the lens of becoming an exemplary nurse. I will be audiotaping the interview, which will be undertaken following your verbal and written consent to participate in the study. Each interview should take up approximately 2 hours.

Following the interview your audiotape will be transcribed. I will endeavor to transcribe your tape myself but if I need assistance a professional transcriber may be used. This transcriber will sign a confidentiality form and no identifying data will be given to the transcriber in order to safeguard your identify. You will be given a bound copy of this interview for your own utilisation and also in order for you to validate the accuracy of my transcript. I will arrange to ring you, or if you prefer – you to ring me, to do this.

Following your initial interview I will ask you to invite a colleague who you know to be exemplary to also be part of the study. This sampling technique is called snowballing or shoulder tapping and allows me to continue interviewing exemplary nurses.

Due to the nature of the research I will probably need to re-interview you again at a later date. This may be anywhere from a few weeks after the initial interview to several years later (the PhD is expected to take not longer than 5yrs from early 2001). I would think that you would probably only be interviewed

**Appendix 2.1.4 cont.**

Committee of Victoria University of Wellington or my supervisors Dr Alison Dixon or Ms Margi Martin at the Nursing and Midwifery Department of Victoria University of Wellington.

You have the right to determine the time, place and general conditions of your interview(s) and you may bring a support person if you like. If you identify as Maori, I will endeavor to follow your wishes regarding consultation with appropriate whanau, hapu or iwi. For all participants you should be aware that this study conforms to all the principles of the Treaty of Waitangi.

Sometimes during interviews where people are telling important or sensitive information it can get a bit emotional. If you feel like you need a break during the interview or you would like the tape stopped – just ask and it will be turned off. If we bring up some issues that are too hard to handle between the two of us I can refer you on for professional support. I am also aware that nurses do not often talk about our ‘good’ points and indeed we may need a little time to really get into the swing of things. However, what you do is really important for you and our profession and it needs to be found out and shared. I would like to think that you get as much out of this study as ultimately our profession and I will.

I thank you for your time in reading this information guide. As I have said before if you have any queries, please do not hesitate to contact me. I look forward to hearing from you.

Thank you again

Rae Noble-Adams

*(date)*

## Appendix 2.1.5: Letter Confirming Agreement to Participate.

### APPENDIX B.1.

#### LETTER CONFIRMING AGREEMENT TO PARTICPATE IN THE RESEARCH PROJECT

16 Glenbrae Place

Loburn

2RD Rangiora

03 3 12 8144

025 216 4730

[rae.nobleadams@xtra.co.nz](mailto:rae.nobleadams@xtra.co.nz)

Date

Dear \_\_\_\_\_

Thankyou for agreeing to participate in my doctoral research project entitled "The X-factors - Being and becoming an exemplary nurse".

I enclose a biographical data sheet (which is optional) and two consent forms to be signed before we commence our first interview. One is for you to keep and the other for me to file.

I will ring you within a fortnight of posting these documents to confirm that you wish to be part of this study and to arrange our first interview.

I look forward to participating in the research process with you.

Yours sincerely

Rae Noble-Adams

**Appendix 2.1.6: Participant Biographical Data Sheet.****APPENDIX B.2.****BIOGRAPHICAL DATA SHEET FOR PARTICIPANTS**

Age \_\_\_\_\_

Gender \_\_\_\_\_

Ethnicity \_\_\_\_\_

Nursing Qualifications \_\_\_\_\_

Non-Nursing Qualifications \_\_\_\_\_

Years of nursing experience \_\_\_\_\_

Specialty choices \_\_\_\_\_ years \_\_\_\_\_  
\_\_\_\_\_ years \_\_\_\_\_  
\_\_\_\_\_ years \_\_\_\_\_



## Appendix 2.1.7: Participant Consent Form.

### APPENDIX C.

#### CONSENT FORM TO PARTICIPATE IN THE STUDY –

**“The X-factors, being and becoming an ‘exemplary’ nurse”**

*I have read the information for participants' sheet (dated \_\_\_\_\_) regarding the study designed to explore “exemplary nurses”. I have had the opportunity to discuss this study with the researcher and I am satisfied with the answers that I have been given.*

*I understand that taking part in this study is voluntary and that I may withdraw from the study at any time up until the second stage of the data analysis.*

*I understand that if I wish to withdraw from the study my data will be destroyed or given to me.*

*I understand that my data will be kept secure during the study and will be destroyed within 5 years of the study being completed.*

*I understand that my participation in this study is confidential and that any information I provide will be kept confidential to the researcher, her supervisors and the professional transcriber. My identity will remain confidential throughout the study process and through any potential publications and presentations. I am aware that extracts, raw quotes or whole parts of my story from my interview transcripts may be used to illustrate points during the writing up of this project and subsequent publication or presentations unless I agree otherwise.*

*I understand that this study will be reviewed if the research process should appear harmful for me.*

*I have had time to consider whether to participate.*

*I know who to contact if I have any questions regarding the ethics of this study.*

*I consent to my interview being audiotaped and transcribed by a professional transcriber if required.*

*I consent for up to a total of three interviews and am aware that further interviews are at my own discretion.*

