An Ethnographic Study into the Meanings and Manifestations of Professional Caring in Nursing and Midwifery Hospital Settings and Quest for Educational Strategy

Vivien M Woodward MSc, RN, RM, ADM, PGCEA

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Abstract

Based on an interest in the impact of policies affecting contemporary nursing and midwifery practice and education, the research examines the phenomenon of professional caring. Caring is explored at length in the nursing literature, but rarely against the context of day-to-day practice. The research addresses this deficit and explores the interpretations and values practitioners attach to the concept of caring and how these are manifest clinically. It is argued that caring is a moral obligation of the health care service and is conceptualised as necessitating relationship, which is Other-centred and responsive to the patient as an individual. It is imperative that caring feelings are transformed into active response and therefore, optimum clinical decision-making and skills are equally crucial. The research was undertaken with the intention to extrapolate findings to the educational context in order to investigate potential educational strategy.

The study adopts an ethnographic approach, which involves two hospital-based case studies and convenience samples of six palliative care nurses and seven midwives within a postnatal / antenatal ward. Qualitative data were generated through non-participant observation and semi-structured interviews. Contextual data, such as patient to staff ratios and admission and discharge numbers were also collected, in addition to patient / client comments regarding care when the opportunity arose. Data were transcribed, followed by abductive thematic analysis and interpretation.

Comparison of observational and interview data across settings identify qualitative differences in how caring is conceptualised, articulated and manifest. While the maternity setting experiences greater pressure of work, this does not totally explain the practice differences. In particular, the use of a theoretical model to guide care, strong team identity and clinical leadership within the palliative care setting appear to produce visionary rather than routinised, task-orientated practice. In addition to educational strategy, this implicates socialisation processes as the means to establish and perpetuate caring values.

Recommendations for a strategy to place caring at the centre of practice highlight the need for organisational and educational collaboration. There is emphasis placed on the
importance of clinical leadership and a clinically based educator to facilitate team solidarity through reflection on clinical practice against a theoretical framework which encompasses caring values.
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Chapter One
Background and introduction

This chapter recounts the process by which the research topic achieved salience and an impelling significance which motivated the work detailed in this thesis. The impact on education of the government’s intentions for nurses’ and midwives’ contribution to health care is identified. It is suggested that these compound pre-existing shortfalls in traditional caring agency. It also appears that organisational goals are beginning to both subordinate professional control of practice and determine the professions’ identities. Moreover, the way in which professional education is commissioned provides little resistance. The intended contribution of the research is identified.

Throughout this thesis, unless it is stated that specific reference is being made to either nurses or midwives, reference to nurses, practitioners or clinicians denotes both. Also, the term patient refers to individuals who are hospitalised due to illness or childbearing. In specific midwifery contexts, the terms women or mothers will be used.

1.1 The concern which prompted the research

This thesis has emerged in response to the many changes introduced in nursing and midwifery education in recent years. Since I began working as a qualified teacher in 1989, preparatory course for nurses and midwives have evolved from certificate to diploma level and there are previously, unimagined opportunities for nurses and midwives to obtain first level and higher degrees. The goal to achieve higher academic levels and integration into higher education necessitated personal involvement in regular curriculum development, in which research, critical-thinking, decision-making, reflection and greater emphasis on professional, legal and ethical issues became ‘educationally correct’ in keeping with current official proposals (DoH 1993a, DoH 1994a, ENB 1995). My initial concern was that, while these were being incorporated into curriculum documents, when faced with programme delivery, I perceived a lack of organisational support and an assumption that an educational qualification enables you to teach anything. I perceived that the espoused professional ambitions were not being
given the resources to ensure that they would be realised. Personal insecurities aside, this disquiet was the probable source of my increased attention to related issues.

I was involved in preparing qualified midwives to support the new diploma and undergraduate students. The midwives expressed anxiety that academia would subordinate the knowledge embedded in their many years clinical experience. These midwives perceived that they were providing skilled care and their scepticism sharpened my awareness and exposed uncertainty as to why higher academic levels were being advocated. The rationale appeared to be related to the encouragement midwives and nurses had received to develop their professional roles (DoH 1993a, DoH 1994a). Arguably, increased cognitive skills enhance practice by enabling practitioners to provide optimum care by questioning what they do and through associated research awareness, appreciation and activity. Also, the envisaged increased credibility and equal partnership with doctors might assist nurses and midwives influence and implement health care strategies for the good of patients.

This motivated me to write for publication in an attempt to argue that higher educational levels were of potential benefit to the profession (Woodward 1996). Views evident in my literature review, suggested that the existing culture might negate any new perspectives and approaches to practice students might gain as a result of the programmes (Bircumshaw 1989a, Page and Healey 1990, Watson and Kiger 1994). As a result, my article advocated that students requires the support and encouragement of midwives. I encountered other disconcerting issues, such as the lack of agreement regarding the content of courses at different academic levels (Davies and Burnard 1992), persistent difficulty in relation to assessment (Bujack et al 1991) and most significantly, evidence that the benefits of higher academic levels were not proven (McCloskey 1983, Bircumshaw 1989b, McDonald 1995). Moreover, there were suggestions that academia may adversely affect clinical care-giving (Bryar 1995, Wagstaff 1991). Authors suggest that an emphasis on cognitive skills may inhibit the affective domain (Krathwohl et al 1964) and subdue caring impulses (Bauman 1993). In contrast to reasoning with concepts, standards and rules, caring as a moral emotion involves tacit knowledge (Bauman 1993).
I had come to recognise a crucial omission and that, despite the sharp focus on academic skills, caring relationship attracted cursory regard. Perhaps I, like others, assumed the caring nature of practice, had internalised the minimal effort given to education of the affect (Boud et al 1993, Gardner 1993) or had become distracted with alternative discourses. I began to investigate the underlying purpose of contemporary nursing and midwifery education and the place of caring as a practice value.

The Briggs report (1972) clearly identified nursing and midwifery as professions in which caring is central to practice. Also, caring is implicit in recent publications, in which the government promotes the professional health care role as necessarily patient-focused, sensitive and morally sound (DoH 1994a). Yet, my review of the literature revealed long-standing deficits in professional caring agency.

1.2 Shortcomings in care

Relationship and “being with” are fundamental to caring for others (Jarvis 1996, Bauman 1993) and while communication and the interpersonal relationships are emphasised within caring theory, Fielding and Llewelyn (1987:282) cite research which suggests that:

"Communication is both one of the most demanding and difficult aspect of a nurse’s job, and one which is frequently avoided or done badly although being central to the quality of patient care."

Fielding and Llewelyn (1987) maintain that nurses would rather engage in administration tasks rather than interaction with patients and identify that it is the lower status carers who communicate the most with patients.

Salvage (1990) identifies that despite assertions that nurses’ therapeutic use of self promotes healing, this rarely occurs in general hospitals, where the focus is on physical needs and little attention is paid to the therapeutic potential of the relationship. “Doing to” rather than “being with” may be observed as practitioners manage bodily needs as quickly and effectively as possible and find ways of avoiding more involvement with
patients (Campbell 1984). There are indications that some practitioners provide care unequally for people (Kelly and May 1982) and use their power discriminately against the interests of particular patients (Stockwell 1972).

This apparent neglect of caring relationship is compounded by contemporary government health care objectives, which appear to constrain practitioners’ caring intentions and thereby undermine caring as a central value. Also, other aspirations place the interests of the patient and practitioner in opposition.

1.3 The impact of professional and organisational change

The Griffith’s report (House of Commons 1983) brought about a major reorganisation of the National Health Service (NHS) and was concerned with conservation and rational use of limited resources (Mohan 1995). Jenson and Mooney (1990) assert that this has created a shift from a deontological ethical framework which favours the individual to utilitarianism concerned with achieving benefit for the greatest number. This automatically compromises nursing intentions to provide individualised care.

Budgets have been tightened and efficiency is now an accepted goal in health care (Jenson and Mooney 1990). Rationalisation may well be necessary as health care costs rise, yet in a commercial world, which requires tangible and standard measures of input and outcomes (Dickens 1994), caring is likely to be left unaccounted for. Despite concerted efforts, unlike the products of medical intervention, the benefits of practitioners’ caring actions remain difficult to measure clinically (Bujack et al 1991). Resulting from the lack of priority and funding awarded to caring, Wilkinson (1995) maintains that its meaning has become confused with measurable and observable acts which nurses perform. Concern has been expressed that a member of NHS management alluded to the caring element of practice as “random care” (Hart 1991:20). It was also asserted that support staff should take on this role, in order to free qualified staff to concentrate on clinical skills. Benner and Wrubel (1989) concur that nursing skills are presently undervalued in favour of technological knowledge and skills and arguably practitioners adopt corresponding perceptions of their contribution to health care. This has potential adverse consequences for both nurses and patients.
Patients as well as practitioners perceive lack of time for activities which convey caring (Mackay 1990, Oakley 1993). However, from the current perspective of optimising clinical effectiveness (NHS Executive 1996), disregard for the benefits of caring may represent an unfortunate oversight. According to Goleman (1995), there is growing evidence that the care of patients’ emotional states, as well as physical conditions, positively influences both preventative measures and treatment. It appears that while nurses and midwives are being asked to identify their contribution to the nation’s health (DoH 1993a), a vital part of this is being simultaneously eroded.

Other government intentions for the health service involve strategies which appear patient-centred but combine potential detrimental consequences for nurses-patient caring relationship. The government’s “Health of the Nation” document (DoH 1992) emphasises the responsibility of individuals for their own health (Mohan 1995). This reflects the World Health Organisation (WHO) recommendations for health promotion and education (WHO 1985) and the increasing influence of consumerism (Fulford 1996). Care delivery aimed at increasing patient-power has been initiated in the form of patient/woman centred care and the partnership between the carer and cared-for (Fulford 1996, DoH 1993b). Distribution of the workload to teams and primary care are strategies which have been introduced in nursing and midwifery alike, in an attempt to minimise the number of practitioners patients encounter, with the view to enhancing communication and mutual trust. This also offers nurses and midwives increased responsibility and accountability in the form of primary carer and lead professional roles, respectively. Therefore, the possible reduction in practitioners’ sense of personal worth has coincided with the opportunity to counter this through the greater involvement in more complex procedures and work previously undertaken by doctors (UKCC 1992a). It has been suggested that recent initiatives have, in part, been introduced to challenge medical dominance (Mackay 1990). This redistribution of technical activity also has the potential to reduce NHS expenditure, but at the same time might dominate nurses’ and midwives’ professional roles.

Despite the staff shortages (Francis and Humphreys 1998), the opportunity to push back practice boundaries may appeal to nurses and midwives. Some practitioners may
achieve increased job satisfaction in this way and patient care may be enhanced through continuity of care and carer that increased scope of practice may offer. However, the danger exists that technical skills may monopolise and diminish the caring relationship. Leininger (1981) considers that technology dehumanises care and the engrossment of practitioners in technical competency may compete and conflict with the utilisation and development of caring agency. Benner and Wrubel (1989) warn that technology is both unsafe and unfeasible in the absence of skilful, compassionate care.

1.4 Educational shortcomings

Efforts to sustain a caring culture within the current health care climate appear problematic. Organisationally, professionals are increasingly governed by managerialism and targets of efficiency and effectiveness. As noted, skills and competencies are increasingly emphasised (Usher et al 1997, Jarvis 1997). Contemporary educational contracts are based on the commissioning of programmes of study by hospital Trusts (Francis and Humphreys 1998) designed to produce practitioners “fit for purpose” (DoH 1994a:5). Education has therefore adopted a utility orientation, in contrast to the aims of modernity’s education which focused on optimising an individual’s potential and autonomy (Jarvis 1997, Usher et al 1997). In Usher et al’s terms “Utility displaces vocation, technique drives out calling” (1997:14). Knowledge has become a commodity in the market relationship between educators who produce role performers and health care institutions who are the consumers (Usher et al 1997). Given the overall organisational emphasis on instrumentality, caring relationship is likely to be given low priority. This situation indicates that the officially designated caring professions (Briggs 1972) have little autonomy in the determining the values which underpin their practice.

Yet, paradoxically, current educational objectives support ongoing professionalisation which concerns theory building. This is intended to identify a body of knowledge to represent the professions’ unique contributions to health care (Bryar 1995, Kitson 1993, May 1990). Two statements which indicate the association between theory
Building and professional ambitions are evident in the options identified by Gow below (1982 cited by May 1990:311):

1. Professional identity based on a distinctive body of knowledge and professional expertise from which equivalence as scientific colleagues to doctors could be constructed.

2. Professional identity as expressive specialists, derived from a distinctive body of knowledge of psychosocial dynamics, and skills in therapeutic relationships.

Higher status through either theory building or the development of technical skills may help to equalise power between nurses and midwives and their medical counterparts, but may only serve to increase the power division between themselves and the people they care for (Oakley 1993). Professionalisation and higher status represent self rather than patient centredness (Oakley 1993, Campbell 1984). In order to dispel accusations of self-interest, practitioners need to ensure that the advocated change in power base from professional carer to patient is not compromised as the balance of power between themselves and the medical profession is being sought and established.

Without dismissing the potential of theory to enhance practice (Bulmer 1984a), its uncertain application to practice is well known (Miller 1985). Additionally, the prioritisation of theory over practice (Corbett 1998) reduces the opportunity to develop skills in relationship building with patients. Knowledge which impacts on practice is more likely to be perpetuated as it is passed from generation to generation, initially through apprenticeship and later through accumulative clinical experience (Bishop and Scudder 1990). This highlights the serious implications of the overt examples of non-caring mentioned earlier, since these may serve as the foundation for a neophyte's caring values. In order to perpetuate ideal practice, learners require role models who make available caring agency for cultural transmission.

Caring may also become endangered as a central value as recruits may be motivated by the opportunity to acquire an academic qualification rather than out of the desire to
care for others. In this case, there is even greater need to develop education which focuses on the values and virtues which enable caring.

The lack of educational focus on caring may also be perpetuated by feminist schools of thought, which promote the discourses that caring is innate (Smith 1992). In contrast, it is argued that caring, as a moral emotion, is not in fact, such a given. Without professional and educational focus, practitioners may remain unaware that caring, like any other activity, needs to be developed, practised and perfected (Salvage 1990). Whereas one can acknowledge ethical principles such as beneficence, non-maleficence and values such as maintaining integrity, dignity of persons and truth (Brown et al. 1992), internalisation and commitment to such values is not as straightforward as learning new information or a new practical skill. It may take years of perseverance through success and failures to achieve the essence of a caring attitude towards fellow human beings (Bevis 1981). Faced with a lack of organisational and professional support, the onus is on the individual practitioner to find personal meanings through which to sustain caring practice. The outlook appears bleak if caring is not organisationally sanctioned.

1.5 Conclusion and intended contribution of the research

It is concluded that in the current health care context, caring capacity is under-achieved due to individual, organisational and political factors. Nursing and midwifery appear to have experienced transformation associated with current discourses and demonstrate role ambiguity and lack of caring vision against which to evaluate the impact of policy and discourse on practice. The deliberate means to promote and sustain a commitment to caring and to negotiate and overcome contemporary diversions, appear non-existent. During this initial encounter with the issues, I found it difficult to understand how the desire to master technical skills, to achieve higher academic levels and professionalisation have become such powerful discourses, which subordinate something so central and fundamental as caring. The nature of the service provided for our society's weak, sick and vulnerable, symbolises the extent to which we value human beings. Caring embodies values, such as respect for the
unconditional worth, dignity and individuality of persons, which I believe is a component of our health care system which must defy rhetoric and be preserved.

Based on the premise that this situation may be remedied by education and organisational reform, this research aims to contribute to a greater understanding of professional caring in action as opposed to theoretical exposition. It is intended that from this understanding a means to address caring educationally might be forthcoming. It is also hoped that the study will contribute to and generate discussion which restores the wider potential contribution of nursing and midwifery practice.

1.6 Structure of the thesis
The political influences, identified above, which govern nursing and midwifery practice, indicate the futility of exploring practice issues in isolation. The following chapter, therefore, places professional caring within a political and ideological context. Chapter three attempts to illuminate the essence of professional caring based on conceptualisations in contemporary literature. This provides deeper insights as well as the conceptual framework on which the research is based. Thereafter, chapter four outlines the difficulty with which the research aims were specified due to the nature of professional caring and the desire not to introduce or perpetuate distortion. The rationale for deciding upon an ethnographic research design which encompasses non-participant observation and qualitative semi-structured interviews is explained. The practical aspects of implementing the research strategy and data analysis follow. Chapters five to nine, present, analyse and develop understanding of professional caring from the data. These indicate qualitative differences across the two research settings both in terms of manifestation of caring, articulations of the meanings given to caring and contextual constraints and supportive structures. These interpretations are then extrapolated to the educational context. Based on experiential models of learning, the place of theoretical frameworks to guide practice and socialisation processes, recommendations for a combined educational and organisational strategy are offered. The research process is then evaluated, in order to scrutinise the extent to which the findings and recommendations are credible and trustworthy. Finally, suggestions for future work are identified.
Chapter Two
The institutionalisation of caring: the historical legacy

This chapter traces the origins and evolution of professional caring. These explain the contemporary health service dynamics which constrain nursing and midwifery practice and impose moral obligation upon the organisation. While Christianity contributed to the establishment of collective responsibility for the care of the sick and vulnerable in western society, one current discourse argues a mutually exclusive association between caring and Christianity (Bradshaw 1994, Roach 1984). This presents difficulty for any vision of caring in today’s secular society, if it perpetuates a belief that caring is dependent upon religiosity. This chapter attempts to dispel this assumption. However, it is argued that due to the nature of illness and hospitalisation, caring as a central value is a moral necessity. Nurses and midwives achieve closest proximity to patients and are therefore instrumental in the maintenance of a caring environment. The nature of institutionalised activity and nurses’ subordinate status represent two major constraints to the achievement of these ends. It is noted that values which become embedded in institutionalised practice risk decline unless counter measures are constructed and the lack of authority over their sphere of practice is disempowering.

This thesis presupposes that modern-day nursing and midwifery face similar challenges in maintaining caring as a core moral principle. In fact, they have different origins and one section will outline the historical aspects of midwifery and how it came to share similar challenges to nursing. The evolution of western modern day health care is regarded within the context of changing ideologies. The chapter concludes with the view that, since modernity shaped the current organisation, post modern ideology provides professional caring with an opportunity to achieve greater emphasis.

2.1 The emergence of health care institutions

Social institutions, such as, marriage, family, religion and education, lay the foundations for social life (Giddens 1989:381). They provide continuity in thinking and behaviour across the generations and therefore perpetuate the established ways into which people are socialised (Jones 1993:28). Responsibility for care of the sick in society appears to be
influenced in the same way. Caring is fundamental to human survival (Leininger 1981, Watson 1981) but care of the ill, distressed and vulnerable in society has not always been managed as it is currently. Prior to widespread Christianity, care of the sick was the responsibility of the family and kinship unit (Bradshaw 1994) and although Greek medicine existed, this was through scientific rather than compassionate motivation. Also, in awe of nature and the gods, the Hippocratic ethic excluded treatment of fatal diseases. Both Greek and Roman religions, taught that the sick and sinful were not worthy of the Gods and they therefore became society’s outcasts.

During the middle ages (5th-15th centuries), Christianity, in western society, transformed care of the sick as the teachings of Christ introduced an opposing perspective (Bradshaw 1994: 101-5). The Gospel made no such distinction between sick and healthy, since it told that individuals suffered one supreme ailment alike; that of human sinfulness. The early church emphasised the possibility of self-healing and salvation through commitment to duty and self-sacrificial caring for the sick, based on a love of Christ and his compassion. The church’s emphasis on moral emotion (compassion) and caring motivation which necessitates practical expression are reflected in modern-day analyses of the nature of caring, to be discussed in the following chapter.

In those days, the Christian church, as both a religious and politico-social institution was extremely powerful. Care of the sick and poor was central and while this became the responsibility and vocation of the Christian religious orders, each individual in the community was responsible and duty bound to contribute. Bradshaw (1994) argues that it was the immense influence of the early church which stimulated collective concern for the community’s sick and poor. At that time, the emphasis was on supporting the sick rather than attempting cure (Bradshaw 1994) and if treatment of illness was sought, this entailed a combination of folk remedies, prayer and magic (Giddens 1989).