## Appendix 2.1.7 cont.

*I am aware that this study has ethics approval from the Human Ethics committee of Victoria University of Wellington.*

*I wish to receive a summary of the results* YES/NO

*I wish to be informed when the thesis is available to be read* YES/NO

*I wish to use my own name on any written reports/thesis* YES/NO

*I wish to use a pseudonym on any written reports/thesis* YES/NO

*Pseudonym* \_\_\_\_\_

*Would you like your name given out in the courtesy letter to you director of nursing?* YES/NO

*I* \_\_\_\_\_ *hereby consent to take part in this study.*

*Signature* \_\_\_\_\_ *Date* \_\_\_\_\_

*Researcher* \_\_\_\_\_ *Date* \_\_\_\_\_

## Appendix 2.1.8: Interview Guide.

### APPENDIX D. Semi-Structured Interview guide – for the researcher -Rae Noble-Adams

#### *Main question:*

Can you tell me your story of becoming a nurse?

Just anything that comes to mind from childhood through to the present time. Can you tell me about the things that may have impacted or influenced your choice of going nursing through to becoming the exemplary nurse that you are today? If I want to ask you more about a point I will.

#### *Prompt questions (to be used as needed):*

- Where were you placed within your family?
- Was there anyone within your family circle who encouraged you to go nursing? – tell me more about this.
- Did you do any other kind of work before you went nursing?
- When did you decide to go nursing?
- Why did you decide to go nursing?
- Who was involved in this decision?
- Tell me more about your experiences as a student nurse?
- How about as a new staff nurse?
  
- Can you explain in your own words what exemplary means to you?
- Can you tell me some of the core attributes or characteristics that you have?
- What do you think the factors are that made you an “exemplary nurse”?
- Prompts: Personality? Training? Role models? The nurse-patient relationship?
- Do you think that you had “exemplary” abilities and skills from early on?
- When exactly in your career were they made apparent?
- Can you give me an example of what occurred (scenario) to make you know you had these abilities?

## Appendix 2.1.9: Letter to Prospective Directors of Nursing.

### APPENDIX E.

#### LETTER TO PROSPECTIVE DIRECTOR OF NURSING.

*16 Glenbrae Place*

*Loburn*

*2RD Rangiora*

*ph: 03 3 12 8144, 025 216 4730*

*fax: 03 3128145*

*e-mail: [rae.nobleadams@xtra.co.nz](mailto:rae.nobleadams@xtra.co.nz)*

*Date*

*To whom it may concern,*

*I am writing this letter as a courtesy gesture in order to inform you that some of the nurses working within this institution may be involved in my research study; "The X-Factors – being and becoming an 'exemplary' nurse". This study has ethical approval through the Human Ethics Committee of Victoria University of Wellington.*

*I am a New Zealand Registered nurse who is carrying out this study as fulfilment for a PhD in Nursing, Victoria University of Wellington. The research method for this study is informed by Narrative Life History and Grounded theory, both qualitative methodologies that entail interviewing nurses to find out the experience of being and becoming exemplary nurses. The interviews for prospective nurse participants will be held out of their normal work hours. Initial selection of participants will rely on my personal knowledge of these nurses but during the later stages of the research process, I may need to advertise for participants to join the study. If this is thought likely, I will contact you again in order to find out the appropriate people I should contact regarding access to various nursing departments.*

*It should be noted that the names of participating nurses will be confidential, unless the participants themselves wish to divulge their participation in this study. If you would like further details on this study or would like any points clarified please do not hesitate to contact me.*

*Yours Sincerely*

*Rae Noble-Adams*

**APPENDIX 2.2: Confirmation of Changes and Full Ethics Approval****COPY FOR YOUR  
INFORMATION****VICTORIA UNIVERSITY OF WELLINGTON**  
*Tē Whare Wānanga o te Upoko o te Ika a Maui***MEMORANDUM**

---

**TO:** Rae Noble-Adams  
Nursing & Midwifery

**FROM:** Graeme Kennedy  
Convener, Human Ethics Committee

**DATE:** 22 February 2001

**SUBJECT:** APPLICATION FOR ETHICAL APPROVAL: BEING AND BECOMING AN  
EXEMPLARY NURSE

---

Thank you for making the revisions to your application as requested by the Standing Committee of the Human Ethics Committee.

Your application as revised is now approved. Approval is given for the period 22 February 2001 to 28 February 2003.

With best wishes for your research.

Graeme Kennedy  
Convener, Human Ethics Committee

---

## APPENDIX 2.3: Proposed Changes to Participant Information Sheet

16 Glenbrae Place  
Loburn  
2RD Rangiora

03 3 12 8144  
[rae.nobleadams@xtra.co.nz](mailto:rae.nobleadams@xtra.co.nz)

27.08.2001

Dear Professor Kennedy,

I am writing to you regarding some slight changes to the Information Sheet for Participants in my study "Being and becoming an exemplary nurse", which gained ethical approval February 2001.