2.2 The shift from covenant to contract and the impact of Christianity on caring
In the late sixteenth century, while the parish was responsible for the care of the sick in their own homes, in extreme poverty and need people were taken to almshouses, pest houses and hospitals. Here, the “poor, needy and sick” were “refreshed, maintained, comforted,
found, 'healed and cured of their infirmities'" (Bradshaw 1994:111). Notably, medicine achieved its foothold in the institutionalisation of caring within the Christian movement. In the late sixteenth century, physicians were involved in fulfilling both caring and healing functions and received payment from the parish (Bradshaw 1994). The scientific revolution in seventeenth century provided medicine with the credibility to permit collaboration with the church to eradicate rival cure options such as witchcraft and pagan medicine (Ehrenreich and English 1973). The enlightenment in the eighteenth century, with its emphasis upon education, empirics and rationality challenged religious values. The medical ideology which proposed that the origin of illness is physical and explicable in scientific terms, de-stabilised and surmounted the former religious monopoly of caring for the sick (Giddens 1989). The positivist paradigm introduced the notion of universal human values, creating the potential for reductionism and loss of attention to individual particularity. Conversely, from the individual’s perspectives, the enlightenment caused immense social change and loss of community coherence, since it favoured individualism. Individuals had mutual ties due to utility rather than human ties. To use Tonnies’ terminology, human relationships once based on ‘Gemeinshaft’ (companionship) changed to ‘Gesellschaft’ (commerce) (1955 cited in Bradshaw 1994). Religion was now personal and private in a fragmented society, based on declining Christian values. The concept of care built on freely given, mutual service in fulfilment of God’s covenant had become based on commerce. Christianity remained the main source of philanthropy, but new hospitals funded by private charity included secular motives (Bradshaw 1994:117).

Christianity enabled ‘women’s powers’ to be directly employed within society for the first time (Bradshaw 1994:109). As medicine developed, doctors required assistants to monitor their patients (Abbott and Wallace 1990:23) and with a belief in their innate caring nature, women were ‘called’ to extend this natural attribute beyond the family (Bradshaw 1994:117). Nursing as an occupation was attractive to women as it provided security at a time when contemporary ideology portrayed women as morally and socially wanton (Bradshaw 1994). Bradshaw alludes to the ensuing loss of spirituality and notes the coexistence of two types of nurses, those of ‘loose morality’ and employed for meagre

\[1\] Dictionary definition: provided with meals, heating and bed linen
wages and beer money and ‘good nurses’ (page 118). Additionally, the move from covenant to contractual obligation created a practitioner rather than patient-centred ideology.

Campbell (1984) questions the caring values of health professionals who earn a living through the misfortune of others and argues that nurses should do more to prevent illness. While he may be correct in believing that preventative efforts could be more proactively undertaken, even in the event of mammoth prophylactic efforts, it is difficult to envisage a world without illness and the need for professional care-givers. There may be concern that remuneration for caring activity creates inappropriate incentive and cannot ensure caring but neither does it exclude it.

In the early 1900s, under the influence of Mrs Bedford Fenwick, nurse registration and professionalisation consolidated the shift from a religious to contractual basis for nursing practice (Bradshaw 1994). Nightingale objected to this, insisting that, nursing was not only a ‘calling’, but also a means of achieving religious satisfaction.

*The nurse was a missionary, not with words but in her loving and devoted actions. Without God she was nothing: her mission was to be like Christ* (Bradshaw 1994:138).

Mrs Bedford Fenwick also recognised that mere physical competence was insufficient and that a sense of vocation, selflessness and altruism transformed common tasks into caring of the finest quality (Bradshaw, 1994). Bradshaw (1994) and Roach (1984) both contend that there is a positive correlation between religious and caring values. This assumption potentially dampens aspirations towards a vision of professional caring, in an increasingly secular society. Arguably, Christianity provided a favourable milieu in which caring was socially valued, but, it cannot be automatically assumed that religious membership ensures caring. Maggs (1988) highlights the potential threat of religious zealotry and points out that the religious sisters were accused of emphasising the spiritual aspects and having an allegiance to God rather than to hospitals and doctors and the development of nursing skills. Giddens (1989) notes that during the thirteenth and fourteenth centuries, women
entered religious orders in order to embark on teaching or nursing vocations, which were under religious control. As these professions separated from the church, numbers in the orders fell. This suggests a primary allegiance to the occupation rather than religion.

The view taken in this thesis is that religion is not the only source of altruistic values which motivate caring. Alternative sources of commitment to caring agency exist and could become established like any other institutional ideology, through legitimation and internalisation of the relevant values (Berger and Luckmann 1966). These socialisation processes are influenced by contemporary discourse which renders certain activity either popular or outmoded.

Bradshaw’s perspective above is a theological one and it is necessary to point out that Christian caring values cannot be entirely isolated from coexisting ideology which also emphasised collective responsibility for fellow members of society. According to Lukes (1973, citing Walter Ullmann’s ‘Individual and Society in the Middle Ages’), the influence of the Roman ideology, which proclaimed the paramount status of the common good was also dominant at that time. The individual did not exist in his own right and his personal interests could be forfeited for the common good of society. This illuminates two possible attitudes regarding society’s sick, which Lukes does not make clear. Either they are equal members and the society shares the responsibility for their support, or the sick individual constitutes a burden on the society, and is cast out. One can only speculate that Christianity may have tipped the balance in favour of the former, since it promoted the equal value of each individual.

This social complexity exposes the limitations as well as benefits of seeking answers in the past, since from a positivist perspective, there is insufficient evidence to propose specific cause and effect. Even so, potential lessons may be extracted and importantly, at the time of the early church, Christianity provides an example of a time when caring for the Other was a dominant ideology in society. At least, it can be proposed that a commitment to caring was realised through the fortuitous coexistence of compatible discourses, that is, Christianity and the primacy of the common good. Gradually, these dominating paradigms were challenged by individualism, capitalism and the emerging scientific paradigm, which
possibly introduced a new perspective on the potential costs and benefits in relation to self-sacrificing caring agency. Admittedly, it is difficult to elucidate the precise nature of relationship between care-giver and recipient, since Christianity placed emphasis on both duty and emotion (compassion and love), a dialectic which will be discussed in the following chapter. However, it is felt important to firstly express the view that Christianity facilitated a step forward for mankind and an appreciation of the example it provides of a society in which altruistic agency and concern for the Other, thrived.

This personal view conflicts with that of the humanist, Huxley (1969), who argues that human destiny lies not outside, but within the human mind and denies the possible contribution of religion, such as Christianity, to human destiny. His view is clear in the following citation.

*Any belief in supernatural creators, rulers, or influencers of natural or human process introduces an irreparable split into the universe, and prevents us from grasping its real unity. Any belief in Absolutes, whether the absolute validity of moral commandments, of authority of revelation, of inner certitude, or of divine inspiration, erects a formidable barrier against progress and the possibility of improvement, moral, rational or religious..... theistic religions, with their inescapable basis of the divine revelations and dogmatic theologies, are today not merely incompatible with human progress and the advance of human knowledge but are obstacles to the emergence of new types of religion which could be compatible with our knowledge and capable of promoting our future progress (Huxley 1969:109-110).*

It is countered, that Christianity may not fit today’s individual, technological, rational world, but it is perhaps only in consequence, that the human capacity for such altruistic moral agency, can be presupposed.

The difference in ideologies between Huxley (1969) and Bauman (1993), in the time frame of approximately twenty five years, is striking. While Huxley appears to be influenced by
positivism and sees the non-empirical nature of religious beliefs as undermining human
destiny, for Bauman, rationality threatens human morality. While humans seek to achieve
the ideal, a universal definition of what this comprises is defeated by the existence of
multiple competing, conflicting ideologies. The above contrasting perspectives may
indicate the rise and fall of modernity's emphasis on rationality and science, which will be
addressed later in the chapter. Such a dichotomy highlights the need to address Kuhn's
(1970) notion of the inevitability and dynamism of revolutionary discourse as part of human
existence. The interplay of competing and changing ideologies supports Marx's theory that
conflicting ideologies create social change and that this usually involves the vested interests
of one group in bringing about change in order to achieve status and power. Some, as in
the case of Christianity and the current focus on phenomenology and existentialism may
favour caring, others, such as positivism, wide sweeping application of grand ethical theory,
may not. Whether caring values derive from secular or religious beliefs, with political
awareness, nurses and midwives might represent a force to protect and promote caring in
the face of unfavourable discourses. The influence of changing paradigms on nursing
philosophy and caring will be explored in the following chapter.

2.3 Midwifery
Midwifery has very different origins to nursing, and was an occupation prior to Christianity.
However, as medicine gained status, midwifery eventually became medically controlled and
today shares similar difficulties with regard to professional autonomy and authority. Before
the seventeenth century, childbirth was controlled by women and the midwife (meaning
'with woman') was expected to be in charge of the birth. She also played an active role in
helping women maintain a 'female culture' and the perpetuation of postnatal rituals, which
gave women immediate respite from marital duties (Wilson 1995). Midwives received
payment from the women or from the parish, in cases of poverty. Her alternative name,
'grace-wife' indicates the expectation of remuneration. Commercially, therefore, the
origins of midwifery in the United Kingdom are similar to those of physicians.

Later, women wishing to enter an occupation had little interest in midwifery as, before the
reformation, midwives were considered immoral and incompetent, a portrayal which,
Ehrenreich and English (1973) argue was perpetuated by doctors. Medical men criticised
midwives and their practice, and only grew interested to monopolise midwifery in eighteenth century. Initially, these male-midwives cared for the rich, who could afford their fees, while midwives continued to care for the poor (Abbott and Wallace 1990). The Midwifery Registration Act in 1902 resulted in the registration and education of midwives under the control of the medical profession, who determined the division of labour and boundaries of midwives' and doctors' work (Abbott and Wallace 1990). Government reports (Cranbrook 1959, Peel 1970), which advocated hospitalisation and medicalisation have resulted in only a bare existence of independent midwifery and most midwives work within a medically determined sphere of practice. Within their scope of practice, midwives have more autonomy than nurses while pregnancy and childbirth remain uncomplicated, although policies which determine 'normality' are medically determined (Towler and Bramall 1986, Schwarz 1990). In the event of complications, the situation is similar to that of the nurse (Symmonds and Hunt 1996) and involves referral to doctor and undertaking of medically prescribed care.

Since the professionalisation of midwifery in 1902, training could be undertaken either with or without a prior nursing qualification (Donnison 1988). During 1972, 'direct entry midwifery' was under threat of abolition, in an effort to align training with Scotland and Northern Ireland. Only one institutions providing direct entry training survived until the 1990s, since when there has been a gradual revival. Even so, currently, most midwives have undertaken nurse training prior to midwifery and are therefore socialised accordingly. While not having origins in Christian caring values, one could question if midwifery shares nursing's concern for caring agency. The Briggs report (1972) politically legitimated midwifery as a caring profession when it proposed that caring is central to both nursing and midwifery, compared to medicine, in which cure predominates.

Given the politically perpetuated medicalisation of illness and childbirth, the associated social isolation and individual vulnerability imposed by hospitalisation and/or medical intervention, midwifery practice clearly has a strong moral basis, in which caring is imperative. The following section which identifies the public expectations of the NHS and the vulnerability associated with exposure to institutionalised care, provides powerful grounds for this view.
2.4 The responsibility of professional carers

Members of society are usually cared for in the community by those with whom they have an emotional attachment, such as family, friends and neighbours. Professional caring has evolved to become a supportive structure which provides care and caring when lay resources are unable to meet the person’s health care needs (Kitson 1987). As Kitson (1987) identifies;

*... professional carers set themselves up as a specialist service meeting the caring needs of those who are either unable to care for themselves or others in an acceptable manner* (Kitson 1987:164).

Since the early 1900s, medicine has established a large number of hospitals, which demonstrates western society’s acceptance of scientific treatment of illness and that hospitals are acknowledged institutions within which more serious illnesses are managed (Giddens 1989:588). A number of Government reports have ensured that childbearing has experienced a similar fate (for example, The Cranbrook report 1959, The Peel Report 1970). Dependence upon national health care provision therefore, represents a substantial investment of public confidence and trust. Health care practitioners owe an obligation to society to ensure the primacy of patient interests, as identified in Code of Professional Conduct provided by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC 1992b).

Kitson (1987) suggests three characteristics of the relationship between professional carer and cared-for; there is a commitment from the carer to provide a sustained and continuous service until such time as it is no longer required; the practitioner has the knowledge and skills to meet the patient’s needs and there is an underlying premise that the relationship upholds the individual integrity of recipient of care. In order to achieve the latter characteristic, it is maintained that practice needs to incorporate caring values. It is suggested that these may be sensitised by an appreciation of the impact the admission into a health care institution has on the individual and family. Also, the legacy of health care institutions as self-professed resources of care and cure, necessitates that professional carers have a moral obligation to provide optimum care.

2-9
2.5 The experience of Illness

Obligations of the care-giver arise in consequence of the experience of illness and hospitalisation. Vulnerability gives rise to expectations, which, in Pellegrino's (1982) view, become promises, each time the professional is present and offers to help. The professional promises that he has authentic knowledge, skill and competence to offer the ill person and to act in his best interest. It is maintained that the factors identified in this section apply equally to midwives' care of childbearing women.

Berman (1983) offers insights into the potential distressing experiences and many threatening features of the health care system, through which practitioners are required to assist persons to attain / maintain health. For example, patients may need to depend on health care personnel for their usual daily activities, personal integrity and even survival. Patients undergo intimate procedures which cross normal social barriers, appear incongruent with adult life and which may provoke embarrassment, fear and anxiety (Lawler 1991).

Hospital settings are associated with loss of control (Pellegrino 1982, Schorr and Rodin 1982), health care personnel are unfamiliar (Bergman 1983); their roles and culture are alien and their language is difficult to understand. The physical setting permits minimal personal control and privacy and routines are different and disruptive to usual lifestyle, confusing and frightening. There is uncertainty and fear relating to illness or fear for future personal, independent ability and dignity. The health problem or status draws attention to personal inability to deal with usual day-to-day activity and frustrations which result due to loss of self-sufficiency. Such feelings of inadequacy are compounded by the perceived power of professionals, which may result in the patient adopting a passive, dependent role and perfunctory co-operation and conformity. In the maternity setting, Wendy Savage (1986), an obstetrician and advocate for women's participation in childbirth choices and decisions, identifies how the hospital environment favours the staff rather than the women,

*It is too easy for the professionals to become distant from the reality of patients' feelings. For example, doctors and midwives feel at home in hospitals, the surroundings are familiar, we know all the people, we have...*
the pleasure and satisfaction of having accomplished worthwhile work in
the building, and it is hard for us to see the place as an outsider does,
frighteningly impersonal, overlarge, filled with remote people in a rush -
and often associated with unhappy memories of illness and death. The
routine, the forms, the technology may make some people feel secure but
others feel lost and depersonalised - the very size overwhelms them. In
this frame of mind understanding explanations becomes difficult, and the
patient is acutely sensitive to attitudes and the way things are said and
done (Savage 1986: 177).

Pellegrino (1982) suggests that the element of compassionate help is grounded in the
understanding of the experience of illness and hospitalisation and concerns maintaining the
personal values of the patient. Goleman (1995: 164) explains that when faced with illness,
"the illusion of invulnerability" is shattered and in consequence we become emotionally
fragile. While health professionals may ignore patients' emotional reactions (Goleman
1995), illness and vulnerability have a unique and major impact. An individual's freedom to
act is curtailed and the moral integrity of the person is diminished either through incapacity
or emotional despair. Pellegrino (1982) asserts that the professional has the responsibility
to preserve the moral integrity by acting in accordance with the patient's concept of health,
his values and the kind and quality of the life he holds as worthwhile. The patient's choices
and decisions become contingent upon the knowledge and skills of professionals and with
loss of freedom to act as a person, he relies on the carer for the preservation of the values
he holds.

Just as the patient's decision may be poor due to lack of understanding, Campbell points
out that professional knowledge alone is also insufficient. The world and experience of the
helped (assumptions, hopes and aspirations) must meet the world of the professional.
Dialogue between patient and professional, which facilitates choices based on shared
perspectives, best fulfils the moral sense of benevolent concern for the Other (Pellegrino
1982), as does the accommodation of dependency, where this is the patient's true choice
(Campbell 1994).
Yet, institutionalisation of caring and the dynamics of the health care organisation, in particular, medical dominance and nurses’ intermediary role, present major challenges to the achievement of the above caring ideal. These issues are addressed next.

2.6 The impact of institutionalisation on caring practice

This section argues that, due to the potentially detrimental effects of unavoidable routinisation and habituation, structures which affirm and reiterate institutional caring values are paramount.

Institutionalisation concerns the routinisation and standardisation of behaviours and the original meaning of an activity becomes embedded in the routine (Berger and Luckmann 1966). ‘Habituation’ reduces the need for choice, since actions are automatically undertaken. Husserl introduced the term ‘natural standpoint’, to represent the habit of mind or perspective which makes the world familiar and taken-for-granted (Kestenbaum 1982: 14). There is an absence of ‘self-conscious reflection’, which results in an uncritical performance of role and practice behaviours (Kestenbaum 1982). Arguably, routine activity may be undertaken without harmful effect. For example, some human needs are universal, such as those mentioned by Bradshaw earlier (page 2-3) and hence these can be anticipated and offered as standard. Schorr and Rodin (1982) suggest that predictability enhances patients’ perceptions of control and expectations of how they are to behave. Also, where the quality of practice is variable, standardisation in the form of policies and codes of practice may enhance care. Yet, as will be identified more fully in the following chapter, caring concerns responding to the particular needs of the individual. Based on this principle, it is suggested that routinisation presents a major challenge within caring institutions, as it threatens to mask foundational caring values. The way in which values exist and survive in institutions is described next.

Habermas (1972) in referring to Freud’s work, identifies how despite the impossibility of individuals living in isolation, they resist the consensus necessitated by communal living. Yet, institutionalisation relies upon shared knowledge, values and activity which form the tradition, provide boundaries of acceptable practice and which serve as a “channelling and controlling force” (Berger and Luckmann 1966 84). These require some sign system
(usually linguistic) which serves as an 'instrument of the collective stock of knowledge' in order to be objectified and amenable to transmission. For the survival of the knowledge and meanings which constitute the institution, there must be procedures, formulae and symbols to ensure that these are impressed upon individuals and that values are constantly reaffirmed (Berger and Luckmann 1966:86-88). Even when agency was based on Christian beliefs, caring became distorted. Bradshaw (1994) describes the work of Vincent de Paul, who was a devout Christian in the seventeenth century and founded nursing orders which emphasised committed service and altruism. His following instructions illustrate that he was forced to clarify, who the religious institutions were meant to serve,

*They will be very faithful and exact in following their rule .... particularly those which concern the perfecting of holiness in themselves .... But, nevertheless, .. whenever necessity or obedience requires it, they must always prefer the service of the poor to their own practices of devotion, bearing in mind that in so doing they are leaving God for God (Wilson 1973, cited in Bradshaw 1994:113).*

Although religious values may have been in decline, Berger and Luckmann's theory above regarding socialisation processes, places the reduction in institutional and traditional values within the nature of institutions themselves. If applied to caring institutions, this emphasises the need to formulate caring structures, in order to nurture and reiterate caring values, rather than automatically place the blame upon the inadequacies of individuals. The extent to which caring has become displaced in nursing and midwifery, both organisationally and educationally and how this might be rectified is the major concern of this thesis.

This following section examines the impact of nurses' and midwives' caring roles within the wider perspective of the modern-day health care institution. While the Briggs report (1972) identified caring as a central value, it will be shown that nurses and midwives have limited control over their sphere of practice with which to maintain it as such. In addition to countering the effects of institutionalisation outlined above, organisational constraints also need to be neutralised. The aim of the analysis is not to devalue medicine, but to
examine how institutional structures enhance or undermine caring, in order to develop this thesis.

2.7 Twentieth century health care and medical domination
Within the newly formed health care institutions, activity was arranged so that nurses looked after the physical and emotional environment, while doctors decided which interventions were necessary (Abbott and Wallace 1990). It is argued that the combination of the initial power structures and division of labour, resulted in an inevitable, medically-determined, instrumental focus. Nurses and midwives became intermediaries mobilising and implementing care prescribed by the doctor and in consequence experience reduced autonomy over their scope of caring agency.

Maclntyre suggests that institutions are concerned with external and internal goods (1984). External goods refer to the wealth, material goods, structured power and status necessary to support and foster continued practice. Internal goods concern the actual practice, how practice is undertaken and the underlying philosophy. The widespread increase in medically dominated hospitals demonstrates that medicine is politically legitimated and in MacIntyre’s terms, external goods involve the responsibility to the government and tax payer to provide a safe, efficient, effective service, providing treatment of illness within allocated resources.

As mentioned, nursing and midwifery established their position in contemporary health care service through the close association with medicine and therefore share the above responsibility. None-the-less, nursing and medical internal goods differ. Medicine is likely to focus upon discovering improvements to diagnosis and treatment. Based on the forgoing arguments, it is maintained that the internal focus of nursing and midwifery practice encompasses role specific instrumental technique and caring relationship.

2.8 The care-cure divide and evidence of doctors caring
The above arguments are based on the traditional assumption that while the medical domain concerns cure, nurses’ concerns care (Briggs Report 1972, Roach 1984). There are suggestions that nurses use caring as a political tool and inappropriately identify caring as their own, without recognising the caring roles of other health professionals (Baker and
Diekelmann 1994). This thesis concurs with Holden’s rejection of the ‘care-cure’ dichotomy, evident in the following comments:-

\[\text{The curative value of nursing care undoubtedly lies in the nurse’s empathetic skills, which in turn, depends on mastery of the therapeutic relationship. Conversely, the caring value of medicine lies in the physician’s anxiety to deliver successfully the patient from his or her current afflictions (Holden 1991:1378).}\]

Any notion of a self-serving care-cure dichotomy needs to be avoided since self-interest is incompatible with caring (Bauman 1993).

In current literature, there are numerous examples of medical concern for the moral basis of care and caring discourse (for example, Kestenbaum 1982, Fulford et al 1996, Sorrell 1997). This caring perspective was evident during my meeting to obtain the consultant’s consent to undertake the study in the palliative care setting. The doctor openly expressed his disapproval and frustration with medical paternalism in his previous work. This had inspired him to set up the palliative care unit, specialising in dignified care of terminally ill patients. His personal values seemed to empower the rest of the medical and nursing team.

For an optimistic moment, one can envision a united caring - curing health service, with reversal of the present role fragmentation, power struggles and disunity of the instrumental and relational elements. Oddly enough and for unrelated reasons, the necessary beginnings are already current policy. For example, as previously identified, there is potential for nurses and midwives to expand their scope of practice and undertake certain tasks in the place of junior doctors. This is related to the strategy to reduce junior doctors’ hours and preserving financial resources. In Russia, nursing and medical education comprise one unified system. Although nursing and medicine are separate professions, nurses are able to undertake additional, rather than a completely diverse training, to become doctors. Doctors also undertake some caring activities (Guskova and Lubov 1997). As a result, doctors, nurses and patients enjoy closer partnerships in care. Any merging of role boundaries in the UK health care system would present immense implications for education,
since medical and nurse/midwifery education have no practical knowledge of the other. At present multi-disciplinary education is being promoted in order to improve multidisciplinary team working (Spencer 1994), but could constitute the basis for negotiation regarding alternative divisions of activity.

In reality, existing structures which perpetuate medical dominance in terms of status and power, secured during the seventeenth century scientific revolution, appear robust. While it has been shown that it is inappropriate for nurses and midwives to claim ownership of caring, the institutional structures which preserve medical dominance, concurrently ensure that doctors' contact with patients is sporadic and brief. This gives nurses and midwives dominance and hence responsibility in terms of close encounter with the patient. The cure-care dichotomy is rejected, but it is argued that nurses and midwives are primarily placed to undertake and safeguard caring. In particular, within the intermediary role, the nurse/midwife plays a crucial role in countering the doctor's objectification of the patient's illness and in preserving the integrity of the individual's values and dignity (Pellegrino 1982). Arguably, as identified in chapter one, this opportunity and moral imperative is inconsistently achieved. It is suggested that within the intermediary role, which gives nurses and midwives the primary responsibility for the patient experience, there are inherent constraints to fulfilling this purpose.

2.9 The nurse's and midwife's intermediary role
Giddens (1989: 286) argues that professionals within bureaucratic institutions tend to have privileged autonomy for the following reasons; preparation for practice is specific, they specialise in the development of technical knowledge, national and international rather than institutional bodies define the nature of the activity. Also, professional expertise cannot be easily reduced to bureaucratic duties and fits with difficulty into the organisational hierarchy. Administrators may control finances and material resources, but professionals determine the tasks. Even so, different professions have divergent levels of control. Nurses and midwives may be thought of as professionals but have limited control of their working conditions, due to their subservience to nursing supervisors, administrators and medical staff (Giddens 1989). It has been argued that nurses and midwives are the gatekeepers to the patient's experience. Unfortunately, their intermediary position and lack of influence
over policy, seriously constrain their autonomy to centralise caring relationship and therefore, undermines the very essence of their role. Moreover, as with other members of society, they may espouse the dominant medical perspective on the management of illness. It may be that as Freire (1993) suggests, the dominant group establishes what is important and receives attention. In consequence, subordinated groups lose their cultural identity and unique sense of value and purpose. It is suggested that a potent 'caring discourse' is required to resist the dominant constraining structures discussed and to re-develop the subordinated, caring element of nursing and midwifery roles.

In the past and as doctors' assistants, nurses and midwives have had insufficient opportunity to evaluate, question and challenge the scientific and technological emphasis that the medical profession have perpetuated in the treatment (rather than care) of the ill and childbearing women. Given the increased academic preparation which arguably provides the capacity to contemplate, formulate and develop practice, nurses and midwives are faced with the unprecedented possibility to re-establish foundational, caring values. Additionally, philosophical discourse is in alignment. The dawning of new epistemology and ontology perspectives provided by twentieth century writers who challenge modernist emphasis on science and rationality provide caring, as deeply personal and relational, with an opportunity to flourish. Greater recognition of the value of the non-instrumental elements of practice and alternative knowledge sources may be at hand.

2.10 The fading of modernity and rebirth of personal and social knowledge
Earlier in the chapter, it was identified that medicine achieved dominance, due to its compatibility with modernist values. These place emphasis on rationality, science and objectification, which subordinate the immediate experience and personal, intuitive knowledge.

Ironically, the practices and discourses aimed at achieving modernity's hopes of human betterment, constrained human warmth and spontaneity on which human caring relies. The nursing reforms in the late nineteenth century, reflected the ambitions of modernity, although, admittedly, there were opposing visions of nursing. For instance, Florence Nightingale's perspective of nursing as an art and calling compares with Mrs Bedford-
Fenwick’s view of nursing as a scientific and rational enterprise (Rafferty 1993). Arguably, both perspectives were based on the effects of modernity’s belief in rationality and science and required that the self was distanced from agency. Rafferty (1993) argues that Nightingale’s approach was based on beliefs about gender differences, as a result of Darwin’s theory of evolution which classed women as emotionally and psychologically unstable and unpredictable. Rectification of this perceived deficit overrode intellectual educational targets which led, instead, to the training of moral character and self-control. It will be seen in the following chapter, that to some extent, the discourse regarding the benefits of emotional distancing, continue today (May 1991, Morse 1991).

Modernity placed faith in rationality and science as a means of realising progress and human betterment (Usher et al 1997). Post-modernism represents an awakening disillusionment with theory and science as a means to counter unrelenting global inequality, conflict and despair, and a recognition of the limitations of technical rationality.

This thesis resides in both modernist and post-modernist thinking. It is based on the belief that things can be made better, more humane and caring. At the same time, it derives hope from the post-modern challenge to technical rationality and revives the acknowledgement and trust in individual experience, meanings and knowledge. This middle position perhaps reflects why some authors refer to the late rather than post modern era (for example, Jarvis 1997). The origins and subsequent disillusionment with the values of modernity are now outlined.

The Renaissance which asserted the superiority of man over God (Bauman 1992) and gave rise to modernity, provoked recognition of the vulnerability, instability and unreliability of human order. In remedial effort;

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.. it devalued and demonised the 'raw' human condition. It prompted an incessant drive to eliminate the haphazard and annihilate the spontaneous
(Bauman 1992 xi).
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Faith was therefore replaced by a belief in science and the ability of human consciousness to be imperviously self-contained, in order to objectify knowledge (Linge 1976). The emphasis on objectivity allotted negative value to a knower’s subjectivity. The latter was perceived as the source of prejudice and distortion which needed to be transcended, in order to achieve valid understanding (Polanyi 1958). Modernity constructed a universality which denied particularity (Bauman 1992) and scientism resulted in the theory-practice divide which, as Polanyi identifies, had self-alienating consequences.

So that, the theory being placed like a screen between our senses and the things of which our senses otherwise would have gained a more immediate impression, we would rely increasingly on theoretical guidance for the interpretation of our experience, and would correspondingly reduce the status of our raw impressions to that of dubious and possibly misleading appearances (Polanyi 1958: 4).

The educationalist, Dewey argued that the dogmatic intellectualism of science created an unnatural separation of human, primary experience and nature; “When intellectual experience and its material are taken to be primary, the cord that binds experience and nature is cut” (Dewey 1958: 21 & 23). Humans became alienated from their subjective experience, their hopes and dreams, fears and sorrows (Kolb 1984: 116). Individual responsibility was to be fulfilled through instrumentality, rationality, practical achievement and the moral mission was to eliminate ignorance and enlighten others with objective, universal and impersonal ‘truth’ (Bauman 1992 xxii).

The doubting of personal knowledge was not new since the intentions of epistemology, as a philosophical enterprise was concerned with the nature, source and validity of knowledge (Grayling 1996). Claims to knowledge, facts or truth had to counter the challenge of scepticism, that is, how such claims could be verified as facts as opposed to errors, delusions, dreams or misconceptions. Habermas (1972) asserts that at least scepticism served for the individual to reflect upon knowledge. Once epistemology was replaced by a philosophy of science, this was accepted unquestioningly as the only legitimate form of knowledge. The dichotomy of reality and appearance was eliminated by scientific
empiricism (Hammond et al 1991) and personal knowledge derived through experience and reflection lost all legitimacy (Habermas 1972). Habermas (1972) notes that while science created a disregard of individuated experience, it also made language formalised, theoretical, monologic and separated from its embeddedness in everyday social interaction. Similarly, Wittgenstein argues that with increasing levels of abstraction and thought, entities become perceived as material objects and are distanced and void of significance in daily existence, tradition, culture, spirituality and morality (Finch 1995, Cooper 1996).

The value afforded tangible and measurable activity, compared with more elusive phenomena, such as caring was alluded to in chapter one, and reflects the modernist perspective above. During the twentieth century, resistance to this alienation of the self from the world and others in society has gathered momentum. Contemporary thinkers legitimate the personal experiencing of the world and utilise the notion that meaning is socially constructed through language and therefore situates rather than isolates individuals in the social world.

Wittgenstein sums up the new resistance to the objectification of human’s experience. He argues that humans are the ultimate source of meaning, it is through their conscious acts, or practical activities, that meaning comes into the world. Finch (1995:169) shares Wittgenstein’s sentiments in the following quote;

\[
\text{... we are already, all of us, where we ought to be, and that if we cannot find the main source of truth somewhere in ourselves, we will never find it anywhere else.}
\]

Defiantly, Wittgenstein asserts that, in addition to the externalisable element of humanity, which science has extracted and abstracted, is the experience which cannot be expressed. This is our human essence, immediacy, spontaneity, joy and freedom (Finch 1995).

Husserl founded phenomenology (Linge 1976, Hammond et al 1991) with the conviction that human existence is different from all else and cannot be treated as ‘natural’ objects, where behaviour is explicable in causal terms (Cooper 1996). Phenomenology also rejects
the dichotomies of Cartesian dualism of mind and body and the real versus apparent (Hammond et al 1991).

In contrast to scientific realism, phenomenologists consider pre-scientific experience as the only 'real' world (Hammond et al 1991). Consciousness is not a self-enclosed entity filled with ready formed mental images. These are shaped as we perceive the things themselves 'in direct givenness'. Things are known intuitively and have a pre-reflective givenness of a thing undistorted by theoretical application or anticipation. Contrary to a world of meaningless, material objects which Heidegger refers to as 'presence-at-hand', his concept of 'readiness-to-hand' contains the notion that objects are known and imbued with meaning in terms of their utility and intention within the human practical activity (Mulhall 1990).

Phenomenology is closely accompanied closely by existentialism, which is advocated by philosophers such as Kierkegaard, Sartre (Cooper 1996) and Merleau-Ponty (Hammond et al 1991) and envisions humans as meaning-giving, authentic persons who shape their lives through a set of values and interpretations. This transfers responsibility for personal morality from reliance upon scientific objectification to the individual. Sartre coined the phrase 'Bad faith' (Cooper 1996) to portray how people are made anxious by such responsibility are abetted by science to locate the cause of personal shortcomings elsewhere. Sartre argues that regarding ourselves as 'subjects for science' requires us to adopt a third-person perspective which is distanced from the experience of ourselves during everyday, engaged existence (Cooper 1996). Similarly, Wittgenstein notes that doing sometimes appears to be separated from experience. He argues that modern-day science has accustomed us to thinking of behaviour in terms of psychological and social causality rather than personally determined reason (Finch 1995). He asserts that there is the need to recover immediacy, autonomy and uniqueness of action and, in explaining acts, rather than causation, reasons why, desires, motives, wishes and beliefs need to be revealed.

Modernity's epistemological and ontological norms have implications for nursing and midwifery socialisation processes. Current values which are given unchallenged primacy comprise, defensive and inward-looking concepts, such as evidence-based practice, risk
management, efficiency and audit. The post-modern view offers the chance to rediscover the personal meanings, which find little expression in contemporary health care practice.

There can be little that is more personal and immediate than caring and these new ontological perspectives can be the spur to shape caring professional practice. Nurses and midwives may perceive lack of autonomy to take charge of their sphere of practice and feel disempowered to challenge constraints imposed by governmental, medical and administrative policy. If nurses and midwives are to embrace caring as central, caring for the Other needs to be better understood, addressed educationally and destructive policy artfully challenged. A deeper understanding and clear sense of caring as a central value, is required if nurse and midwives are to proactively win ownership of their sphere of practice and enhance the patient experience. Moreover, in view of contemporary government policy which appears to offer greater influence and responsibility for service provision (DoH 1993a, 1993b, DoH 1994a, 1994b), practitioners need to assert the distinct practice they claim to profess.

2.11 Summary

This chapter has argued that, although the roots of nursing as a vocation are embedded in Christianity, similar pitfalls in the achievement of Other-centred agency face individuals whether the context is Christian or secular. The discussion also highlighted the importance of being aware of the complexity and impact of transient ideologies.

The ethical obligation of the NHS to care for patients was examined in the context of the experience of illness. It is argued that, although caring is not unique to nurses and midwives, their scope of practice places them in closest proximity to the patient’s distress. This therefore situates them as the main gate keepers to the nature of the patient’s experience. Even so, due to the way in which institutionalisation of health care has evolved, ownership of nursing and midwifery practice is severely curtailed, due to their role of medically accountable intermediary. Also, routinisation and habituation occur due to institutionalised activity, which results in a taken-for-grantedness of values and non-reflective practice. In consequence, it is argued that deliberate strategies are required, in order to establish caring as a central practice value.
Nursing and midwifery have evolved in association with medicine, which found opportunity within modernity’s emphasis on science and objectivity. It is suggested that emerging ontological and epistemological perspectives herald a favourable social climate in which caring could achieve greater emphasis and value.

The following chapter presents findings from an exploration of the literature to identify the essence of professional caring. This, in part, forms the conceptual basis of the research field work. This is designed to explore the practice of caring and how education may strengthen understanding and commitment to caring values.
Chapter Three
The divisions and essence of professional caring

Arguably, the underlying caring assumptions of the original health care institutions and constraints of the nurse’s intermediary role accounts for the previously limited exploration of the caring phenomenon. In contrast, the current interest in caring as a core ethic, provides a distinct move towards achieving explicit caring ideology. This chapter commences with an examination of the theoretical utilisation of the concept of caring in midwifery and nursing. Thereafter, the discussion surrounding a variety of definitions and perspectives within contemporary literature concludes that emotional and conative dimensions and Other-centredness are essential elements of caring for Others. Also, while the current emphasis on the role of cognitive processes and scientific knowledge within professional practice is rationalised, it is maintained that caring responds to the individual. Consequently, caring cannot be understood in terms of unresponsive, pre-determined activity or reduced to inert subconcepts. This signifies the importance of relationship and the uniqueness of each caring interaction. While caring is an elusive phenomenon due to its individual and contextual variation, it will be suggested that its essence concerns a constant conscious intention to be available, receptive and responsive to the Other’s experience and to act in ways which benefit the person cared-for.

It is also argued that the contextualisation of caring within transient paradigms may disguise the essence of caring and is potentially counterproductive. Discussion of these changing perspectives provides the impetus to discuss the concepts of reciprocity and altruism, caring as a means to an end versus an end in itself and the dichotomy of emotion versus duty / rationality as a source of moral agency. Moreover, it is argued that the health care context and professional caring necessitate particular considerations which have been previously neglected.

3.1 The relationship between caring and midwifery
Firstly, it is necessary to identify that the attention given to the concepts of care and caring in nursing are not equalled in midwifery. Although the term ‘care’ is used as frequently, there is little in the midwifery literature which refers specifically to caring in its philosophical
sense. Only one paper was found which referred specifically to caring and this is written by an Australian student midwife (Dickson 1996). Even so, while caring per se is not examined, concepts related to caring such as kindness, consideration and respect (Page 1995) are referred to and literature also evidences concern for the experience of childbearing women and their families (For example, Laryea 1984, Ball 1994, Page 1995, Kargar and Hunt 1997, Clement 1998). The lack of attention given caring may be due to the different origins of midwifery and nursing and patient conditions in nursing may provoke emotions, such as compassion and sympathy more readily which bring feelings of caring into consciousness. It is maintained that the exploration of caring in midwifery is crucial. While the majority of pregnant women are well, some experience severe illness and the previous chapter made clear that hospitalisation in itself creates vulnerability. That caring is falling short of the ideal is supported by the Changing Childbirth Report (DoH 1993b) which highlights that maternity care would be improved by a change in the attitudes of staff. This aside, it is maintained that whatever the context, caring for the Other is the concern of every human being. The study of caring is as relevant and ethically desirable in midwifery as in nursing and organisational and educational structures appear lacking.

3.2 The relationship between caring and nursing

There is little doubt that caring is perceived as a desirable and rewarding concept in nursing. Watson holds that caring is ‘the most valuable attribute nursing has to offer’ (Wesley 1995:122). Yet there is an apparent confusion regarding the relationship between caring and nursing. Caring may be conceived as being synonymous with nursing (McFarlane 1976, Phillips 1993, Parker 1993) and inseparable (Roper 1998). Also enthusiastic claims that caring is unique to nursing (Boykin and Schoenhofer 1993) are contained by those who counter that caring is not unique to nursing but rather in nursing (Roach 1991). This recognises that nursing as a human helping discipline, which involves a multitude of caring attributes, exists alongside other caring occupations and professions, as identified while addressing the cure-care divide in chapter two.

Alternatively, there is evidence in the literature that caring is regarded by some as either rhetorical (Gaut 1981) or as a new emerging concept in nursing (Dunlop 1994). In the United States, the goal to have caring acknowledged as a core ethic in nursing, is gaining
momentum and revolutionising the nursing curriculum (Tanner 1990, Boykin and Schoenhofer 1993). This provides a powerful incentive to identify the nature of caring and how it contributes to health care outcomes (Roberts 1990). Yet, based on the previous exploration of the origins of nursing, it is argued that, contrary to caring being a new phenomenon in nursing, caring has always been valued as an intrinsic part of nursing. In this sense, the view that nursing and caring cannot be separated (Roper 1998) may exclude the exploration of caring as a separate concept. Literature which identifies caring deficits evidences that sadly, nursing activity and caring are separable.