While my philosophical viewpoint or methodological underpinnings have not changed, I am changing my method to that informed by Constructivist Inquiry (Guba & Lincoln 1985, 1989, 1992). This is very similar to my original proposed method of narrative inquiry and grounded theory and has in-fact tenets of both included in the approach.

The changes to the Information Sheet are that I have noted the change of method and informed the participants that they **will be asked** rather than **maybe asked** to participate in three interviews. This does not change the consent form as three interviews were part of the original and un-changed consent form.

I enclose a copy of the revised Information Sheet with the changes in bold type.

I look forward to your reply

Yours sincerely

*Rae*

Rae Noble-Adams

---

## APPENDIX 2.4: HEC Approval of Revisions

### Main Identity

---

**From:** "Linda Bowden" <Linda.Bowden@vuw.ac.nz>  
**To:** "Rae Noble-Adams" <rae.nobleadams@xtra.co.nz>  
**Sent:** Wednesday, 29 August 2001 6:06 p.m.  
**Subject:** Re:

>Hello Rae

>

>

>I confirm that that the Human Ethics Committee has approved the revisions  
>to the information sheet for your project "Being and becoming an exemplary  
>nurse".

Please accept this as a formal acknowledgement of approval.

Kind regards

Linda

13/11/2005



## APPENDIX 2.5 : Request for Extension of Ethics

### Main Identity

**From:** "Linda Bowden" <Linda.Bowden@vuw.ac.nz>  
**To:** "Rae Noble-Adams" <rae.nobleadams@xtra.co.nz>  
**Sent:** Tuesday, 5 August 2003 10:10 a.m.  
**Subject:** RE: Ethics for Rae Noble-Adams

Hi Rae

I have forwarded your message on to Allison Kirkman, convener of the HEC, and asked her if she would approve an extension until 2005. I'm sure Allison will respond to you about this shortly.

Regards, Linda

-----Original Message-----

**From:** Rae Noble-Adams [mailto:rae.nobleadams@xtra.co.nz]  
**Sent:** Monday, 4 August 2003 4:23 p.m.  
**To:** Linda Bowden  
**Cc:** Alison Dixon  
**Subject:** Re: Ethics for Rae Noble-Adams

Dear Linda,

I have just realised my ethics approval has lapsed. I enclose your last e-mail so you have something to work from. I took 9 months leave from my PhD (August 2001-May2002) to have my fourth child, and therefore I am doing my PhD very part time. I have not changed anything in my study and am currently undertaking my second round of interviews. I hope to have the study finished in the year 2005, which is within the 5 year time frame for part-time PhD's.

To this end what do I need to do to get my ethics approval up to date?

Thanks for your time

Rae

----- Original Message -----

**From:** "Linda Bowden" <Linda.Bowden@vuw.ac.nz>  
**To:** "Rae Noble-Adams" <rae.nobleadams@xtra.co.nz>  
**Sent:** Wednesday, August 29, 2001 5:06 PM  
**Subject:** Re:

>

>>Hello Rae

>>

>>

>>I confirm that that the Human Ethics Committee has approved the revisions

>>to the information sheet for your project "Being and becoming an

exemplary

>>nurse".

>

> Please accept this as a formal acknowledgement of approval.

>

> Kind regards

>

> Linda

>

14/11/2005



**APPENDIX 2.6: HEC Approval for Extension of Ethics****Main Identity**

**From:** "Allison Kirkman" <Allison.Kirkman@vuw.ac.nz>  
**To:** <rae.nobleadams@xtra.co.nz>  
**Sent:** Thursday, 7 August 2003 9:25 a.m.  
**Subject:** Extension of ethics approval

Page 2 of 2

Dear Rae

Thank you for your request to have your ethics approval extended until 2005. As convener of the Human Ethics Committee I will approve this extension in the light of your explanation below.

Linda Bowden no longer works for the HEC and she forwarded your message on to me. If you have any other queries please don't hesitate to contact me directly.

Best wishes with your ongoing PhD studies.

Regards

Allison Kirkman

Dr Allison Kirkman  
Convener, Human Ethics Committee  
Victoria University of Wellington Te Whare Wananga o te Upoko o te Ika a Maui  
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<http://www.vuw.ac.nz/home/research/overview.html>

14/11/2005

### **APPENDIX 3.0: Letter to Participants Asking for Confirmation of Names/Pseudonyms**

16 Glenbrae Place

Loburn

3RD Rangiora

03 3 13 8144

13 August 2004

Dear \_\_\_\_\_,

I am writing to let you know that in the next few months I will be posting out a draft chapter of the findings of the research to date. I have decided that to do 'justice' to all your awesome stories I needed to share as many of them as possible to illustrate the findings. In this chapter I want them to be in your words and not mine.

Therefore the chapter has been written using a lot of the participants "own words, exemplars and stories". For the first time in the research process you will be able to read excerpts from both your own interviews, poems or associated documents and stories from the other participants. Therefore before I send this out, I need to know what you would like to be known as, in this chapter.

So far you have conveyed to me you would like to be known as "\_\_\_\_\_". Can you reply to this letter confirming that you are happy that the chapter goes out to the participants with this name or let me know what pseudonym you would like to use.