An alternative view that caring is a concept which requires renewed understanding in contemporary society and hence nursing, can be supported by several proposals. For example, Roach (1984) and Bradshaw (1994) suggests that the erosion of moral values within society and the loss of the religious foundations has created the current quest to define the concept of caring. This chapter will demonstrate that as nursing has adopted different philosophical perspectives, nursing practice and consequently the meaning of care and caring has changed. Other authors identify ideological motives for raising the profile of caring in nursing. For example Brown et al (1992) and Johns (1996) would have believe that caring has been previously undervalued due to its association with the role of women in a patriarchal society and consequent taken-for-grantedness and low skill value. Dunlop (1994) implies that nursing is using the confusion between the two meanings of care, that is, physical care and caring as love, to exchange its identity concerned with physical care and ‘dirty work’ to ‘cleaner’ areas that deal with people’s minds and emotions. Similarly, Phillips (1993) argues that the term “may well have been appropriated as a verbal icon of the movement towards professional identity” (Phillips 1993:1558)

The view adopted in this thesis is that competing, contemporary paradigms such as focus on technical skills, quantification of activity and consumerism present practitioners’ caring intentions with unprecedented difficulties which have stimulated a fresh look at practice values. In earlier chapters, it was suggested that, rather than take control of their own practice, nurses fail to develop role identity and purpose and offer little resistance to medical and managerial policy which gives nurse-patient relationships low organisational and funding priority. As Kitson challenges,
All too often the nurse's perception of her work role was determined by the medical model of care rather than any clear understanding of her caring function (Kitson 1987: 157).

There will be little success in re-establishing caring as central amongst these other preoccupations, unless criticisms regarding the lack of clarity of the caring role are heeded and invalidated through development of professional caring practice. Without serious efforts to increase understanding, those who argue that caring constitutes nursing rhetoric and that nurses are only concerned with the desirable image the word caring affords (Gaut 1981, Rawnsley 1990), will have their doubts confirmed. Yet, the difficulty in evidencing that caring is central to nursing (Leininger 1981, Roach 1984, Watson 1981, Kitson 1993) permits some sympathy with the assertion, that the provision of competent care is all that is necessary in modern day health care (Kluge 1980 in Roach 1984) and other nursing identities, which subordinate the caring element were alluded to in the chapter one (page 6, May 1990).

With the opportunity to revise core role values, one can then perhaps be justified in asking the ethical question, why be caring? (Roach 1984). Roach (1984) considers that such a question is beyond ethical reasoning because its answer is already given. Based on Aristotle's "Ethics", Roach (1984) contends that nurses do not deliberate about whether or not to care, but how best caring can be achieved. She makes evident her view of caring as a human mode of being in her statement, "To care is human; to be human is to care" (page 1) and describes nursing as the professionalisation of human caring. Carter (1989: 65) similarly considers the response to the question, why do nurses care? and gives the reply;

\emph{At the most fundamental level, we care because we must. Caring is the core, the very essence of our professional practice. This core element is elusive and difficult to explain fully to others because it is so central to all that we do in our practice........ to say that one is an uncaring nurse is logically inconsistent. To be a nurse is to care.}
Similarly, Arndt (1992) considers caring ontologically as 'everydayness'. She asserts that nurses do not recognise their nursing practices as caring because it is bound up in what it is to be a nurse and therefore is embedded in practice. Carter's and Arndt's views illustrate both the elusiveness of an understanding of caring and complacency that it is naturally inherent in nursing. To accept the view that caring and nursing are synonymous would eliminate the development of even a rudimentary description of caring and limit both this research and the intended consideration of educational strategy. To return to the question of "Why be caring?", my personal answer to this question was argued in chapter two and is grounded in the moral responsibility owed to persons experiencing illness and hospitalisation and nurse-patient proximity.

The descriptions so far identify a deficit in understanding and that motives for utilising the concept of caring may be ideological and self-serving. This chapter while being faced constantly with a variety of discourses, now attempts to move beneath the ideology, to discover the essence of care and caring by extracting what appear to be common, consistent understandings and interpretations of the caring phenomenon.

### 3.3 Caring definitions and perspectives

The relevant generic definitions of care and caring from the Collin's dictionary (1986), indicated below, identify that an association between caring and health care is well established.

**Caring**
- feeling or showing care and compassion: a caring attitude
- of or relating to professional, social or medical care: nursing is a caring job

**Care**
- to be troubled or concerned: be affected emotionally
- care for/about: to have regard, affection or consideration for
- to provide physical needs, help or comfort for
- protective or supervisory control

None-the-less, while the definitions include both emotional and practical elements of caring, they fail to reflect the depth of meaning that professional caring encompasses. The concept
of supervisory control identified within the final definition of care may even be considered contradictory, if it reduces the autonomy of the Other.

White (1964) associates the notion of care with the social expectation that people will pay attention to potential risks in order to avoid harm to others. This is embedded in the legal concept of ‘duty of care’ which is particularly pertinent in modern health care, where the reduction of risk of litigation is a major managerial focus (Capstick 1993, Dimmond 1994, 1995).

Some writers have explored the linguistic origins (for example, Gaut 1981, Dunlop 1994, Eyles 1995) and identify that the word caring derives from the old English and Gothic words, carina and kara or karon. Bradshaw (1994:13) notes that the word care derives from the Anglo-Saxon words caru, caern, meaning sorrow in the sense of having concern for others. She argues that in modern usage the word implies both a concerned disposition towards others and associated agency. If, in a society where members were only occupied with personal needs and wants, there would be little hope of the ill and destitute regaining functional status. Perhaps for this reason, some consider caring as the means of human survival, as ill and vulnerable people are dependent upon care from others in society (Leininger 1981, Watson 1981).

Bradshaw (1994) argues that Agape or God’s all embracing love from which all human love, Eros, derives, is the motive which underlies the concept of care and which represents the way in which human beings fulfil God’s purpose in society. The interpretation of caring based on the Gospel’s teachings presented in the previous chapter, identifies emotion in the form of love and compassion and the imperative of placing the Other above the self, impartiality and practical expression. That nursing and midwifery in Britain and Europe have different roots from American counterparts, perhaps explains why the Christian words Agape and Eros are found infrequently in their literature.

Alternatively or additionally, American nurse theorists writers are influenced by existential writers such as May (1969), Mayeroff (1971) cited by a number of nurse writers who began to integrate existential philosophy into nursing theory (Bevis 1981, Leininger 1981, 3-6.
Roach 1984, Dunlop 1986, Boykin and Schoenhofer 1993). The existential writer, May (1969) addresses the consequences of the “loss of God” on humankind. He asserts that while God is lost, Agape, which he defines as, God’s love for man or the devotion to the welfare of others, consequently loses its meaning. This is challenged since, as argued in the previous chapter, while Christianity was instrumental in establishing social responsibility for care, caring does not depend on Christianity for its existence.

Existentialism provides its own meaning of care. The nurse theorist Bevis (1981), bases her work on Heidegger’s existentialism and identifies his meaning of care as ‘the source of will’. For him ‘will’ is the driving force of life and care is the source of motivation which transforms feeling into agency. Bradshaw’s (1994:xvi) differentiation between Heidegger’s notion of care and care as Agape raises an important caution. Heidegger identifies two words which represent different perspectives of care; ‘Sorge’ and ‘Angst’. Bradshaw points out that ‘Sorge’ translates as self-concern or anxiety and ‘Angst’ involves personal awareness of existing in the world. These then are self-centred concerns compared to the Other-centred care as represented by the word Agape. One method of concept analysis or discovering the essence of things (within a particular context), involves building meaning and conceptual boundaries by deciding if cases are, for example, model or contrary (Wilson 1966). Bradshaw’s critique exemplifies how the notion of Other-centredness can be utilised to question the appropriateness of the existentialists’ interpretation of care for nursing practice.

Other-centredness and caring as both feeling and activity are made explicit within contemporary discourse regarding social gender divisions. Attention to women’s role as lay carers has resulted in further distinctions between caring ‘for’ and ‘about’ (Graham 1983). Caring ‘about’ is an affective process of displaying concern for others. Caring ‘for’ entails the practical tasks of tending to someone’s physical needs. The two processes are perceived as being unified in the role of motherhood, which constitutes women’s social role. Men’s stereotypical social function is more focused on caring ‘about’, with particular responsibility for financial provision. Graham (1983) argues that, in consequence, caring represents both a socially endowed feminine identity and activity. Respectively, caring is women’s nature and women’s work. She objects to the non-recognition of the value of
women's role in caring for children, the elderly and handicapped which is implicit in the above assumption. The caring occupations such as nursing are predominantly female (Abbott and Wallace 1990) and the notion that caring, as woman's work, is undervalued and underpaid has led the feminist movement to target nurses as an oppressed group (Bough and Wang 1994). This is a further example of the word caring being utilised ideologically.

As the above conceptions of the terms care and caring indicate, activity and feeling are constants. Within professional caring the distinction between 'instrumental' and 'expressive' caring activities (Morrison 1992) mirrors this duality. Instrumental caring refers to what the practitioner does, and involves actions undertaken to meet physical, psychosocial and spiritual needs associated with health. Expressive caring refers to the affectivity with which activities are undertaken. For example, these may or may not convey concern, respect and kindness. The similar dichotomy of practice as art or science has been reconciled by the perspective that it comprises both (Kitson 1993).

While this thesis concentrates on caring in its relational sense and argues that emphasis on technique potentially constrains it, readers may assume a personal derision of science. Yet, it is argued that a coequal relationship between emotion and agency is essential in the achievement of moral caring practice. The view is strongly held that science potentially contributes to moral practice and is indispensable within caring agency. While the reductionist potential of paradigms such as research-based practice and evidence-based practice are acknowledged and rejected, research may prevent exposure of health care users to ineffective or even harmful interventions (Franks 1996). It has been argued that formal theory is equally decisive in achieving caring practice and since caring cannot be imposed or coerced, central governance of individual practice is paramount. Additionally, in the climate of budgeted resources and prospect of rationing treatment and care (Wells 1994, 1995), prevention of wastage on ineffective use of resources is ethically justifiable on utilitarian grounds. Never-the-less, the potential for routinisation in the guise of clinical effectiveness needs to be recognised and as Tanner (1990) argues below, neither evidenced-based protocols and codes of practice can ensure that agency is individualised or Other-centred. In contrast to the pure, rational application of science, caring agency
involves artistry in practice. This involves receptivity and responsiveness to the individual, as Tanner indicates in the following quote:-

What we do (in caring) depends not upon rules, or at least not wholly on rules - not upon prior determination of what is fair or equitable - but on a constellation of conditions that is viewed through both the eyes of the one caring, and of the cared for. By and large, we do not say with any conviction that a person cares if the person acts routinely according to some fixed rule (Tanner 1990:71).

Campbell (1984) supports the importance of individuality by arguing that no one person can know what is best for another and although it may demand extra time and attention from the care-giver, most people have their own view of what is helpful.

We feel cared for when our need is recognised and when help which is offered does not overwhelm us but gently restores our strength at a pace which allows us to feel part of the movement of recovery. Conversely, a care which imposes itself on us, forcing a conformity to someone else's ideas of what we need, merely make us feel more helpless and vulnerable (Campbell, 1984:107-108).

This emphasis on individuality highlights the relational and responsive elements of caring. Within this analysis, it is maintained that agency is antithetical if it is predetermined, unresponsive and fails to acknowledge the Other’s experience. Of course, it would be naive to think that nurses approach patients without any idea of what activities they will undertake. Practice, as professional discipline, could not exist without nursing activities which are typified, socially countenanced and embedded in role identity. Nurses therefore have a store of knowledge and skill based on practical experience of helping patients. What is argued, is that caring requires that the impact of agency is registered and intervention modified in response to the individual. It is when nurses care, that they take time to look (Griffin 1980, 1983). This is referred to again in the following section.
As mentioned earlier, the term expressive caring is useful to differentiate between what from how activity is undertaken. Yet, the term fails to distinguish role behaviour from the deeper personal interaction. Bishop and Scudder (1990) argue that patients can be treated with dignity and respect even when care is impersonal (page 149). In such a scenario agency is undertaken in the absence of caring affect, individual concern and relationship. Consequently, the term expressive caring is easily transformed into pre-determined instrumentality. It is for this reason that within this thesis, the term ‘relational’ caring is adopted where it is necessary to differentiate between caring agency and caring affect.

Since instrumentality receives primary attention in nursing, the above divisions also risk that the relational element of caring may become an add-on concept which requires additional consideration rather than being a quality which permeates all activity. For the purposes of this thesis, the separation of caring and nursing has become pre-requisite to attempts to explore both the manifestation and lack of caring in contemporary nursing practice as identified in the previous chapter. It is maintained that, ideally, nursing and caring are inseparable and in agreement with Roach (1991), that caring is unique in nursing and midwifery. This imperative and uniqueness derive from the obligation professional carers have, not only to establish caring relationships with patients which endorse ethical principles, but also the ability to meet the patient’s hopes and expectations of health care as discussed in the last chapter.

It is summarised from the foregoing, that the words care and caring comprise both the noun and verb forms; that is, caring comprises both feeling and activity. Traditionally and historically, caring involves feelings of concern for others and self-less responsive agency. What this thesis assumes and advocates is that the nursing profession wishes to embrace this unified sense of caring and the relationship which sustains it.

3.4 Caring as moral, responsive relationship

In health care and philosophical literature, rather than interests such as time, quantity and continuity (Hinde 1979), the qualitative nature of the interaction is what constitutes relationship. Within the realities of health care, relationship, may involve only one interaction between the practitioner and the patient and may be instrumental and superficial
or represent a moral, humanistic concern for the Other, referred to in health care literature as caring, other-centred, 'connected' or achieving 'closeness'.

The descriptions of caring, moral relationships provided by the philosophers Levinas (1985) and Buber (1958) are not infrequently applied by nursing theorists to practice. Both accounts portray a giving, un-predetermined, Other-centred, unconditional, moral encounter which exists as an end in itself. Levinas identifies the concept of face-to-face relationships, in which it is the meeting the person's 'face' that bids personal and moral responsibility for the good of the Other (Bauman 1993). Without preference, partiality or patronage, the meeting of the Other as ‘face’ calls us to be responsible towards the person.

Buber (1958) differentiates between the inter-personal ‘I-Thou’ and impersonal ‘I-it’ relationships. He notes how, within I-Thou relationships, both the ‘I’ in relation to the Other and the ‘Thou’ are transformed. The Other is not objectified and is met without personal judgement, labelling or expectation. There are no prior aims or personal ambitions since the I-Thou relationship has no means beyond itself. The ‘I’ within I-it relationships is detached from the Other, individualised and self-seeking. While, within the I-Thou relationship, the I is aware of the self as personally distinct, there is the experience of coequal existence with others within a shared world.

The previous chapter identified the potential for institutions to encompass taken-for-granted practice, which represents a major hurdle to the provision of caring and enhance relationship. None-the-less, the above forms of relationship suggest that practitioners can become committed to consciously transcend routine. However, the applicability of Buber's thesis to nursing has been questioned. Bishop and Scudder (1990) suggest that Buber's conception that the I-Thou relationship has no means beyond itself conflicts with nursing purpose, which aims to help others. Also, objectification of the other cannot be avoided in nursing since practice involves illness and therefore attention to the 'body-object' (page 154). Yet, as Bishop and Scudder (1990) note, procedures are aimed at helping the patient and it was pointed out earlier, that helping, which implies response to distress, is central to caring agency. It is maintained that it is the responsiveness to the Other which determines the caring nature of the relationship. As both Buber (1958) and Levinas (1985) identify
responsibility for the other is based on the necessity to respond and has no means beyond itself.

Because caring involves responding to the individual Other, it cannot be determined before hand. This makes it possible to differentiate caring from instrumental relationship. Instrumental activity may be undertaken in relationship which maintains the patients values and responds to help the patient and constitutes caring agency. Alternatively, instrumental activity occurs in the context of routine and ritual, hurrying to get the work done and predetermined technical performance.

The essence of caring therefore has no standard manifestation and this highlights the limitations of attempting to understand caring by deconstruction into sub-concepts, attributes or inflexible patterns of behaviour. These result in circular rather than progressive understanding of the caring phenomenon, which is responsively interactive. For example, unrealistic, pre-set expectations are contained within Bevis's (1981) portrayal of the caring relationship which is dependent upon the successful achievement of four stages; attachment, assiduity (devotion), intimacy (to feel comfortable with the other's presence and sharing of innermost thoughts) and confirmation. Before moving from one stage to another, certain tasks need to be achieved. As has been pointed out, caring as concerned response to an individual cannot be undertaken as pre-set strategy imposed on a passive patient.

Eyles (1995), with the intention to seek out a 'definitive meaning of caring' has undertaken conceptual analysis by 'exhausting' available literature (page 22). Forty caring attributes were identified from a variety of literature and used as a basis to examine forty two journal articles submitted to the British Journal Of Theatre Nursing. The occurrence of the identified attributes were taken to signify the extent to which caring is present in theatre nursing practice.

Examples of empirical, quantitative studies which have resulted in lists of caring sub-concepts include those which have involved collecting practitioners’ perceptions of caring (Swanson 1991, Morrison 1992, Dyson 1996, Wolf et al 1994, Gardner and Wheeler 3-12
and values underlying professional practice (Fagermoen 1997). Qualitative studies (for example Forrest 1989, Clarke and Wheeler 1992) have undertaken thematic analyses of data generated through interview. These studies have collected practitioners’ responses to questions such as; what is caring?, what affects caring? (Forrest 1989) and what is involved in being supportive, communicating and caring ability? (Clarke and Wheeler 1992). Similar outcomes derive from studies which focus on nurses’ and patients’ perceptions of nurse-patient relationship (Crotty 1985, Morse 1991, McCrea 1993, Bottorff and Morse 1994).

Contemporary literature also witnesses an explosion of the conceptual analyses of specific concepts associated with caring, such as empathy (Morse et al 1992, Baillie 1996, Price and Archbold 1997), reassurance (Fareed 1996) touch (Estabrooks and Morse 1992), comfort (Kolcaba and Kolcaba 1991), trust (Meize-Grochowski 1984, Pask 1995) and dignity (Mairis 1994). Identification of concepts and concept analyses may be useful as bases for research, as is the case in this study, yet, as mentioned earlier, they inadequately represent the uniqueness of each caring relationship. The uniqueness of each caring encounter depends upon the nurse’s ability to decipher, and provide caring response to patient cues, which form an individual’s personal manifestation of human help seeking and responding activity. Concepts such as support, empathy and advocacy have both beneficial and non-beneficial elements. For example, advocacy may benefit persons receiving care in a situation where they are physically and emotionally dependent on the carer. Where this is not the case, inappropriate advocacy disempowers and undermines a person’s opportunities for personal growth (Kohnke, 1982). A situation in which routinisation results in loss of autonomy is a further example. Bauman (1993) argues that virtually every moral impulse, if acted in full, leads to immoral consequences. Therefore, receptivity to the patient’s experience and awareness of the impact of nursing actions are fundamental requirements to caring. This is essentially related to the nurse being available, having sensitivity of perception to the Other and the recognition of distress. In contrast to routine intervention, the nurse’s judgement of what is appropriate in the specific relationship, necessitates attention and interest, theoretical, practical and tacit knowledge.
Accordingly, it is therefore argued that sub-concepts or attributes subsumed under caring fail to take into account the individual and situational factors which influence interactions and both nurse and patient activity. They therefore provide limited illumination of the principles and parameters of the caring relationship and potential organisational and educational strategy.

So far, this chapter has examined the relationship between caring and nursing, caring definitions, perspectives and divisions. Ontologically and ideologically, caring has been given meaning as the source of oppression and exploitation on the one hand and the source of life itself, on the other. None-the-less, from amongst a variety of ideological descriptions, the essence of caring has emerged and is conceived as having moral basis, being available and receptive to the Other; it encompasses concerned response to the Other’s distress which is emotionally mediated. Agency is Other-orientated and individually-focused and non-predetermined. These latter two elements necessitate that agency includes theoretical insights as well as practical and tacit knowledge.

The following section overviews influential nurse theorists and paradigmatic eras through which professional caring has journeyed. Within the process of conceptualising caring, these represent further divisions and raise additional issues.

3.5 Caring: major theorists and influential paradigms
Once engaged in the literature it is apparent that specific authors impose great influence. These include non-nursing theorists such as Mayeroff (1971) and May (1969) who are commonly cited within the nursing literature. Other sources include the existential and theological authors, such as Heidegger (1962) and Buber (1958), respectively. It is apparent that particular nurse writers (mainly from North America), who have devised nursing/caring models are cited extremely frequently. In particular, Watson (1981), Benner (1984), Benner and Wrubel (1989), Leininger (1981) and Roach (1984). These authors draw on the aforementioned authors, in addition to one another and are cited in a wide range of nursing publications.
When examining the conceptualisation of caring in nursing, authors identify the influences of different social and historical eras and a multitude of perspective from which caring has been examined. This illustrates how the phenomenon of caring receives fresh interpretation and application to practice as new paradigms emerge. For example, Bradshaw (1994) provides a comprehensive analysis of the philosophical and theological foundations of nursing models and demonstrates how caring has responded and evolved with contemporary discourses. She identifies how altruism and service to others as the central values of Judaeo-Christianity were replaced by the later philosophies of pragmatism, existentialism and pantheism.