Looking forward to your reply

Rae

## **APPENDIX 4.0: Letter to Participants with Final Validation of Quotes Used and Pseudonyms To Be Used**

11/11/3005

Dear All

I am writing to let you know that the thesis is nearly finished and the first draft is almost completed.

At this stage I need to confirm you wish to be called the same name/pseudonym or that you wish to change it. I also need to know that you feel happy with your quotes/story vignettes being used throughout the thesis for its publication and for any subsequent presentations.

I enclose a copy of the methods Chapter where several of your last interview quotes have also been used. Please let me know if you want to comment or change these. I need to have my second draft thesis into my supervisors before the end of December, so I would appreciate your feedback before then.

I aim to have the finished thesis submitted in April 3006, when I will send you all a copy of the thesis for you own use.

I thank you all once again for your dedication, support, wonderful data and support of this project.

Kind regards

Rae

## APPENDIX 5.0: Letter to Participants With Definition of Exemplary and Notes To Read Before Second Interviews

July 3003

Dear All

Well it is that time again for a wee chat about my PhD "Being and Becoming an Exemplary nurse". During the past year and a half I have transcribed and analysed your wonderful transcripts of your interviews and have heaps of fantastic information. I have also looked at being and becoming in philosophical terms.

Three major themes emerged from the data of your interviews.

1. **BEING:** which was about being genuine and authentic when nursing your patients, knowing yourselves – what you do well and what you don't do so well, knowing what made you tick (intrinsic drives), knowing what you enjoyed about your practice, that nursing was 'meant to be' and being passionate about it, giving 110%, being frank and being a reflective practitioner.
2. **BEING AN EXEMPLARY NURSE:** which was about the amazing stories and experiences of your practice and lives as nurses. It included such things as: being an expert, caring for another, connections with another, knowing another, its the patients journey and working with colleagues by showing leadership and working with others
3. **BECOMING AN EXEMPLARY NURSE.** Was how you got to where you are. It included stories about wanting to become a nurse, training to become a nurse, specialty choice, becoming knowledgeable, and having critical friends that helped you on your way.

Of course there were several sub categories under these headings and I have lots of awesome stuff here.

Also during this time I re-looked at what Being and Becoming an exemplary nurse really meant. On personal reflection, reading philosophy (I did really!), analysing your interview data and taking many of your comments on board about feeling uncomfortable with the title 'exemplary' I came up with the following:

The term 'exemplary' nurse, conjures up an image of being better than other nurses. It is a term that invokes descriptions of being excellent, and setting a good example but also of being ideal, the consummate nurse, the perfect person; match-less, peer-less and even "godlike" (Roget's Thesaurus, pg 944). Nobody is perfect and I believe that nobody would want to be perfect. For to be perfect one would have had learnt everything, there would be no challenges and no rewards, as one would 'have' and 'know' everything. If being exemplary was a trait that could possibly be achieved it would take a very long time, and if you were Hindu it would be one that would take many life times. The stories of the participants are narratives of being and becoming exemplary. The core feature is about knowing oneself and the path one has traveled, reflecting on the experiences and the information one has learnt and using that knowledge to 'become'.

For me, being and becoming an exemplary nurse is a work in progress, a forward moving, revolving interweaving of past, present and future experiences and praxis, which is reflected

on by a person who is authentic and knows themselves. A person who is a conscious self; a being who is exemplary in both their being and their becoming. I believe that 'being' exemplary is an aspiration. The participants have been exemplary in specific situations in the past, and will be exemplary in time to come. But these are moments in time, reflections of self situated in a life that is evolving and fluid. By continuing to reflect on their 'being' and their relationships with others and learning from these experiences to improve, they will continue the journey of being and becoming an exemplary nurse.

So the things to think about before we meet again are:

- please reread your transcripts before our next interviews and think about your stories of practice and let's talk about how they have and do influence your being and becoming. How do these stories serve as a mirror for you in your practice?
- I would also like to know how you stand with the 'exemplary' title and the struggles you may have with being this type of person. I want to unpick the notion of authentic being. Your ability to stand as a whole (being greater than the sum of your parts) and the ability for you to continue to practice what you preach. What keeps you getting up each morning and continuing your journey of becoming exemplary?
- Also how have you made sense of this so far by being in the research?

So that's that. I really appreciate your time and continuing support in our research and I look forward to meeting up with you soon.

Love and best wishes Rae

## APPENDIX 6.0: Interview Logs

<b>1<sup>ST</sup> INTERVIEW INFORMATION</b>			
<b>Name</b>	<b>Date of interview</b>	<b>Pages of Transcript</b>	<b>Place of interview</b>
Chris	14/03/01	80	Home
Janet	18/04/01	40	Home
Jayne	38/04/01	37	Home
Kate	14/05/01	40	Home
Liz	31/05/01	45	Home
Kirsten	01/06/07	39	Work
Sharyn	33/06/01	36	Home
Joc	16/07/01	61	Work
Anna	15/04/03	80	Work
Ellen	18/13/01	85	Work

<b>2<sup>ND</sup> INTERVIEW INFORMATION</b>			
<b>Name</b>	<b>Date of interview</b>	<b>Pages of Transcript</b>	<b>Place of interview</b>
Chris	33/08/03	33	Home
Janet	16/08/03	31	Home
Jayne	10/08/03	37	My Home
Kate	17/08/03	31	Home
Liz	06/08/03	35	Home
Kirsten	01/09/03	13	Home
Sharyn	31/07/03	33	Home
Joc	16/08/03	37	Work
Anna	39/08/03	33	Work
Ellen	30/07/03	33	Work

<b>3<sup>RD</sup> INTERVIEW INFORMATION</b>			
<b>Name</b>	<b>Date of interview</b>	<b>Pages of Transcript</b>	<b>Place of interview</b>
Chris	09/13/04	n/a	Home
Janet	07/13/04	n/a	Phone
Jayne	04/13/04	n/a	Café
Kate	06/13/04	n/a	Café
Liz	07/13/04	n/a	Work
Kirsten	06/13/04	n/a	Phone
Sharyn	06/13/04	n/a	Phone
Joc	9/13/04	n/a	E-mail
Anna	38/03/05	n/a	Phone
Ellen	09/11/04	n/a	Work

## APPENDIX 7.0: Letter to Participants with First Draft Findings

33/10/04

16 Glenbrae Place

Loburn

3RD Rangiora

03 313 8144

[rae.nobleadams@xtra.co.nz](mailto:rae.nobleadams@xtra.co.nz)

Dear (in this draft thesis chapter you are known as ),

Well at long last I have the privilege of returning to you the draft findings chapter. It's a big read but I hope like me, you find it stimulating and incredibly powerful to read. I have also included the prologue so you understand the koru metaphor and also an Appendix where some of your backpack stories are included. I would like you to keep these chapters and to feed back to me what you think about them. Any comments that you would like to share with me will be very useful. This will also be your chance to edit any of your stories before they go into the thesis proper.

At this stage I am still working on the methods section, where some of your details as participants will be recorded. Again I will write and show you what I have written for your comments, before it goes to print.

I would really appreciate if you could let me know your comments on the finding chapter by the end of November 2004. To do this, I can either come and see you for a chat or we can do it over the phone. I have an attachment that can record our phone conversations and if this is your choice, I will remind and ask your permission to tape it before we start.

I thank you again so much for all your wonderful stories and insights. They are truly inspirational. I hope you enjoy reading them. Thanks for your continued time and commitment to this study. I will contact you at the end of November.

Kind regards

Rae

## APPENDIX 8.0: The Participants' Backpack Stories

In this Appendix I share some of the participants' stories to illustrate how diverse the backpack stories were. The participants told many stories during our interviews. These stories were usually emotive but not always. It was important for me as the researcher to acknowledge that all the stories were important to the storyteller and while the story may not seem 'significant' to me I understand it holds significance and meaning for them.

### Chris's story

Chris's powerful story about working with an adolescent diagnosed with cancer illustrates many points such as: going the extra mile and taking a risk to make a difference.

*"I really think he decided he didn't want to have anything to do with this whole thing of, having cancer, having to take pills or doing anything.. now when you are suddenly, we are very used to dealing with toddlers and things, that won't do things, and really, how do you suddenly when you are confronted with a 15 year old that's not having a bar of any of this, what do you do? And it had really got to the stage with his parents that he was just as bad with them as he was with us, and I think all he wanted to do was curl up into a little ball. And just for the world to go away, didn't want the windows, didn't want the curtains opened, he didn't want anything, didn't want to talk to anybody. He certainly wasn't going to be taking any pills. He wasn't going to do anything. And of course his parents were mortified, because this wasn't how they were as a family, you know? And you see what happened was that people did not know what to do with him... And we can't actually do any of this, unless we get him on side. This is not actually working. He is not wanting to eat, drink, take his pills or do anything, he is just not doing it. He will not speak and of course, we sort of almost, I mean he just, Oh he hated me so much at the beginning because I, you know? I sort of, it was almost like I, it was almost like a dog with a bone, I just kept at him and you see, what happened on other shifts was that people would just leave him alone, because that was what he wanted. And people wouldn't do anything. But I would try to sort of keep talking to him and he would get so angry and say "you're not part of my family!" and I said "I know that, I know that, but" I said "I am part of your life at, at this point in time" and I said "I am in it, with you. I'm in it for the long haul with you" and he would just, you know say "I hate you! I want you to go away!" and then it became actually so bad and he was getting sort of, you know, angry and it was getting that he would be sort of, relatively abusive. And so I thought, Ok we have got to step back from, we have got to forget about the whole issue of cancer here, because we are not getting anywhere there with that. He doesn't want to know about*