Kitson (1993:34) associates the nature of caring with three nursing paradigmatic eras; caring-as-duty, caring-as-therapeutic-relationship and caring-as-ethical-position. While her framework permits a view of the influential ideas, it suggests a linear progression, which overlooks the likelihood of pluralistic values within clinical practice. Additionally, as mentioned, writers adopt both single and multiple perspectives. For example, while Roach is placed under Kitson’s caring-as-therapeutic paradigm, she also writes theologically which Kitson encompasses within caring-as-duty. Watson (1988) adopts a combined existential and ethical view and therefore spans the second and third categories. More significantly, this chapter argues that caring combines all three of Kitson’s categories, that is; duty, therapy and ethics. Respectively, it has been shown that caring relationship encompasses responsibility, the intention to benefit the Other and moral agency. None-the-less, as mentioned earlier, temporary deconstruction of concepts may provide deeper insights. In addition to that aim, the following discussion aims to illustrate the potential, problematic consequences of synonymising caring with contemporary nursing discourse rather than seeking to understand caring as caring.

Examples from Kitson’s caring-as-therapeutic-relationship and as ethical-position paradigms are detailed below. While humanistic, existential and ethical theory highlight important principles within human caring relationships, such as responsibility and reciprocity, the ease with which caring can become distorted into agency which depersonalises the Other, will be demonstrated. Thereafter, the paradigm of caring-as-duty

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and the dichotomy between duty and emotion as the source of moral agency will be discussed.

3.6 The caring-as-therapeutic paradigm

In the early 1960s, the needs-based approach to nursing which had so far dominated health care was superseded by interaction theories based on the growing popularity of psychoanalysis and psychotherapy (Kitson, 1993). Therapeutic techniques which have emerged over the past fifteen years have provided a focus for care (Bradshaw, 1994, Kitson, 1993). These evolved through the influence of humanistic psychology and interpersonal approaches such as Heron’s sixth category intervention analysis (1986) and Carl Roger’s psychotherapy and the therapeutic use of self (1961).

According to Campbell (1984), nursing was one of the professions which fell under the moral influence of the counselling ideology with its promotion of warmth, unconditional positive regard and the belief in love as a therapeutic skill. Campbell (1984) questions the feasibility of promoting a spontaneous emotional response (love) as a therapeutic technique, since it cannot be provoked at will. Even so, concepts such as sensitivity, being present for the other and validation of patient’s experiences were introduced, in addition to the idea that it is acceptable for practitioners to feel and express emotion (Kitson, 1993). Whether these prompted the numerous studies which identified deficiencies in nurse-patient relationships and interaction (Kelly and May 1982) or were adopted to provide solutions is not clear.

A reservation of counselling style relationships is provided by Salvage (1990) who agrees that patients want information and to be treated with warmth, kindness and sensitivity. However, this does not mean that they want “close relationships of a quasi-psychotherapeutic kind” (page 44). She notes that within the counselling model of care, clients enter of their own free will and there are explicit goals aimed at resolving emotional problems rather than hospital patients with physical problems who need “relief from pain and discomfort, rather than a meaningful relationship”. With reference to the therapeutic nursing relationship, Bradshaw (1994) questions Carl Roger’s conceptualisation of equal partnership between patient and therapist compared with I-Thou helping relationships
which are asymmetrical. Salvage’s (1990) concerns above, may be further exacerbated by existentialism which aims to obtain deeper insights into the patient’s experience.

The influential work of Mayeroff (1971) is clearly based on humanistic psychology and psychotherapy and while he provides some interesting insights into caring, a number of his suggestions are inappropriate to nursing. His central interpretation of caring concerns helping individuals to grow and to actualise themselves. He defines growth as a person’s increasing ability to care for self and others and to be self-determining. The capacity for growth during illness can be questioned by applying Pellegrino’s phenomenological descriptions referred to in chapter two (1982). The immediate experience of illness is more likely to be associated with loss of equilibrium and stasis, if not regression (Millard 1996), rather than growth. While Mayeroff suggests that the well-being of the helper is associated with the growth of the person, he notes that it needs to be recognised that persons are self-determining and must be free to grow in their own way.

One major difficulty with Mayeroff’s focus on personal growth is his assertion that one can only care, if the other can be cared for. For example, he regards that someone with extensive brain damage is unable to grow in any meaningful sense. They may be comforted but not be cared for. Neither can people who lack depth and the capacity to grow, be cared for. This interpretation of caring therefore promotes partiality, discrimination and is incompatible with caring as conceptualised in this thesis and the underlying responsibilities of health care practice.

In addition, a number of caring virtues identified by Mayeroff require careful scrutiny before being adopted by nursing. Three in particular are now discussed and these exemplify how some interpretations of caring are inappropriate for application to nursing.

Mayeroff (1971) suggests that the carer requires **patience** for others to grow in their own time and **trust** them to achieve this in their own way and that they are able to learn from their mistakes. As growth in these circumstances cannot be anticipated, the carer requires **courage** to assist this entry into the unknown. Practitioners facilitate patients’ self-determination daily through information-giving which enables patients to make choices and
give consent for treatment. Yet self-determination may involve the choice to request that
the practitioner decides on their behalf, what is best. Patients may be unable to make
decisions through illness or disability and the vulnerability due to the experience of illness
has been previously noted. It is obviously a nonsense that practitioners would stand by and
watch patients learn by their mistakes. This constitutes abandonment (Pellegrino 1982) and
an act of omission which contravenes the requirements of the Code of Professional
Conduct (UKCC, 1992b) and civil law, in terms of failure to fulfil a duty of care (Dimmond
1995).

Bradshaw’s (1994) assertion that existentialism has been misinterpreted and ill-applied to
nursing has been referred to earlier. Bradshaw argues that a further misunderstanding
concerns the existentialist view of being as man’s freedom for self-discovery and
actualisation. She notes that these existential aims are denied by the inherent goal-
orientated approach to nursing care within unequal nurse-patient relationships. Nurses
decide and control care, while the patient is the recipient. A further assertion which
existential practitioners might find difficult to morally justify is Bevis’s (1981) claim that:-

*The purpose of caring is first to facilitate mutual self-actualisation. All other
goals are subordinate to that overall purpose. Attaining one’s full potential is
life’s most important goal* (page 51).

One need not even refer to Maslow’s hierarchy of needs to dispute Bevis’ assertion.
Common sense tells us that achieving survival is the first aim of health care. Her statement
also makes understandable, how writers get notions of health professionals’ exploitation of
the sick for self-serving interests (Campbell 1984). While, it has been noted that Other-
centredness is an essential feature of caring, the notions of reciprocity and altruism are
examined in more detail next.

### 3.7 Reciprocity versus altruism

As will be discussed more fully shortly, Blum (1980) labels as altruistic, emotions such as
sympathy, compassion and concern which motivate caring. In conceptualising altruism,
Blum rejects the connotation of self-sacrifice and self-neglect and defines altruism as:-

\[ a \]
regard for the good of another person for his own sake, or conduct motivated by such a regard” (1980: 9-10). From a similar perspective Williams considers that altruism involves; “the possibility of limiting one’s own projects” (1973: 250). These descriptions, therefore, do not imply total disregard of the self and in view of problems of abuse and violence against health care professionals (Whittington 1997) appears a balanced view to adopt.

As mentioned, Bradshaw (1994) identifies the lack of symmetry, within health care relationships. This favours the professional who has the majority of control over what happens. However, regardless of the context, Bauman (1993) notes that moral encounters, in themselves are inherently unequal. That is, that the I in relation to the Other, pays no attention to calculations of balancing cost and reward and has no expectation of reciprocity. While, this recognises that it is the person who responds to the Other’s need has the power to give and therefore withhold, the moral relationship places responsibility on the agent to respond.

The concept of reciprocity and professional benefit, emerges through the therapeutic relationship paradigm. While Crowley (1994) states that reciprocity concerns carer satisfaction in response to the growth of the other rather than expectation in kind, it is identified that some acknowledgement by the cared-for that caring has been received, helps to sustain caring. While self-interest is not a legitimate consideration, caring, none-the-less provides mutual benefit to carer and cared-for alike and some consider reciprocity a vital element within caring relationships (Bishop and Scudder 1990, Campbell 1984, Leininger 1981, Mayeroff 1971). People experiencing the stressful life events which bring them into contact with health professionals benefit from the comfort and support that caring provides. Many practitioners enter the professions through caring about people and the wish to help (Roach 1984) and the fulfilment of this desire and appreciation of their caring role provides them with personal satisfaction, sense of self-worth and motivation (Mackay 1990).

A more active approach is advocated by Brown et al (1992) who suggest that patients have a moral responsibility to acknowledge good care and that nurses should learn how to facilitate this. The feminist school is keen to espouse a model of nursing which favours
reciprocity. It rejects metaphors such as duty and calling and dispels myths of women as self-sacrificing carers (Condon 1992). Arguably, a moral act favourably affects all involved parties (Shaffer 1971) and so there could be some expectation of mutual benefit. However, special circumstances exist within health care contexts, such as the imbalance of power between carer and cared for and possible preoccupation of the ill persons with their situation. Uncaring behaviour can never be morally justifiable and although it is hoped that personal satisfaction through caring occurs, it is held that caring is indiscriminate and does not depend upon expressed gratitude and appreciation. If such expectations are legitimised, practitioner self-fulfilment may be pursued through channels which disadvantage those who represent the focus of care. As Stockwell (1972) demonstrated a good number of years ago, patients who fail to show appreciation are considered ‘bad patients’ and receive less than optimum care (Stockwell, 1972 and Kelly and May, 1982) and this dichotomy between egoism and altruism requires remedying rather than condoning.

The response to particular patient behaviours introduces a further conceptualisation of reciprocity, in contrast to the meaning of reciprocity as personal or mutual reward, as mentioned so far in this section. Relationships are inherently reciprocal, in that each responds as an individual to the Other. This reciprocal interaction makes each relationship unique which invalidates expectations of typifiable nurse-patient interactions, which permit assessment of the connection between nurse and patient (Crotty 1985, Morse 1991, Morse et al 1992, Bottorff and Morse 1994). Just as each patient is individual, so is each nurse. Also, on the premise that patients act reciprocally in relationship with the nurse, the nurse must shoulder some responsibility for patient behaviour.

3.8 The caring-as-ethical-position paradigm

Noddings (1984) suggests that through an authentic ethical commitment to maintain one’s self as caring, it is necessary to develop and exercise virtues such as patience, fortitude, compassion, in addition to taking responsibility for competence to provide care. Noddings considers that caring is a moral end in itself. In contrast, others view caring as means to achieve moral practice. Within Benner and Wrubel’s (1988:1073) explication of caring as an ethical imperative or core ethic, they identify caring as a motivating force which facilitates involvement, attachment, connection and concern with the recipient. Caring is
ethically desirable as it enables the practitioner to identify subtle changes in the patients, discern problems, find and implement solutions. Griffin (1980, 1983) presents a similar view and argues that moral values such as respect for persons, influence the perception of the nurse as they motivate and energise the attention. Caring is an essential element if the nurse is to base her/his selection of alternative clinical options on the grasp of the overall context of a patient’s mental, emotional and physical condition. In this context, caring is given a utilitarian purpose and its ethical contribution is to enhance clinical effectiveness.

In contrast to Nightingale’s day and reflecting postmodern resistance to techno-rationality, emotional attachment with patients is valued within current literature, and professional duty receives a certain amount of negative focus (Fry 1991, Morse 1991, Kitson 1993). May (1991) proposes three reasons why, historically, nurses were encouraged to distance themselves emotionally from the patient; maintenance of respectability and moral protection, organisational efficiency and defence against anxiety caused by dealing with illness, distress and death. As will be discussed shortly, the Kantian conception of emotions, as typically partial, unreliable and difficult to control accounts for the encouragement for nurses to distance themselves emotionally from their work (Oakley 1992). In studies of nurse-patient relationships, these are categorised as over or under-involved or distanced or something in between (May 1991, Morse 1991, Morse et al 1992, Bottorff and Morse 1994). Authors imply that professional and duty-orientated relationships are superficial, task orientated, mechanistic and inauthentic and undermine caring relationship. This view appears to be based on the notion that emotion is instrumental in deciphering patient cues referred to by Benner and Wrubel (1989). Such expectations and judgements regarding the appropriate level of involvement appear simplistic and fail to account for the variable manifestation of caring encounter based on individual personal characteristics and wishes of both the patient and nurse, as referred to earlier.

In similar vein, Bishop and Scudder (1990) express their views regarding nurse role behaviour. They identify that nurse-patient relationships are regarded by some as an optional rather than an essential element of practice, as the following citation indicates.
Nurses who say they have no time for personal relationships with patients apparently believe that the personal relationships with patients are dispensable, add-on requirements. For them, establishing personal relationships with patients is regarded as another moral imperative in addition to their regular professional duties. In that case, a nurse is mainly responsible to the moral imperative to be related personally to the patient rather than being responsible to the patient (Bishop and Scudder 1990:150-1).

Implicit in Bishop and Scudder’s argument is their failure to acknowledge that caring values cannot be enforced or simply adopted. In the absence of natural personal attraction, I-Thou relationship involves moral responsibility and possibly, effort. As such, they disregard the Kantian argument that moral agency is based on duty and moral reasoning rather than solely emotional response (Blum 1980, Oakley 1992). In contrast to Bishop and Scudder’s view, in the absence of commitment to caring values or indeed to supplement them, it is argued that caring affect and a reasoning consciousness are necessary, if the moral responsibility to health care users is to be fulfilled.

To develop the above argument further, the following section addresses Kitson’s (1993) third category; ‘caring-as-duty’ and identifies Kant’s objections to emotions as the basis for moral agency and Blum’s (1980) and Oakley’s (1992) counter arguments. It is maintained that it is a misleading dichotomy, since, as maintained, neither duty or caring emotion alone can be guaranteed to fulfil the professional caring imperative. It is also suggested that while contemporary nursing literature attempts to conceptualise caring, there is insufficient emphasis on the unique nature of caring within the health care context.

3.9 Duty versus emotions in motivating caring

Blum (1980) and Oakley (1992) reflect the views of authors who advocate caring as a means to enhance saliency of the patient’s distress and to motivate caring practice. They therefore oppose Kant’s view that duty is the only possible basis of moral agency. As will be argued, neither perspective alone is sufficient to ensure professional caring.
Blum (1980) and Oakley (1992) defend the moral significance of emotions, such concern, sympathy and compassion, which they describe as altruistic. In contrast to pure feeling, Blum portrays altruistic emotion as crucially 'operative' and stresses that our response to a person's 'weal and woe' depends on the fact that we recognise it in the first place. Blum (1980) maintains that this is what characterises persons as caring, since they perceive situations in terms of the Other's weal and woe. The kind, compassionate, sympathetic, concerned person perceives people differently from someone lacking these qualities.

Yet as Blum points out, while recognition and appreciation of the Others' distress are cognitive processes, cognition alone is insufficient to ensure agency; it is the emotional connection which motivates the conative dimension (Blum 1980 and Oakley 1992). This provides the basis to argue that affective processes are central to the transformation of perception into agency and in consequence, emotion or sentiment into caring agency.

Oakley (1992) utilises the following quote to exemplify the receptive element of concern for the Other and it is noted that this perspective mirrors Griffin's (1980) and Benner and Wrubel's (1989) view that caring emotion increases the saliency of patients' cues.

>a sense of indignation makes us sensitive to those who suffer unwarranted insult or injury, just as a sense of pity and compassion opens our eyes to the pains of sudden and cruel misfortune.... We notice through feeling what might otherwise go unheeded by a cool and detached intellect. To see dispassionately without engaging the emotions is often to be at peril of missing what is relevant (Sherman 1989 cited in Oakley, 1992:82).

It can be noted that Blum's notion of caring for the Other is subtly different from Levinas' and Buber's, since he focuses on emotional response to the Other's distress rather than the person's presence, which may or may not involve distress. This makes it necessary to clarify, that in the conceptualisation of caring within the health care context, the essence of caring relationship is taken to mean a conscious attention to both the Other's being and well-being.
In contrast to the above, while Kantians may experience moral emotions, only dutiful actions constitute moral agency and it is the moral appropriateness of acts which are judged (Blum 1980, Oakley 1992). Oakley (1992) counters that where moral acts depend upon fulfilling duties, immoral action may result through holding false beliefs, for example, about what is good for a person, rather than being individually responsive. This mirrors Bauman's (1993) objection that, rules only tell us where duty starts and finishes and personal morality is far more complex and precarious than this.

While emotions transform our values into action, they also provide the strength of will and a motivation more likely to bring success (Oakley 1992). Our deepest attachments, which are crucial to our sense of self-worth, essentially involve emotions. Emotions such as care, interest, sympathy and courage play an important role in our doing and being motivated to do what we believe is good.

It is useful to introduce Rollo May's (1969) association between love and will here, since it effectively portrays agency in response to caring. He argues that love and will are inseparable, will without love is manipulative and love without will is mere sentiment. Caring is a human capacity and state of being rather than an emotion, such as compassion, which may come and go. It creates the ability to recognise in others shared human experiences such as joy and pain and the awareness that we all stem from common humanity. Caring evokes will and the motivation to act for the well-being of the person cared for. Caring is a state in which something matters, it is the source of human tenderness and without it we would not survive beyond our first day of life. Bevis (1981:50) summarises Rollo May's notion of caring as follows:

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\text{Caring begins as a feeling, but because it is the feeling of caring it cannot remain only in the feeling domain. Caring compels the acting out of one's feelings. When something matters, we are willing to expend energy in structuring life so that positive things happen to and for the ones we care about.}
\]
In contrast, Kant expresses scepticism in his “Lectures on Ethics” and maintains that emotions may be substituted for concrete action, as the following passage reflects:

*It is not possible that our heart should swell from fondness for every man’s interest and should swim in sadness at every stranger’s need; else the virtuous man, incessantly dissolving like Heraclitus in compassionate tears, nevertheless with all this goodheartedness would become nothing but a tenderhearted idler* (Kant’s Lectures on Ethics cited in Blum 1980: 153).

Blum (1980) counters that Kant’s view of emotion amounts to romanticism, that is, glorifying dramatic and intense feeling for its own sake. None-the-less, Blum’s emphasis on cognition and therefore the rationalisation of perception, emotion and agency, implies recognition of the sometimes unruly nature of the emotions. Goleman (1995) points out that Aristotle did not reject emotionality only the appropriateness of its expression. Reciprocally, Kant recognises that emotions of love, sympathy and concern help to fulfil duty. For example, compassion may assist an agent fulfil duties of beneficence (Oakley 1992). In consequence, Kant argues that people have a duty to cultivate such emotions and this very much echoes Buber’s, Levinas’ and Nodding’s references to the responsibility to be caring. This evidences the view that caring involves a conscious effort and commitment to acquire a state of being in relationship with others and hence the notion of obligation and duty.

Kant objects to emotions as the basis of moral agency for several other reasons; emotions and feelings are transitory, changeable, weak, subject to mood and inclination, unreliable, inconsistent, unprincipled and irrational. He argues that feelings and emotions can defy reason and rationality and divert us from morally directed thinking and judgement. A nursing example of this situation might be a situation in which a nurse’s intense sympathy for the patient, prevents her/him from carrying out a painful procedure. The apparent contradictory feature of causing pain while caring, is a main factor which makes caring unique in nursing. This is related to the moral obligation of health care professionals to be caring argued in this thesis. It is based on the assumption that restoration to health or
functioning is the alleviation of human distress, and this requires, on occasion, painful interventions. Despite the nurse's identification of patient discomfort, responsivity will usually involve sympathetic support rather than discontinuation of the procedure. This will be based on the intention that the care is beneficial and congruent with the patient's wish for recovery. In this context, professional caring necessitates optimum clinical competence to reduce suffering, a knowledge of the potential phenomenological experience of the patient and willingness to respond to the patient as an individual. This represents the ultimate balance between caring instrumentality and relationship.