that, so I thought we have actually got to look at, and I got some help here, because it is different, we can't have you know sticker charts and stuff like that for a 15 year old. But what do you do, how do you deal with this? So what I actually instituted with him was, rights, we sort of did rights, rules and responsibilities and he didn't want to have a bar of it. I remember sitting in his room this morning, just me and him, with his curtains pulled and his bedclothes over his head, you know and him telling me to "Fuck off!" and you know, "I do not want to know you, you're such a pain, when are you leaving me?" you know? "When can I get you out of my life?" and so I went through what, what did he, did he think he had any rights as a patient here? And you know, as a person here on the ward? And what were his rights? And then what were my rights as a nurse? Because he was really treating me, you know, it wasn't sort of like very good. So we needed to try to change the sort of dynamic of it. Oh we went through what rights each of us had and it was a bit of a one way conversation, although he was actually listening, I think because every now and then he would butt in with something, like you know, he didn't want to know! But I think he was listening, so we talked about that the first thing both of us had was the right to respect. And then other things that he had and that I had. And what some of our responsibilities that I actually had responsibilities as a nurse caring for him. And then what maybe were some of his responsibilities as a 15 year old. And you see because what was actually going down really for him because his nutritional status was a bit of a problem; he was getting to the stage where he was getting to be very near a naso-gastric tube. So it was, sort of felt a bit like a one way conversation, but I put a copy of what we had done, in an envelope for him, in his drawer. And the other thing I tried to say to him was I tried to sort of instill that "I believe in you!" "I trust you, you can do it" you know? "You can do this, you can get through this!" and the other thing I tried to do was get him to have his pills when he, like he could do it, it was just that he didn't want to. Anyhow, good lord in heaven! The next couple of days, this boy was just - well I got on duty one day and he came, he wanted to tell me all this stuff about himself, he was just so different! Something had, I don't know what had happened, something had clicked or he thought I don't know, maybe he thought Oh well I can't beat her I may as well join her! But trying to sort that, because he was sort of a kid who once he was down it was very hard to, and hard of him to see how he could get out. And so I'd written him something else one day when you know we were at our wits end, and I just wrote something for him and said you just have a think about that and then we'll continue on. And yeah so from me being his worse nightmare, I'm sort of the, the first person he now rings when he is up in Christchurch, and he rings me and says "Lets go and have a coffee.." (Chris, 1<sup>st</sup>, 0, 158-338).

## Jayne's Story

For Jayne the story she carries of a baby dying in a different country, away from its mother highlights the mentoring and of a doctor colleague. This man encouraged her to be true to herself and make sense of death. He guided her in her initial dealings with the deaths of babies and the care of their families and taught her skills she carries to this day.

*"A few years ago, I did a retrieval or a transport, we went to Nuemea to pick up a baby there who was born with a heart defect and I went with one of the doctors, in fact, I think I have got some pictures of him in here, somewhere, on the transport. And we landed in New Caledonia to pick up this baby and brought the baby back. I never met the mother, because the mother was in one of the outer Islands. And I just remember feeling so, so, dreadful for her. That her baby had been, sort of picked up and taken away from her. And not only taken away from her but taken to another country, where they didn't speak French. And her baby was, terribly, terribly sick, it was just really awful. And unfortunately, this baby died. And I remember being absolutely, really saddened for her because, you know, she never, never saw her baby again. And so I remember, one of the Neonatologists said "Well what are you going to do about it?" In a nice, nice helpful way. And because we always took photos, I said "Well we should take some photos". So we took some photos and he put me in the photos as well. And I said "Oh no, no no!" And he said "No. You know it will be important for her to know that you were there, caring for her baby". And so I thought Oh, ok. So, he took the photos and then I said "Well it is not good just sort of sending her these photos", so I wrote, I remember writing her a really long letter, in English, because I can't speak French and she didn't speak any English (Jayne, 1<sup>st</sup>, 1.10, 34-333)...That was interesting because I learnt a lot from that. Because I didn't trust myself. But I have talked to you about that doctor haven't I? He taught me a lot that guy and that was an interesting experience. I learnt a huge amount from him. He said it doesn't matter that you can't write French because someone will be able to read it. He was a role model and a mentor he really was. That man taught me a huge amount. I told that story and I didn't talk more about him. Of all the medical staff that I have ever worked with, he would have influenced me the most. He led one of the first study days I ever went too, and it was on death and dying in the neonatal context and it was awesome. I remember thinking Oh! Right, ok! It doesn't have to be really difficult and there are no rules and you just have to be true to yourself. Ahhh! And to trust your instincts and to trust what the parents are telling you. And what they are telling you they won't always verbalise or be able to say. But if you are open to them, you will know. And there are no rules when it comes to this sort of stuff and it is ok. You just do what is right. He wrote this wonderful wee book, it was called "Life and death are the same*

*mystery". I still feel very emotional when I talk about it! This doctor was a very important part of that time, because a lot of babies died in those days and sort of the skills that you learnt to cope with that and to make sense of that and to help the parents make sense of that are really important. And he taught me those skills" (Jayne, 3<sup>d</sup>, IT).*

Anna's story of her first death was meaningful to her in many ways and influenced her future career choice.

*"I worked in the oncology ward that was where I had my first death. And that was, I was class 5. And I can remember being absolutely and utterly, stunned that this woman had died. Because I mean I was 18, you know this is early on. And this woman, I remember, to the day I die. She was a big woman and she was, going home and I was helping her to pack up. And she arrested. And I can remember her falling to the ground and I can remember thinking Shit! What the hell is going on here? And going blue, and I can remember pushing the bell and the crash cart, coming and, and the, this was a ward, that had a balcony down the end. And it was, you know, a typical, sort of, bit down the middle and then it had little, you know, everyone, one or two bedded or whatever and this was a two-bedded room. Two bedded thing off the main corridor. And I can, and I knew that her husband was coming, like it was virtually on the time that he was coming to pick her up. And I can remember, cause I was really junior, and of course all these, you know, crash carts came and they started resuscitating her and I can remember her lying there, and she had been incontinent and, her clothes on and the whole indignity of it. And of course the curtains only came so far down and you could see her feet sticking out, and, I can remember being really worried about her husband coming and seeing her like that. And of course she died. And, I remember being absolutely just stunned that here was I talking to this woman one minute and the next minute she's dead. And I remember going into the treatment room and somebody, obviously a more senior nurse than me, I was class 5, but I remember bursting into tears and who ever it was came and was comforting me. And then of course they must have got her onto the bed. The must have done that when I had been crying in the treatment room and then of course the next step was laying her out and I was asked if I wanted to do that and I said yes I would...and anyway we went through this process of laying this woman out...and I can remember this supervisor, saying to me now you must always leave the patient with her arms folded and she said it is always important to get a flower and so she rushed off and of course in those days you had to tie the toes and stick things under their jaw and that sort of thing and she came back with this lovely rose. And I can remember her putting it in the woman's hands. And thinking when we stood back I can remember her locker being there with nothing on it,*

*but the only colour was on the white sheet was this rose and of course you used shrouds and all that and I can remember thinking well she doesn't look too bad after all, because there was a sense of peace...so that was class 5 for me and that's , I mean shit that's almost 30 years ago and that's always stayed in my mind. And I still believe that was probably part of the reason why I've gone down the track that I have gone because I think it was a huge role modelling, sort of mentoring experience that was actually really positive in a devastating situation for me at the time. and so I was sort of frightened after that and from a standards point of view I mean there was always something every time I was with somebody that dies or was laying somebody out she always came into my mind and there was always a sense of being respectful, having their dignity, so that was really meaningful for me" (Anna, 1<sup>st</sup>, 1.1, 108-130).*

For Kirsten her first arrest also highlighted a personal powerlessness but also demonstrated excellent role modeling skills by her colleagues.

*"There were lots and lots of patient deaths. Some horrible things, happened, but I learnt so much. One of the things that I do remember happening was my first arrest, and I won't ever forget that! Most nurses probably won't. But somebody actually that I worked with back then reminded me of it the other day, they remembered. I was sponging this man, and had him sitting on the side of the bed and his, eyes just basically rolled back, into the back of his head and he tipped backwards. And I thought Oh my God! So, I knew all the things to do, but of course I grabbed the bell and I pushed it three times, but do you think it worked? Nooo. In a four bedded room! And I was doing the right things but I was in such a panic, my arms were shaking, so I got him back onto the bed, and ran out in to the corridor and just bellowed! Help!!! and then everybody arrived. By this stage I thought ok I need a job I need to do something here, I'll clear the way, you know that, make sure the space is clear for, for the equipment and, you know safe area and that sort of thing. And I was just basically wiping my arm across things, just, wiping everything off the bedside trolley and, like a mad woman, and that was yeah, it was, pretty awful but this man, but, ah, the other thing I really remember about that was that the staff were amazing, I think these are the things, some of these things, the way I was treated, you know I was, a novice, changed the way I practice. One of the things they did was, you know, I wasn't that, I wasn't involved physically in the resuscitation but I was there and then, they said ok Kirsten, Your patient what do you need to do now? And you know, Ok we'll need to ring his wife, and I am sure, the man died. And, they told me to ring his wife and tell her that he was very, very unwell and she must come quickly because things weren't looking*

*good. And that was, you know, a tricky one because he was dead but then in the end I felt pleased that I did that because it was within minutes, and she arrived and I had to take her in, and he was in the treatment room by that stage and you know what it is like? But I think once you have seen something like that, once it is so much easier" (Kirsten, 1st, 1.1, 101-111).*

Jocs' story about a baby dying is remembered by her because she now wishes she had broken the hospital rule and not taken the baby to the mortuary.

*"I've nursed so few babies and I used to be so frightened of babies. That was my biggest dread at Lakes was epiglottitis. But I remember nursing a baby in Intensive Care and it was really the most interesting situation, it was really funny, the parents were a strange religion. And it was so funny and they were in, the child was in a cot and every time they came into the room, the father would go [knock, knock] like that. Against the cot and I thought oh I wonder why he is doing that? And they were very religious like it was Jack and Jill went up the hill to fetch the holy water, you know it was, it was hilarious, but any way it got the better of me after a while and I said to him you know every time you come in here, you go bang, bang, bang against the cot, is that some significance to you? Oh he said I am just trying to get rid of the static electricity out of my [knock, knock] body, you know? But the long and the short of it was this tiny child, this tiny toddler died when I was on night duty, one night and it was expected and it was fine, it was terrible but it was fine and I remember going, taking and I certainly didn't let the child be, laid onto a trolley and taken down to the mortuary, but I did carry that baby down to the mortuary. And that's one thing I have put in my backpack I will never do that again and I say to students, all the time, don't ever do that, don't ever let be ruled by hospital rules that say that the child has to go to the mortuary, they don't! You could have I could have kept that child in intensive care with me until the morning, and it could have gone straight to the mortician or straight to the parents home or wherever they were talking it. You don't have to follow these rules, you don't have to! So it's that reflection again that reflection business and looking at rules and thinking there might be another way of doing this" (Joc, 3<sup>rd</sup>, 454-469).*

Kate's experience with one woman's death was remembered because of her own failure to respect and listen to her patients' dying wishes. She can still see and hear that particular scenario very clearly.