The personal view above that rationalisation contributes to caring practice, conflicts with Bauman (1993) who asserts that;

Moral phenomena are inherently 'non-rational'. Since they are moral only if they precede the consideration of purpose and the calculation of gains and losses, they do not fit the 'means-end scheme'. They also escape explanation in terms of the utility or service they render or are called to render to the moral subject, a groups or a cause (page 11).

This chapter concurs, in part, with Bauman's view since it has maintained that Other-centredness and responsiveness of action in relation to the individual rather than predetermined technique, are the essence of caring. In contention, it is held that rationality, particularly in the complex, institutionalised health care context, is an indispensable element of professional caring agency.

Bauman (1993) argues that being moral pre-exists reasoning and one cannot simply decide to adopt a moral principle, values, attitudes and beliefs (Blum 1980). Just as love can only be received and not taken, emotions of concern and caring cannot be conjured up voluntarily, enforced or taught (Roach 1984, Campbell 1984). These assertions reflect the view that caring is learned pre-consciously during childhood and hence precedes knowledge (Blum 1980, Noddings 1984, Bauman 1993, Jarvis 1997). Accordingly, Bauman (1993) maintains that thinking, which involves concepts, standards and rules, transforms moral impulses in response to the Other, into impersonal ethical reasoning. This
may be the case within the immediacy of the relational encounter but otherwise, it implies that, as persons, we can never move beyond a moral destiny set during childhood. Total acceptance of the view that caring can only be acquired pre-consciously and that rational thinking is incompatible with caring would present the NHS with an insurmountable obstacle to providing a caring service. It is optimistically suggested that, just as the process of moral growth involves eradicating our negative and discriminatory perceptions of others (Blum 1980), so too can positive ways of being towards others be developed.

Oakley (1992) recognises that altruistic emotions cannot guarantee that one will act with sufficient depth of understanding to adequately fulfil one’s duty of beneficence or accurately identify the Other’s need. Material which suggests deficits in caring outlined in chapter one, indicates that appreciation of the patient’s need which motivates caring agency are overwhelmed by other practice demands. The literature evidences patient preference and partiality (Stockwell 1972) and non-caring and these concepts permit further evidence that caring as emotionally mediated agency is best tempered with an awareness of moral obligation. It is argued that professional duty or rationalisation recognises and provides both lesson-guide and safety net for our fallible human nature.

Whether through emotional or deontological processes, it is agency for which we are ultimately, morally accountable (Blum 1980). Because, agency in nursing is so central to the Other’s experience and combines an obligation to the individual and society, expectations of what comprises moral agency within the healthcare culture exist. This relativist consideration emphasises the inappropriateness of total reliance upon altruistic emotion or pre-conscious experience to guide practice.

If neither emotion or rationality alone can sustain caring, then in what ontological state does caring reside? With reference to human prejudice and partiality, Buber (1958) conceives caring as concern for the Other regardless of identity. This implies a state of being in which caring transcends personal negative perceptions of the Other. While so far, caring has been explicated as comprising emotional, cognitive and conative elements, writers mentioned throughout the chapter try to capture, in a variety of expressions, what it is to be caring. For Roach (1984) it is a ‘mode of being’, for May (1969) something more than emotions.
which come and go, but a human capacity and state in which something matters. Noddings (1984) describes caring as an ethical commitment to live caring virtues and for Bauman (1993) caring is being 'for' others.

For the purpose of this thesis, professional caring is conceptualised as being a heightened consciousness of the responsibility of the self in relationship to the Other and Others. It is both the source of altruistic concern, and moral response based on personal, tacit and professional knowledge. The commitment to be caring, necessitates personal reflection on agency within an ethical, relational framework. A grasp of the essence of caring, can be possibly obtained through a conscientious commitment to be caring and a tacit understanding achieved through contemplation of what differentiates caring from emotion, duty and application of ethical principles. This may proffer the astuteness to recognise and counter both organisational and personal constraints to caring practice.

As identified in the introductory chapter, the central aim of this study is to explore the clinical manifestation of caring in order to glean insights into potential future strategies for caring to be given greater support educationally and organisationally. It is acknowledged that the conceptualisation of professional caring, within this chapter, has been formulated heuristically from arguments and consensus within the literature and personal knowledge of personal care-giving and recipience. It is also acknowledged that when tested against real practice, it may be neither adequate or accurate.

While finding it necessary to acquire a provisional idea of a phenomenon, the selection of related concepts and subsequent categorisation is necessarily subjective. Authors identify that researchers may have a personal agenda, wish to prove personal beliefs (Berg 1988), hold ideas which influence interpretation of the data (Brannen, 1992) and negate the intention to view social phenomena through participants' eyes, by imposing prior and possibly inappropriate frames of reference upon them (Bryman, 1988:66). These concerns necessitate that I acknowledge subjectivity and examine and expose my own motives throughout the study. The following section provides insights into pre-understandings and exposes potential sources of bias.
3.10 Personal pre-understandings and biography

While the need to disclose personal values and beliefs has been in my consciousness since the decision was taken to focus on professional caring, it has been a difficult section to write and has been attempted on several occasions. The problem is one of balancing sufficient detail to reveal existing insights and biases without overstretching social norms in terms of exchange of personal information, in the interests of all parties!

To some extent I had limited tangible pre-understandings of professional caring. I think back to my early days of nursing and recall, that while I did my best for patients, I had little sense of the relational sense of caring. I liked the patients and very much wanted to help them. At the morning report and after cares, tasks and routines had been identified and delegated, there were those patients remaining, for whom no more could be done. I remember the sister or staff nurse saying in soft, rich tones that the patient just needed TLC (tender loving care). The words echo now and I recall a sense of special togetherness this seemed to instil in us all. But while I can see the differentiation in the purpose of care, I do not understand it. It makes me ask, what about TLC for all the Others? During the following twenty four years in clinical and educational practice, the most memorable stimulus to reflect on personal caring values was provided by exposure to humanistic psychology and the counselling paradigm. This aside, the greatest influence by far has derived through personal experience outside practice.

While the realisation that caring receives little educational attention provoked my interest, it soon became clear that there was much deeper motivation to explore the essence of professional caring. This arises through the experience of illness both as a patient and relative. Amongst memories of personal illness and hospitalisation, I can recall certain situations with great clarity. Times when I felt cared for in ‘face to face’ relationship (Levinas 1985). In contrast, I recall the occasions when being given ‘care’ dehumanised me. Most memorably, being given hurried, begrudged attention while being told off by the nurse “You’re not the only patient, there are others apart from you”. My shock and sadness were secondary to the shame I felt on her behalf, as the consultant stood and observed in speechless embarrassment. Is it any wonder that nurse autonomy is hard to acquire? As a relative, I experienced the hope and final resignation to the loss of my twin-
brother, Will, almost twelve years ago. I remained silent and bemused at the unthinking comments of those who depersonalised him and found some solace in the kind gestures of those who had time to think of him in his role of very much loved son and brother.

For both better and worse, the wonderful gift of caring I have been given by some and denied by others is now part of my biography. As a person involved in professional caring myself, I am aware that my biography both assists and interferes with the ideal of myself as a carer. I acknowledge that nurses and midwives, who I encounter during this research, will be similarly influenced by their personal experiences of illness.

My personal values derived from experience of hospital care result in the view that, while treatment might rectify physical problems, professional caring should do no emotional harm to patients. Non-caring behaviours which find expression and subordinate altruistic emotions which would spare the Other, are inappropriate. While affectionate and loving relationships are not the intention of professional caring, care ‘which does no harm’ in all its senses, ought to be.

My main concern throughout the study is to avoid being hypercritical of practice and I acknowledge the grounds which could predispose in this direction. Conversely and fortunately, my more positive experiences and insights provide a balance and it is these which give the study an optimistic frame.

3.11 Summary

In chapter two, professional caring was identified as a moral obligation to health care service users since the NHS as a societal institution of health care provision, raises expectations of service orientation and trust in its beneficence and fairness. In addition, illness and hospitalisation create patient anxiety, vulnerability and potential loss of personal integrity. It is argued that this increases professional moral responsibility.

An understanding of professional caring is elusive and assumed and therefore potentially ideological, rhetorical and misguided by passing social and medical paradigms. Within this chapter, there has been the attempt to reach beneath the discourse to identify the essential
features of caring. It has been argued that professional caring comprises core universal features, together with special considerations due to the sensitive health care context. These personal conceptualisations which will form the basis of the research for this thesis are summarised as follows:-

Caring is inherently moral and in contrast to the ability to be caring at will, caring requires the commitment to maintain a caring consciousness in relation to Others.

Caring involves emotions, cognition and agency. Caring makes salient the plight of the Other, altruistic emotions such as concern, compassion and sympathy are provoked and these transform feeling into agency aimed at reducing the distress of the Other.

Caring exists within relationship which is Other rather than self-centred. Relationships are reciprocal and the caring relationship adopts a unique form depending upon the individual characters of each of the dyad. The professional caring response therefore is both individual and individualised. Responsivity requires personal and tacit ways of knowing and therefore excludes the application of unresponsive pre-determined strategy.

The dichotomy between emotion and duty as source of moral motivation was discussed and it is concluded that, in isolation, both emotion and duty have limited capability to sustain caring. While authors argue that caring enhances the salience of distress cues and intrinsically motivate agency, this cannot be produced at will. Similarly, duty as a form of rationality has limitations, as it focuses on the obligation rather than the individual. Rational thinking has in its favour, the ability to master negative feelings such as prejudice, which prevent caring. Based on the responsibility encompassed in Buber's I-Thou relationship and Levinas' meeting the Other as 'face', caring derives from altruistic emotion which encompasses regard for moral obligation.

The following chapter details the research methodology and the consideration given to how the conceptualisation of caring formulated within this chapter, might be observed, articulated and compared with the reality.
Chapter Four
The research methodology and implementation of the strategy

The previous two chapters provided a background regarding the nature of institutionalised health care from the perspective of the patient, nurse and midwife. This chapter details the thought processes involved in deciding on the final research questions, research design and how this was undertaken in practice. Earlier chapters have identified factors which result in professional caring being perceived as an elusive phenomenon. Due to the variable manifestation of caring, this first section outlines some of the difficulty experienced in determining specific research questions, the potential contribution of the research and how caring might be studied empirically.

4.1 The aims and research contribution

While the rationale for the study was addressed in chapter one, identification of the precise research questions, turned out to be a difficult task. Despite the development of a theoretical perspective, I still felt unable to capture caring sufficiently to identify achievable, beneficial research aims. This created the need to re-examine continuously and deepen my understanding of, not only caring, but caring within the professional context. The literature review raised multiple issues and there appeared to be a wealth of practice problems which could be the focus of research. However, each potential research question which came to mind appeared either impracticable or had possible undesirable consequences. For instance, the initial intention to develop an educational package appeared flawed when it was recognised that the benefits of caring in contemporary health care is given little authentic consideration. To counter this, the research could attempt to demonstrate the possible qualitative differences in health outcome due to caring relationship. Yet, this would focus on patients and practice rather than practitioners and education as I intended. Also, as literature presented me with alternative frameworks for practice, such as technical or counselling specialism, other insecurities emerged. The question of 'why be caring' arose in chapters two and three, as the result of my own shaken assumptions, in which I had not considered an alternative way to practice. For me, as the cliché goes; the day clinical care-giving becomes just a job, is the day
to leave. A review of the literature made it clear that caring cannot be enforced or the subject of a rational decision to be caring and sections of current nursing discourse, political and educational agendas isolated me. I began to doubt that my study would be of any value to anyone but myself. Renewed belief and inspiration was provided by Pellegrino (1982) and much of the writing in the book "The Humanity of the Ill" (Kestenbaum 1982). Pellegrino's writings on the phenomenology of illness had a major impact. While there is no necessity to justify moral agency, it seemed to me, that insight into a patient's experience, makes caring a practical imperative. Grounding morality in the Other rather than the self was helpful and gave me the answers I had felt were missing to questions of 'so what?' Caring might receive low, overt organisational priority, but this does not diminish its importance.

That was the first hurdle and the next arose once the individual and contextual nature of caring became clear. I then began to perceive educational aims as problematic for the reason that educational packages usually contain tangible material. If this was my intention, I might attempt to identify practitioners' activities 'in relationship', the salient features which provoke emotions and the associated caring responses. I could examine moral issues within situations, values held and the factors which positively influence, constrain and frustrate. When I considered the use to which data might be put educationally, there appeared to be the risk of endangering caring by the production of another pre-determined model of attitudes and behaviours, such as the counselling paradigm. This option was soon rejected.

The next difficulty arose through aspects of caring not being amenable to empirical study; could I research caring in a valid and credible way? Consequently, the formulation of specific research questions entailed a complex process which involved identification of questions and parallel consideration of the generation and collectability of the necessary data. This required confidence that caring could be recognised.

One approach to conceptualising phenomena involves asking, "Would you know it if you saw it?" (Melia 1993:115). Described in the previous chapter as a conscious state of being towards
Others and the Other or as ‘a mode of being’ (Roach 1984), I wondered how I might know caring. If practitioners cannot explain the tacit experiences and judgements involved in caring for the Other, how could I get the data? I felt inadequately prepared and lacking in sufficient insight to attempt to get inside people’s heads. Additionally, I had no idea how practitioners would respond to any questions about caring (and during my dark hours, if it existed at all).

Kaplan (1964) notes that it is difficult to learn about any phenomenon if its nature is unknown and in the case of conceptual notions, a means of associating these with available empirical data is necessary (Melia 1993). Brewer and Hunter (1989:126) describe the function of concepts in the following way:

_We construct social science concepts in the hope of capturing social reality with ideas, and thereby making that reality easier to comprehend. With some of our concepts, we try to identify phenomena that need explaining and to see these puzzling events more clearly by distinguishing them as sharply as possible from other phenomena with which they might be confused._

It appeared useful, therefore, to consider concepts and contrasting phenomena. As identified in chapter three, caring encompasses multitudinous concepts such as concern, empathy, comfort and exploration of caring as a concept per se is of little use. As explained, this is because caring as concerned response is unique both from individual and situational perspectives. Set combinations of attributes and helping activity will therefore, never be constant and predictable. I determined that a focus on principles would prove more useful. I reconsidered again the features identified in the conceptualisation of caring undertaken in previous chapter and contemplated how I-Thou and I-it relationships might be differentiated. The principle that individuals are objectified through delivery of inflexible, predetermined strategies provided some clarity. Caring necessitates moral relationship with the Other, rather than solely, moral clinical activity. The essence of caring comprises concern for the other, receptivity,
responsivity and continued sensitivity to the being of the Other. I thought that such manifestations were potentially researchable.

I had therefore reassured myself, at least for the time being that caring is a desirable ideal for practice and that the use of principles rather than sub-concepts could maintain the integrity of caring as contextual and individual. The following research aims therefore were felt feasible and worthwhile;

- How is caring manifest in practice?
- What are nurses'/midwives' individual understandings of caring?
- How might caring be addressed educationally from a strategic perspective, based on the examination of the emerging data?

As it will be seen later, further deliberation occurred when it became time to develop the observational strategy.

4.2 The research design: choosing a methodology

Bulmer (1984c) identifies that researchers may choose a research methodology which has subjective appeal and the nature of the findings may reflect what they find intuitively, most satisfying. The disadvantage of a predetermined methodology is that alternative, more appropriate approaches may not receive consideration (Brannen, 1992). The following section presents the rationale for deciding upon an ethnographic research design to fulfil the above research aims.

Benefit may be gained from the examination of previous, related studies which offer the opportunity to identify successful methodologies (Bulmer, 1984c) and weaknesses to avoid. A selection of papers which have informed my decision-making regarding the research methodology, are outlined below.
Earlier studies have either addressed nurse-patient interactions and relationships or have examined patients’ or practitioners’ perceptions of caring actions. Kelly’s and May’s (1982) review of studies into perceptions of good and bad patients was based on egalitarian concerns that differential interpersonal treatment might be partially responsible for variable rates of recovery. They expressed the view, that much of the literature is deficient from empirical, methodological, epistemological and theoretical perspectives. They state that concepts used are poorly defined and that while the studies are purported to be about patients, in reality, they concern staff’s perceptions of patients. Questionnaires and interviews were the main methods used and Kelly and May argue that the validity of findings would have been improved by the use of observation. They continue that, methodologically, the studies are reductionist and fail to account for the social structure and processes involved in health care contexts. They conclude by advocating an interactionist approach for future studies. May (1990) also reviews and criticises previous studies into the dynamics of nurse-patient relationships and interactions. His main argument involves the value of observational studies concerned with frequencies, duration and the attributes of verbal interaction at the bedside and argues that as a consequence, little account has been taken of how the social organisation of care influences care-giving. He suggests that since an individual nurse does not work in isolation, such research assumes that the nurse has a high level of autonomy to carry out this individual responsibility and in reality this is probably very limited. He suggests that the findings of such studies have also resulted in prescriptive and dehumanising care strategies.

These two reviews emphasize that caring does not occur in a vacuum; patients also influence relationships and other social and organizational factors affect practitioners’ actions. Research into practitioner-patient relationships and interactions need to take contextual factors into account. Also, the use of observation in support of oral or written data potentially reduces the divergence of what people say and do (Brewer and Hunter, 1989). Argyris and Schon (1974) make distinction between espoused-theory and theory-in-use. They speculate that practitioners may espouse values which they perceive as the ideal, but act in ways which are incongruent.
The following studies focus on descriptive accounts of the nature of caring. Morrison's (1992) book is concerned with a psychological analysis of professional caring and offers a review of previous analyses and related research based on both carers’ and patients’ perceptions of caring. As he observes, much of this work has been undertaken in the United States. Morrison includes details of a study involving observation, which emphasised physical aspects of practitioners’ behaviours and resulted in quantitative data. Four categories were formed from the 1362 caring responses identified. He comments that this approach fails to reflect the lived experiences of both patients and practitioners. His own study into professional care involved personal construct theory and the repertory grid technique. The collected data provided several informative themes, but, as he himself identified, a major limitation of the method is that it may result in an “impoverished account of informant’s experience” (page 93). His subsequent study which used a phenomenological approach, produced findings of particular interest relating to the carers’ expectations of themselves and their perceptions of the personal cost of caring and also highlighted how patients and carers identify different priorities.

As mentioned in chapter three, studies which have concerned concepts associated with caring rather than caring itself, have been undertaken and include Gardner and Wheeler’s multi-method study of caring (1981). They investigated the concept of support, which they argue is a term used frequently by nurses in the United States and as such may imply more specific nursing behaviours and interventions than the term caring. The researchers used a questionnaire which asked nurses to describe a critical incident in which they had given support and a further section in which nurses were asked to define the meaning of support. This aspect of the study is difficult to determine from the description, but appears to have been based on earlier identification of synonyms of support. The authors report a twenty five percent response rate and note hostile reactions of nurses to the questionnaire, which took two hours to complete. This difficulty highlights the importance of assessing the acceptability of the research instruments to participants. Patients’ views of supportive behaviours were also obtained and support Morrison’s findings that patients’ and practitioners’ perceptions of care differ.
Both Morrison's and Gardner's and Wheeler's studies raise the important issue of the perceptions of the person receiving care. As mentioned earlier, caring concerns the appropriateness of the caring intervention for the individual and must be necessarily beneficial. While I was aware of the necessity to observe the person cared-for in order to record the practitioner’s care-giving, I feared that involving patients in interviews might be too intrusive and anticipated that the nurses in the palliative care setting might well have the same concern. Based on the view that the caring relationship is asymmetrical (Buber 1958) it is the nurse’s intentions and way of being-towards the Other, which comprise caring. Therefore, in terms of construct validity (Polit and Hungler 1995), patients' accounts would not provide the data to meet my research aims. I also envisaged that I would run the risk of having unmanageable amounts of data. Still, in reality, I was unaware of what information I might obtain and there was a sense that patients’ views could help to anchor my interpretations in the patients’ world-view. In consequence a compromise was reached and the decision was made to undertake opportunistic discussions, which would keep intrusion to a minimum.

One final study is included as it concerns a further alternative strategy in the form of an experimental design. Oakley’s study attempted to demonstrate the effects of increased social support on pregnancy outcome (1993). The study involved two matched groups of women, one group receiving usual pattern of care and a treatment group who received extra antenatal home visits. Outcome variables included various “soft” measures, for example, maternal satisfaction and “hard” measures, for example, the gestation and weight of the baby at birth. Statistically significant differences only applied to the soft outcomes. Oakley notes that it is unlikely that expensive interventions which fail to address hard outcomes will be implemented currently in the NHS.

It would be inappropriate to adopt a similar research design to study professional caring. Firstly, it would be difficult to specify precisely the interventions which constitute caring as either a dependent or independent variable and secondly, the allocation of patients to treatment
and control groups would present immense ethical problems. Also, quantification creates further difficulty. Higgins (1981:90) derides the positivist approach to measuring caring behaviour and asserts that the "limited positivistic epistemology of counting.... transforms the dynamic processes of action into static elements of content". Moreover, Bond (1993) suggests that the nature of nursing itself makes the requirements for experimental research difficult because care settings cannot be controlled and the variables of interest are sensitive to other influencing factors. Robinson (1993) argues that nursing and midwifery are concerned with social processes which involve intersubjectivity, interaction, intercommunication, language, cultural objects and social institutions. While an experimental or survey approach may generate quantitative data from a large number of respondents, it limits insights into people's experiences and meanings they give to events. Hakim (1987:26) advocates a more holistic approach:

Qualitative research is concerned with individuals' own account of their attitudes, motivations and behaviour. It offers richly descriptive reports of individual's perception, attitudes, beliefs, views and feelings, the meanings and interpretations given to events and things, as well as their behaviours; displays how these are put together, more or less coherently and consciously, into frameworks which make sense of their experiences; and illuminates the motivations which connect attitudes and behaviour, the discontinuities, or even contradictions, between attitude and behaviours, or how conflicting attitudes and motivations are resolved in particular choices made.

Ethnography is presently becoming popular in nursing and midwifery and may be perceived as responding to deficiencies of the quantitative research orthodoxy (Bryman 1988). For example Bond (1993) contrasts nursing with the natural sciences and argues that the reductionist and mechanistic approach associated with positivist traditions are unfitting in many nursing situations. However, Melia (1993) cautions that fashions in research design may in fact restrict the study of nursing. She argues that because nursing spans science, humanity and art, the
utilisation of a range of research methods is needed. She argues that the experimental approach assists health practitioners demonstrate empirically the benefits of interventions. This enables them to provide the most beneficial treatment and offers patients objective information on which they can base decisions. From this it is clear that the research approach depends upon the area of practice under scrutiny and both scientific and ethnographic approaches have their place.

My decision to adopt an ethnographic approach was in part associated with the limitations of the above review of previous studies and of the nature of the data and theory to be generated. As identified earlier, the value and clinical relevance of theoretical nursing models devised by academics, distanced from practice, have been questioned (Kitson 1993). The view has been expressed that an inductive approach with theory generated from practice may be a more beneficial line to follow in the study of caring (Kitson 1993). Grounded theory is intended to be totally inductive and since theory is constructed from the field work, relevant theory is not explored until after the data are generated and collected (Polit and Hungler 1995). As previously explained, for the reason that caring is such an abstract and multi-presentational phenomenon, it was felt impossible to commence the study without undertaking the exploration presented in the previous two chapters. Although Field and Morse (1996) argue that if a researcher knows enough about a topic to construct a conceptual framework, a quantitative approach should be adopted; this was felt inappropriate in this case.

Admittedly, the conceptual framework was derived from theory rather than being grounded in reality. However, Bulmer (1984a:248) notes that theory is an intrinsic part of discovery,

......there is constant interplay between the observations of realities and the formation of concepts, between research and theorising, between perception and explanation.
None-the-less, it is acknowledged that where there is a precise view of the phenomenon under study, the emergence of new discovery as elements outside those identified, may be not perceived (Bryman 1988). The intention therefore, was for the conceptual framework to be 'sensitising' rather than 'definitive' and that it would suggest the direction along which to look rather than what to see (Bulmer 1984a).

Mason (1996) identifies three theoretical relationships between theory and the generation of data; theory may come first, last or be developed dialectically. Respectively, these constitute inductive, deductive or abductive approaches to theory building. While caring has been conceptualised in order to have some insight into the meaning of observation and articulation, there are two main reasons why deductive research is not the aim and there is no intention therefore to contrast data strictly against the theoretical model. As mentioned, caring has no standard presentation and there can therefore be no definitive theory. Also, the literature gives scant attention to caring within the unique context of health care.

The above deliberations resulted in the decision to undertake a research design which generates qualitative data. An ethnographic, descriptive, exploratory study with a guiding framework was deemed best suited to the research aims and the phenomenon under study.

4.3 The ethnographic study design
Ethnography or 'fieldwork' derives from social anthropology and the researcher aims to gain close insights into the research setting, actions, relationships (Mason 1996) and the culture of the group (Morse and Field 1996) in the natural setting (Mackenzie 1994). It assumes that culture determines and guides the behaviour and experience of the group (Polit and Hungler 1995). Morse and Field (1996) differentiate ethnography into two types. Within classical ethnography, the researcher becomes a participant-observer in culture or group over long periods of time. In contrast, focused ethnography, as the term implies, has a narrower intention. Morse and Field (1996) note that it is often used in health contexts and while group
members may be culturally diverse in the broad sense, the ethnographer studies specific topic or events within the work culture.

As methods to generate data, ethnography utilises observation, recorded as field notes, information-gathering from group members and documentation. Phenomenology was an alternative research design which would also provide qualitative data. The method, derives from the philosophical works of Husserl, Heidegger, Sartre and Merleau Ponty and focuses on the experiences or ‘life worlds’ of people involved in the phenomenon under study (Morse and Field 1996). Phenomenology is a suitable method with which to explore caring, but since the research was stimulated by concern regarding the status of caring within professional practice, a cultural rather than individual emphasis is required. Even so, the aim to explore practitioners’ values, meanings and beliefs, necessarily involves obtaining phenomenological insights.

It was therefore determined that the research would adopt a multi-method approach, comprising observation and semi-structured interview and ad hoc discussions with patients. Following data collection and immersion in the data, the strategy for data analysis was to involve manual coding, thematic analysis and identification of categories in relation to the research aims. It was hoped that new understandings of the caring phenomenon within the professional care context would emerge. Data analysis is a lengthy process and this is discussed in greater detail later.

4.4 Enhancing validity through the combination of observation and interview

Some authors argue that qualitative is less creditable than quantitative research in terms of generalisability, reliability and validity. Bulmer (1984b) describes reliability as the extent to which research techniques and instruments yield a consistent result when used on more than one occasion or by different people. Even so, he argues that reliability in itself is insufficient and that it is validity rather than consistency which is more important. He defines validity as “the extent to which empirical research yields knowledge about the construct which it purports to depict” (page 30). Concerns about construct validity, in relation to the caring phenomenon
were mentioned earlier. Polit and Hungler (1995) suggest that the reliability and validity of qualitative data are based on whether or not these reflect the truth. Holm and Llewellyn (1986) define the concept of external validity as the generalisation of findings from a representative sample to the larger population or other subjects. Authors acknowledge the lower external validity and generalisability of qualitative compared with quantitative research, but argue that there are other considerations which are equally important. For example, Hakim (1987) argues that qualitative approaches achieve greater validity, since there is sufficient detail obtained from participants to ensure that accounts and views are as complete and comprehensive as possible. Bryman (1988) notes that while numbers may be small, the qualitative approach involves a range of different people. He also asserts that, rather than generalisation to populations, it is the extrapolation of findings to theoretical propositions or the establishment of a theoretical link between cases, which is important.

Observation increases validity on several counts. Firstly though, it is admitted that the difficulties experienced with attempting to ensure the validity of data generated through observation in relation to the caring phenomenon, resulted in a period that the notion was thought unachievable. I understood the advantages of observation, but had become faint-hearted and temporarily resolved to limit the research to semi-structured interviews. This explains why, as will be reported later, pilot interviews were undertaken in the neonatal intensive care unit, where observation of nurse-adult patient interactions is not possible. Encouragement from my research supervisor provided the necessary confidence and brought observation back onto the agenda.

Indeed observation had much to offer the study. Much of the caring literature is esoteric and I felt it necessary to see with my own eyes caring as manifest daily. There is ample material both in the literature and in the media regarding the level of care in our hospitals and I wanted to observe the constraints and ways in which these are either overcome or perceived as insurmountable barriers. Caring, as conceptualised, is individual, contextual and involves tacit and practical knowledge. Due to the complexity and potential difficulty in explaining practice,
the effectiveness of interview alone was therefore limited and necessitated that I sensed the practice of caring personally. Also, the feasibility of any suggestions for practice or education resulting from the research would need to be assessed, within the context of day-to-day practice.

The combination of observation and interview as means to generate data offers various advantages. In addition to providing data of a more complex nature in order to fully explore the research questions, the strategy provides the means of avoiding the methodological constraints of one single method (Brewer and Hunter 1989). Bryman (1988) also identifies that inferences drawn from one data source can be corroborated and be explored further by another. It was intended that observation may identify relevant features which could be explored in follow-up interviews. From one perspective, therefore, the combined methods could result in richer data.

Even so, the potential that the interview may reveal espoused rather than theories-in-use (Argyris and Schon 1974) placed interview and observation as two separate entities which produce different, independent data for comparison (Brewer and Hunter 1989) or methodological triangulation (Berg 1988).

Just as observation may permit comparison of verbal explanation and practice, interview can provide opportunity to clarify and confirm interpretations of participant’s activity. For example, the ‘Hawthorne’ effect which threatens the validity of observational data is virtually impossible to eliminate (Berg 1988) as practitioners are fully aware that their performance is being evaluated in some way (Holm and Llewellyn 1986). This may influence observed actions either through anxiety or altered behaviour in order to meet their perceptions of what the researcher expects. Each research approach has its weaknesses as well as merits and Bulmer (1984b) suggests that rather than regarding the different research styles as alternatives, they can be used to complement one another, the strengths of one balancing the weakness of the other.
Conversely, the use of multi-method approach introduces factors which threaten the validity of the data gathered. For instance, the amount of time elapsed between methods, may reduce participants' ability to recall events (Bulmer 1984a) and Brewer and Hunter (1989) note the potential problem of data being biased by colleagues discussing the research with one another. With these issues in mind, it was intended to complete both observation and interview phases as quickly as possible, in each research site. Brewer and Hunter (1989) advise that there is also a risk that the method previously used may affect the next method by sensitising the participant to the research focus. To overcome this, methods can be sequenced to ensure that the data most vulnerable to influence is collected first. It appeared prudent to undertake the observation phase first. If the interview preceded the observation and practitioners' concepts of caring had been previously explored, they may feel threatened or inhibited and behave uncharacteristically during the observation phase.

4.5 Design of the observational phase

Berg (1988:68) states that the ethnographer needs to determine clearly the essential aims of the study; knowing what to look and listen for. He identifies that it is necessary to become familiar with the physical setting, develop relationships with potential participants, track, observe and eavesdrop, locate subgroups, 'stars' and central characters. An important part of the research design, therefore, was to determine what to look and listen for.

4.5.1 What would be serve as observable evidence of caring activity

Lack of researcher experience and confidence resulted in great efforts to design an observational strategy which would reduce chances of missing relevant data. However, I discovered a dearth of information on what might comprise qualitative field notes. I therefore resorted to examining the texts of disciplines outside nursing, where there is a long history of observational research. The following section traces my lengthy diversion into the study of communication. Initially, I set out to determine which observable non-verbal and vocal behaviour channels of communication could be utilised to distinguish caring agency. The discovery and advantages of interpretative interactionism which coincided with the elements of
receptivity and responsivity encompassed in my conceptualisation of caring, provided the confidence I was seeking.

4.5.2 Sampling and what to observe
With relief, I read that it is impossible to record everything observed (Kendon 1982). However, this then made it necessary to decide upon what to observe and the realisation that the concept of sampling has dual meaning in an observational study. In addition to the selection of patients and nurses / midwives, it was necessary to consider the best way to sample the available, relevant interactions, relationships and behaviours.

The process of identifying observational categories, was tentative from the outset, as cautions expressed in the literature and outlined below, created fears that an analysis of the phenomenon of caring may destroy its essential qualities and merely add to instrumental component of caring. Dunlop (1986) warns that the problem with devising an operational definition is that the original phenomenon might become unrecognisable. She notes that patterns of caring behaviours are observable in society, but warns that the replication of these in a reductionist way may result in accusations of non-caring. Based on Gestalt psychology, which states that “the whole equals more than the sum of its parts”, Polanyi (1958) refers to the disorganising effects and loss of understanding of a phenomenon, when it is reduced to its subsidiary elements. He recommends that in order regain the original phenomenon following analysis, it is important to return to ‘focal’ vision of the whole.

Kendon (1982) suggests that features for focus during field work can be derived in the first instance from reflection upon one’s own experience as a participant in interaction. This appeared useful advice and I began to take more focused interest in interactions between myself and colleagues and ways in which concern and support for one another was conveyed and reciprocated. Even so, the complexity of situations soon became evident and the need to decide what constitutes relevant data was clear.
Observation can be undertaken at different levels of detail. Microscopic data are precise and highly differentiated compared with macroscopic or global data, which identify only fairly large scale phenomena (Hinde 1979). The former are cumbersome and put the studied phenomena in danger of being lost amongst all the minute detail. In the context of the study of relationship, macroscopic observation may involve identifying what people do together, for example, talking or sitting together (Hinde 1979). Finer microscopic observation could detail how often, what is discussed, and the tone and type of language used. Observation can also be comprehensive or selective (Hinde 1979) or similarly, sampling may be complete or partial (Kendon 1982). Accordingly, the researcher may focus on general behaviour or selected behaviour, such as gaze or facial expression.

The process of identifying potential behaviours which I felt could guide my observation was a long one, since there was a vast amount of material on each of the non-verbal channels. Research has encompassed many different aspects of behaviour, for example, kenesics, which includes proximity, lean, orientation, gestural activity, smiling, gazing, laughing, touch and paralinguistics which involves speech rate, speech latency, loudness, duration of pauses between the speakers switching, loudness and speech duration (Capella 1983). Much of the information gathered was not utilised directly. Even so, the examination made me aware of different perspectives in observing behaviour and importantly it broadened what would be salient in the environment, therefore avoiding a focus which would caused me to consciously or subconsciously exclude certain features. The review made me aware of factors not thought of previously, such as the influence of illness, age, pain, sadness and so on, on people’s behaviour. I realised that there was need to achieve a balance between the unfeasibility of observing and recording everything and not being too narrowly focused on ‘parts’ rather than the ‘wholes’. It also supported notions presented in chapter three that caring phenomenon cannot be studied by focusing on subconcepts or behaviours in isolation.

Although, I had identified receptivity and responsivity as central caring features, the identification of the structural or interactionist model of communication was an invaluable
aspect of the information-gathering. This highlighted the importance of multi-channel approaches with the awareness that patterns and sequences may become apparent during the field work. This will be discussed again a little later.

4.5.3 The drawbacks of a single channel approach

As identified earlier, studies into nurse-patient interactions have focused on specific behaviours (for example, Bottorff and Morse 1994, Estabrooks and Morse 1992). The following discussion highlights the uncertainty of information these can provide. An outline of selected single channel behaviours follows, to indicate how the information deepened my insights. It also identifies the limitations of studying behaviours in isolation, which led to my decision to adopt the alternative strategy.

There is controversy regarding what can be deduced from some non-verbal behaviours. For example, Kendon (1983) identifies that some maintain that gesture is used to clarify and enhance communication. Alternatively, since people use gestures on the telephone, others argue that gesturing may be an automatic by-product of speaking and in not anyway functional for the listener.

Touch implies interpersonal involvement but the meaning of the involvement can range from personalising and humanising of the other to a behaviour which subordinates the other (Heslin and Alper 1983). It is complicated by social norms regarding who has permission to touch whom and the appropriate contexts for such behaviour. For example, a person who initiates touch would be seen as having the status that gives permission to touch. Observationally, a wide range of features can be focused on such as; the mode of touch; for example, squeeze, stroke, brush, pat; the area touched and if there is reciprocation. The motives for utilising touch are ambiguous since it may be used therapeutically or manipulatively. For example, Heslin and Alper (1983) suggest that it can be used to make people feel more positive about experiences or the toucher, to encourage people to give information about themselves, or to comply with requests more readily.
West and Zimmerman’s explanation of the rudiments of speech synchronisation and sequencing between people was very relevant to the notion of caring as reciprocal relationship (1983). As with touch, the power base could be explored by observing conversational turn-taking and if nurses, as speakers, became silent as their voice coincided with the other’s or raised their voice in order to ‘maintain the floor’ (Argyle 1979). There are other features relevant to caring relationships. In terms of concepts such as ‘approach / avoidance’ (Capella 1983), observation may determine if nurses adjust actions in order to achieve symmetry and maintain relationship on behalf of patients. Specifically, do the nurses give time when faced with restricted responses, for example, when patients are in pain?

Eye contact receives much attention within the counselling paradigm and is taken to symbolise attention, active listening and interest (for example, Burnard 1992). Again, the possible categories are overwhelming such as gaze and mutual gaze, one-sided looks, face gazes, mutual looks, eye contact, gaze avoidance, gaze omission, look, gaze, leer (Exline and Fehr 1982). The authors also note the difficulty there may be in observing the nature of the eye contact accurately due to researcher positioning. Waxer (1979) associates eye contact with other behaviours which communicate concerned attention, such as forward lean of body torso, concerned facial expression, close proxemic distance (0.92 metre), tone of voice, smile and head nodding. These compare with behaviours which he suggests indicate diversion, such as writing notes and fiddling with equipment.

Waxer’s classification raises the important issue of whether observational notes include description or inference (Scherer and Ekman 1982). Within a descriptive approach the researcher attempts to be objective and resists making inferences about the function or purpose of a particular behaviour pattern. In contrast, inferential approaches, deduce the actor’s affect, intention or the social function of the behaviour. The temptation to assume the motive for action was therefore brought to my consciousness. This is an important validity issue and it reminded me that, in order to minimise the effects of personal biases and pre-understandings,
assumptions must be continuously challenged. It also supported the plan to combine interview with observation, since the interview would provide an opportunity to check personal impressions.

Even so, I was becoming mesmerised by the necessity for objectification. This placed not only my research aims at risk, but also conflicts with the underlying epistemological and ontological nature of caring. This experience relates to the discussion in chapter two regarding self-alienation as a result of the increased abstraction of knowledge and objectification within the scientific paradigm. While noting the importance of context in deciphering meaning, for example, a smile may convey happiness, resignation or reassurance depending on the circumstances, Ekman (1982) also acknowledges that expression is culturally understood and labels, such as smile, sorrow, frown are reasonably reliable. This offered some confidence that I was not personally devoid of the ability to intuit behaviour. In keeping with the earlier discussion regarding the challenge to modernity’s focus on science, Wittgenstein coined the term ‘language games’ to suggest that we have a socially learned ability to interpret and anticipate the action of others (Linge 1976). In consequence, the product of a person’s inner experience has ‘intersubjective validity’ (Linge 1976). This argument was adopted with the caveat that, there is always the possibility that I might be mistaken and that things are not always what they seem.

I chanced upon other information which identified that over-reliance on a single channel perspective may result in misinterpretation. Capella (1983) argues that observed behaviour alone is inadequate to identify certain interpersonal attitudes and that the simplistic notion that a more positive attitude is cued by more touching or gaze must be eradicated. The nature of the relationship and the response of the recipient to the behaviour, is therefore what determines the appropriateness and the meaning of the behaviour. As Kendon (1982:445) notes,
A gesture is not to be understood in the first place as an expression; rather it gains its significance from the way it is treated by a recipient. Meaning is thus born in the social process.

Before ideas of interactionism were developed, interaction was often formulated according to the stimulus-response model in which behaviour was linear (Kendon 1982). The linear model focuses on outcome rather than the way in which behaviour changes throughout the interaction and which maintains the social situation. The interactionist model assumes that each participant pursues a line of action, but each adjusts the actions in the light of information the other’s actions provide. It is a reciprocal process with each participant under continuous guidance of the other.

As mentioned, while developing my observational strategy, the examination of literature provided much useful background information. It was clear though that too much focus on a limited number of behaviours would not generate the data required to meet the research aims.

4.5.4 Interactionist or structural approach
The above considerations resulted in the application of the interactionist or structural approach to the observation of interactions. This entails that rather than focusing on one individual’s behaviour or channel, one studies the synchrony, mutual influence and modification of each one’s behaviours to accommodate the other and the combination of behaviour channels, as each seeks his/her goal.