*"I lost the plot with one woman one night, who I was absolutely furious with, she really excited the most primeval behaviour in me. And she, had gone out of the Hospice for the afternoon, and I thought Thank goodness! I, we had, you know, we had just hit a, brick*

*wall, being able to, cope with one another. And she came back, she had a horrible fungating tumour and it was icky, picky smelly, and she had been out and about, and we suggested she had a bath and we would help, because the problem was she had not ability to smell it either, so it relied on us, to tell her, that, because that was one of her requests, because she did not want to have this awful smell, so I had reminded her and I had run the bath, and was sorting it out, and she dug her toes in and said she wasn't having it because she was going to die very shortly and, she had to get herself ready for that, and I said Oh! Don't be so stupid! I was really horrid. It was just really horrid. I don't know why I was so horrid to this woman, it was so stupid, really, really it is so awful now when you think about it. I went away and run the bath, cause you know, I just dug my toes in, god knows for what reason, I am absolutely appalled to think of that, and I went back to tell her the bath was run and she was dead! And when I opened her wardrobe door, she had been out, all afternoon doing all her shopping, she had bought everybody's Christmas and birthday presents for the next twelve months. She had known absolutely, that she was dying and I'd been so damn arrogant and, high handed, I hadn't stopped to listen. I had just absolutely.. I'm not proud of that! And most of the time, I'd look at being at my practice as being able to listen and hear and sometimes, you don't get it right. But at least, I owe people the respect to do that. So there is a case that I can still see and hear very clearly, the whole scenario because it really pulled me up, with a start" (Kate, 1<sup>st</sup>, 0, 100-106).*

For Anna, caring for her first Maori patient who had an extremely distressing death, has stayed with her and has impacted on her cultural practice ever since.

*"And I can remember a Maori, this poor guy, because they were just doing, you know, we were starting off with the transplants and he'd been sent down from the Waikato or somewhere, but from the North Island, anyway. And, of course they had to be isolated, and he was just, I must have been doing night duty for some reason, must have been doing night duty but I was at this particular time, must have had to share it, and I was doing some nights and of course he was I, and Christ I mean he was just beside himself, because he was stuck, you know? and he couldn't get out. And, he'd been transplanted and he had graft versus host and he was dying, I mean, he did actually, die, he died on that, on that, that group of nights that I was doing. But before he died, he used, he used to wail. And he was just so, traumatised being, and he was away from his roots and the whole.. And probably, probably that was one of the most significant, cultural, patients, you know from a Maori point of view, I mean cause we didn't look after many Maori's down*

here. But the whole spiritual thing, I can remember, for him the whole pain, was, it wasn't physical pain, it was this, well he probably did have physical pain cause he had graft vs. host, but it was the whole, the trauma, of being removed, and being plonked in, away from his family, well he did have his, his wife was there and what have you. But his sense of, absolutely spiritual isolation, and the trauma that it caused him and I can remember being with him, sitting with him, and him, him just moaning and wailing and, and trying to get a sense of, what was happening. And of course, that's what it was. He was just, and he knew he was dying. And yet, and he was, but he was saying "don't, don't let me, don't let me", you know, "don't leave me like this, don't let me", you know, and I can remember, getting his wife in, and this was on the night that he died. And he blew up, he obviously had a bleed, an abdominal bleed or something and I can remember ringing the Registrar and saying I think this man is dying, you better come in and I can remember him coming. And, and just the whole, and of course then the wife was wailing, and I mean he died, not a particularly nice death, because he was in acute pain. And it was quick. And just, the, the whole sort of trauma of this, being out of his own environment, and nobody, there and nobody, sort of really understanding what it all meant. And certainly I don't think I did. I mean I did on one level, but not on another. I mean I knew that it wasn't physical, but I didn't really understand, because I didn't know, I mean I didn't, I didn't know, you know I didn't know at that time about the whole, importance of the, you know the spiritual, being for them, and you know, all that being away from his roots and all that sort of thing. There was nothing we could do, but there was, a real sense of helplessness, because we couldn't, we couldn't, contribute or we couldn't do anything. I mean not only for the physical point of view to stop him dying, well we knew that was going to happen, but to help his wife and, family, here he was stuck in a room, miles away from home, and he was you know, it was just, it all seemed so wrong, you know? And, and that had a huge impact on me" (Anna, 1<sup>st</sup>, 1.1, 331-354).

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