Consideration of the above model identified some elements in common with my conceptualisation of caring. Also, examination of the deficits proved useful in clarifying behaviours or categories of behaviour which theoretically distinguish everyday goal-orientated social interactions (and indeed day-to-day nursing interaction) from caring. As regards the motive which might underpin interactions, Carper (1978) notes that nursing is goal-orientated
and in the following quote identifies that choices and priorities made in practice are based on the values we hold.

*To be humane, sensitive and caring practitioners, we must believe in the dignity and worth of the person, and we must understand firmly the meaning of values, choices and priority systems within which values are expressed* (Carper 1978:18).

If we value getting the routine work done, this undermines other-centred and individually-focused care-giving. The interactionist model also implies the ontological perspective that the patient has some influence over their carers and the care environment in that there is modification of the nurse’s own behaviour to accommodate the Other. Hinde (1979) notes that although predispositions will exist, social behaviour depends on both participants in each interaction. In much the same way as caring has been conceptualised, individual action is the property of the specific interaction rather than the individual person. In applying this to my study, a caring nurse may act in one way with one patient but differently with another.

Interactionism therefore, acknowledges the place of receptivity to the response of the other and in consequence, the impact of self. Subsequent response is determined by perception of person’s cues and reactions. Where the interaction is a caring one, cues of distress or need will be salient.

The variability of how actions will be received and reciprocated by each member of the dyad highlights the complexity of studying human interactions and relationships. Additional features found in the literature were thought relevant to the research.

Relationships are affected by many variables, such as past events within the relationship (Hinde 1979). Knapp (1983) notes that the frequency and duration of behaviours are likely to vary considerably at different points in the relationship. Certain behaviours may need to be more
frequent while a relationship is being established compared with maintenance behaviours. Some behaviours may subsequently disappear as others emerge. Initial cultural and sociological behaviours in new relationship may be replaced by more idiosyncratic communication as the individual becomes known. These factors made it necessary to be aware of the length of relationship between nurse and patients during fieldwork. At the same time, I was aware that many of the factors influencing relationship would be known to the interactants alone.

It was noted in the studies outlined earlier, that some failed to take into account contextual influences (Bryman 1988). It was therefore planned to gather information about the research settings such as staffing levels, patient allocation and shift patterns. This could then be correlated alongside other data collected.

While time consuming, the review of communication literature provided some reassurance for my entry into the field. I had identified disjointed elements which would be present within the whole context I was to observe and in which caring would be embedded. I felt able to return these individual features to my peripheral perception (Polanyi 1958). Strangely enough, I felt able to go into the field, observe and allow the features, patterns and sequences of behaviour to emerge naturally.

4.6 The interview

Interview formats include the unstructured narrative, semi-structured interview discussion and interview schedule. The latter involves the researcher covering a list of questions compared to the semi-structured interview in which the researcher has in mind a range of topics (Mason 1996). The semi-structured interview was selected in order to generate qualitative data and to access the personal explanations of what caring means to nurses and midwives and the values and rules which govern professional caring. I wished to explore wider issues such as how caring values are maintained and transmitted within the workplace. I was interested in why or how individuals developed commitment to caring agency in a national health service in which caring is given little organisational or educational value. My position therefore reflected Morse
and Field's (1996) suggestion that semi-structured interviews are indicated when the researcher has an idea about the questions but not the answers.

Semi-structured interviews also enable the deeper examination of respondents motivations and can also help to validate other data generation methods employed (Cohen and Manion 1994). While observation may identify patterns of behaviour, the dangers of attributing attitudes based purely on observed behaviours and the temptation to mistakenly assume people's motives were identified earlier. Observation therefore is insufficient on its own to explore either an individual's intentions and motives or the meanings and values attached to activity. As discussed in chapter three, practice may be based on caring, duty or role behaviour. This will be explored in more detail in chapter eight.

Although, I was almost decided upon undertaking semi-structured interviews, the idea of encouraging narrative was appealing. Chase (1995) suggests that this places emphasis on there being equal relationship between the researcher and researched individual. The approach acknowledges that participants are engaged in interpreting their own being and factors which shape their lives (Josselson and Lieblich 1995). Caring practice involves personal meanings, tacit and practical knowledge and I thought that insights may be accessible through practitioners' stories. Chase (1995) advocates that interviewers need to invite others to tell their stories and encourage them to take the responsibility for the meaning of their talk. Admittedly, I hold the view that nurses and midwives need to articulate their practice more clearly and assuredly, but also perceive a very fine line between supporting emancipation and patronising people. I was unsure that I could avoid the latter if I adopted Chase's ideology. Moreover, equality of the researcher and researched involves an underlying ontological perspective rather than the research method itself and I could attempt to achieve equality of power bases independently. I was therefore aware of the potential advantages of encouraging narrative, particularly during the pilot interviews but later decided against it as my main strategy.
This decision also reflects my lack of confidence as a research interviewer and I feared that relevant data might be limited without more structure. The aim to obtain relevant data relatively efficiently was a further important consideration, since I planned to keep interviews to between forty five minutes and one hour in length. Nurses and midwives experience extreme pressure at work and it was vital that participation in my research was acceptable and not excessively burdensome.

The quality of data encompassed in participants’ responses is dependent upon the nature of the relationship the researcher constructs (Chase 1995). The format and sequencing of the questions are also decisive. For example, initial questions can be aimed at putting the interviewee at ease (Morse and Field 1996). Conversely, Chase (1995) warns that the initial orientation to the interview taken by the researcher can determine whether participants share experiences and meanings or respond in a report format. Researchers need to ensure that the type of language does not deter interactive response or that the researcher’s agenda does not subordinate the participant’s contribution from the outset.

Morse and Field (1996) suggest that qualitative data, in which values, beliefs, meanings are embedded can be generated by asking open questions such as ‘can you explain’ or ‘tell me about...’, which encourage a description or narrative. They suggest that if too many questions are asked, the unstructured interactive format may be lost and responses may be superficial. As will be detailed later, the actual research questions used during the pilot study were modified for the main field work.

While the interview may take the shape of a discussion, the effort, skill and concentration required of the researcher should not be underestimated, since he/she is engaged in several concurrent cognitive activities (Morse and Field 1996). For example, while trying to understand the response, the researcher might also be assessing the relevance of the information to the research aims, how the questions can be changed to improve the quality of
the data and the focus and format of the next question. The researcher, therefore, needs to listen carefully, remain calm and not be afraid of silences.

In order to enhance the validity of data obtained, Morse and Field (1996) advise that the researcher refrains from asking leading questions and revealing her / his own opinions during the interview. An indication of personal views decreases the likelihood that accurate information is obtained rather than what participants perceive the researcher wishes to hear. My multi-method design necessitated that I was careful not to reveal opinions during the observation phase. Mackenzie (1994) suggests that ethnographers take measures to avoid artificial, participant concurrence and it is argued that the likelihood of obtaining valid data was increased as follows. It was anticipated that by sequencing the observation and interview phases, participants would be less likely to provide information which would conflict with what could have been observed. Also, the observation phase would give the nurses and midwives opportunity to get to know me, which should provide the psychological safety necessary to elicit independent views.

From an ethical viewpoint, Morse and Field (1996) question if researchers provide sufficient opportunity for individuals to refuse participation, exercise their right to withhold information or to withdraw during interviews. I was therefore aware of the need to balance a desire to obtain data to meet the research aims and a respect for the individual’s choice and autonomy. It was intended to audio-tape the interviews in order that the full context of the interview could be accurately transcribed and analysed. Again, I was aware of the need to avoid assumptions that this would be acceptable and was resolute that genuine choice would be provided. Interviews whether taped or not, necessarily involve providing assurances of confidentiality, anonymity and the security of data storage. This encompasses the ethical principles of respect for autonomy and non-maleficence which need to underpin research activity in order to protect research participants (Royal College of Nursing 1998). Information sheets for individual distribution were prepared for this purpose and assurances were to be verbally reiterated.
4.7 The empirical phase

This was commenced in October 1996. As mentioned earlier, the methodology underwent modification and re-modification and the initial pilot interviews were intended to determine the approach necessary to gain insight into caring emotions and how these might be vocalised. Recruitment focused on practitioners in emotionally charged roles. This indicates that within my conceptualisation of caring at that time, emphasis was placed on the affective domain. The neonatal intensive care unit (NICU) was thought to be an appropriate site. NICU is an area where nurses are committed to their work, it is an emotive area where there is a wealth of situations which evoke feelings and the need to respond to others, in particular, the parents of sick neonates. I envisaged access and acceptance would be fairly readily achieved.

After gaining the agreement of the practice area manager, we discussed recruitment. My dependence on her and her staff for the information to undertake and complete my research was humbling and rather than entering the field with pre-set ideas, I suggested options for recruitment and asked her preference and advice. The following options were identified: firstly, the manager could suggest appropriate participants. This potentially increases validity since selection not only depends upon the researcher’s judgement and perception of the model nature of the nurse. However, it is also exposes the manager to the risk of staff resentment and to those selected. Secondly, I could place an information sheet in the staff coffee room to advertise the study and call for volunteers. This was the least preferable to me personally, since I was doubtful of the response rate. Finally, I could ask practitioners known to me personally and snowball from there. I felt this latter option was unethical and might result in invalid data, since the individuals might feel obliged to participate. The manager decided on the second option and an advertisement and information sheet were devised (appendix 1), displayed and attracted three volunteers; one almost immediately and two more after about three weeks.

Mutually convenient times for the interviews were arranged and these were undertaken in a private office where risk of disturbance was eliminated. At the beginning of each interview, I briefly explained the focus of my study, made it clear that no assessment or judgement was
involved and gave assurance regarding anonymity and confidentiality. Verbal consent was obtained to audio-tape the interviews.

Heeding cautions, referred to earlier, that prioritising the researcher's agenda, might inhibit participants' narratives (Chase 1995), I was aware that requesting biographical details at the start of interview may be counter-productive. My alternative view was that it may be beneficial for both parties and this idea was put to the test. As it happened the social aspects of the strategy were more beneficial than the biographical data obtained. While this information included variables which may influence care-giving, such as length of experience, caring appears to be so individual and unpredictable that a positivist approach involving categorisation with the aim of prediction was rejected. However, this initial interaction was found to be a successful means to break the ice, to express interest in the person and make allowances for nervousness, particularly since interviews were taped.

Practitioners were informed that the focal interest involved how nurses experience caring for people in times of vulnerability. Practitioners were asked to recall a caring ‘episode’ which moved them emotionally or a situation in which they felt that they had connected well with the parent. I intended to identify factors which enhance or interfere with response processes and the means to alleviate a person's distress. Based on the notion that caring motivates agency, the particular intention of the interview was to uncover caring triggers. While the nurses were very willing to talk about their care of babies and parents, the cues to which they responded, or which stimulated the caring response, were difficult to elicit.

This pilot study was of immense help to me, because while I had been a participant in a taped research interview I had never undertaken one. It gave me insight into the required concentration and simultaneous listening and thinking, as Morse and Field suggest (1996). These interviews were concurrent with continued study into the caring phenomenon and field work methodology and the combination of the theory and practical activity was developmental. As in caring, no theory can help identify cues which indicate that the question was not
understood or had touched an emotional trigger. In particular, I learned the importance of silence and although enthusiasm got the better of me sometimes, I was careful not to monopolise the interview. I was there to seek information from them, not the other way around. None-the-less, I deciphered cues which I felt called for responses, not necessarily agreement, but acceptance. I knew that it was important not to demonstrate personal attitudes and values, since these would almost certainly provide cues which might influence participants' responses (Morse and Field 1996).

It was also clear that I was interviewing skilled carers and communicators and became aware, that they picked up on my cueing when, for instance I wanted to query something they had said. In this situation they curtailed their flow of conversation in order for me to ‘turn-take’. While there was need to cue interest and validation, in this other respect, a conscious effort to achieve both verbal and non-verbal silence was warranted. My exploration of communication had clearly influenced my perception! Interviews were transcribed and thematic analysis undertaken and factors involved in perceived attachment with the parents and baby were identified.

My regret with this phase is that participants may feel that the information they supplied is given little recognition, since only one finding is referred to in the following chapters. The interviews provided a valuable foundation for the study and therefore contributed immensely to the project. But the experience highlighted that ethically, pilot study participants need to be informed that the information gained may not be utilised in the final report and I would certainly consider this in the future.

4.8 Fieldwork

The following section addresses practical issues relating to access to a research sites in which the main field work was undertaken, the observer role adopted, the recruitment of practitioners for participation in the study and data analysis. The initial contact with the field took place in November 1996 and all the data were collected by the end of July 1997.
It was planned to record observational data as contemporaneously as possible and to tape interviews with the participants’ permission, which would be later transcribed. Theoretical notes, which make inferences from the observational data were made, in addition to a personal diary in which I noted personal thoughts and feelings about people and events which could potentially create bias. In addition, the rationale for changes and decisions taken during the field work were logged.

4.9 The field work settings

While my personal speciality is midwifery, I wished to include both nursing and midwifery in the study. As discussed earlier, both midwifery and nursing are concerned with caring as the same human experiences of vulnerability, risk and distress are involved. Rosenfeld (1982) suggests that in order to study a phenomenon, it is necessary to first identify the situations in which it is most likely to occur and those where it is unlikely to be observed. While it is not possible to be certain that caring will either be present or not, the notion that some places are more likely to be optimal place for observation was useful.

It was necessary to consider whether to undertake the study in areas which entail mainly one-to-one caring or the more usual situation of practitioners caring for a group of patients/women. One-to-one care would have to involve midwives in the delivery unit and the main possibility of matching this in a nursing setting was likely to be restricted to situations where the patients were quite poorly. The advantages of observing one-to-one caring would be that the interactions of one practitioner and patient/woman (and partner probably) could make data collection easier. The disadvantage would be the possible intrusive effects on the patients. In the case of a woman in labour, I could minimise this by providing some care personally, which I am competent to do. The situation is quite different in a critical care area, where my presence could hinder care being given. There would also be reduced opportunity to take into account the social and organisational aspects, since staff to patient ratios are not comparable. The idea of observing caring in the community was eliminated due to the differences in the observable
element of caring that may occur in established relationships. The increased personal control of people in their own home compared to increased vulnerability in hospital may also reduce the opportunity to collect data most relevant to the research aims.

Palliative care is well known for focus on care since cure is no longer a possibility. In Samarel’s words, ‘*Hospice nursing prioritises caring over curing*’ (1989: 324). A lecturer colleague who was responsible for co-ordinating the palliative care course, highly recommended a local hospice and offered to introduce me to the unit manager. I intended to undertake the study in a maternity unit but was unsure whether to negotiate with the hospital where I was based as a lecturer or elsewhere. While having knowledge of protocols and culture of a unit can avoid loss of information due to novelty effects, the converse, that the familiar is overlooked, may also be a problem. I was also unsure whether midwives would feel inhibited both in their practice and information-giving. This dilemma is referred to again a little later.

### 4.10 Permission from the major gate-keepers and the local ethics committee

I met with the nurse manager in early January 1997 and at her request, I met with the consultant in the palliative care unit. This was friendly and informative meeting with plenty of time discuss the study and receive information about the unit. He offered me research guidance and demonstrated great practical knowledge of caring for dying people and their relatives. He also identified aspects of caring that I knew would be beyond the study, such as the signals provided by relatives on the patient’s behalf, which stimulate carers’ love for their loved one.

Permission to undertake the study was requested from the local ethics committee since some impingement on service delivery was inevitable. Following some simplification of the information sheets, the study was approved. The Ethics committee also requested that I contact the director of the Community Trust research and development department (under whose auspices the hospice falls), so that the study could be included in the Trust’s programme.
of research activities. This also was a useful meeting and provided the opportunity for me to present and have scrutinised, my research proposal.

While undecided where to undertake the midwifery related phase of the research, I obtained permission in principle from the general manager to ensure that research in my own unit was, in fact, an option.

The manager in the palliative care requested that I attend the unit at hand over to discuss the study with the nurses on duty in order to obtain personally their views and agreement. Two such visits were undertaken in late January and introductory information sheets were issued (appendix 2). I had identified provisional dates to commence the field work and I was able to meet with three of the nurses who would be on duty.

The question of how much detail to give participants about the study is a difficult issue. If this is too specific, participants may alter their behaviour (Berg 1988) and I initially, considered informing participants that the study concerned practitioners' interactions with patients rather than caring specifically. Brewer and Hunter (1989) identify that deception, in the guise of misrepresenting the study's purpose, is employed in social research, when the facts may cause bias or prevent co-operation. After reviewing the caring literature, the elusiveness of the caring phenomenon and the variability in manifestation was evident. This made it clear that no standard presentation could be feigned. Additionally, previous research studies, as mentioned in the previous chapter, suggest that when asked about caring, practitioners identify subconcepts, such as empathy, sympathy and support. The study's focus on the principles and processes of interaction and relationship such as availability, receptivity, responsivity, synchrony, again made it unlikely that caring could be simply and intentionally adopted. I took the view that the study was intended to describe the manifestation of caring, and could see no point in disguising the fact.
4.11 My observer role

My intention was to become accepted and to shadow one or two practitioners in a non-participant observational role. The research literature identifies that the observer role ranges from complete observer to complete participant (Mason 1996). The role adopted has implications for the amount of undivided attention the researcher is able to give the research topic. There are also ethical overtones associated with overt versus covert observation, where in the latter, the participant may be unaware of their role as researched subject. My options were constrained for a number of reasons and this was highlighted at the stage of gaining permission into the field. In the first setting, I had no background in palliative care and participation was therefore out of the question. None-the-less, there is still the need to consider what to do in the event of someone requesting help (Hilton 1987) and this did in fact occur and is referred to later. As it was, I was advised by the Community Trust’s head of research and development, that I needed an honorary contract, just in case I was at the scene of a mishap in the clinical area. Despite my midwifery background, I decided to adopt the same observer role in both settings in order to achieve equity across the research settings.

4.12 Recruiting participants and building relationships

In view of the amount of qualitative data generated through participant-observation, semi-structured interviews and discussions with recipients of care, the initial intention was to recruit approximately six to eight qualified members of staff on both sites. It was planned that participants would be female or male and be in the position of primary carers with responsibility for a group of male and/or female patients.

I initially planned to undertake purposive selection of participants and to recruit two practitioners at a time. This was in order to achieve some continuity with practitioners and also to observe interactions between different nurse-patient dyads. On this basis, it was also intended to undertake a brief informal interview with individual participants, prior to field work. Brewer and Hunter (1989) suggest that this may help to reduce anxiety and fears and
help to build up rapport and give the opportunity to discuss the practical aspects of the study. These plans were unrealised for various reasons, as explained next.

One reason was the realisation that selection was arbitrary. As was acknowledged during the discussion regarding recruitment for the pilot study, asking managers to identify suitable practitioners has ethical connotations and may create ill-feelings amongst staff.

The change to convenience sampling also occurred due to my employment which limited me to the number and sequencing of days which were possible for my research. It was therefore decided to identify initial dates I was able to undertake field work and accordingly, the practitioners who were on duty on those days were potential candidates and were issued with information sheets (appendix 2). I initially identified eight days in two phases. The first phase was to last three consecutive days and the second phase five days, as follows,

Phase one: 5-7th February 1997
Phase two: 17-19th February, 10-12th March and 17th, 18th and 20th March 1997.

There were two main reasons why the second phase was modified and extended to twelve days as indicated. These will be detailed shortly.

Once field work began, it was clear that the nurses were caring in different ways and all observation appeared informative. In order to obtain breadth of data, field notes were recorded on all nurses, including nursing assistants who entered the observational area. None-the-less, as Berg (1988) above suggests, key people did indeed emerge. Some nurse characteristics influenced the decision who and who not to follow through. For example, one nurse in particular was obviously uncomfortable being observed. Others were orientating to the unit, and while this has provided important data relating to socialisation processes, their actions were non-representative, due to the disorientating impact of the new environment. I therefore modified my field work schedule, in order to achieve continuity with some of the nurses. This continuity assisted me in obtaining greater depth of material and better rapport in relation to requesting and undertaking the interview.
A further reason for the change in schedule resulted from the exhausting experience of collecting and the transcription of the observational data. In order to retain as much detail as possible, I transcribed notes as soon as possible afterwards. This was usually achieved in the evening or at the latest the following day or evening. The amount of concentration needed during observation itself followed by decipherment of the noted descriptions was immense. Three days of field work at a time were only just manageable.

The first phase was intended to test my plans for data generation and collection and provided the opportunity to become familiar with the language, behaviours, organisation and structure of the team. It was also to enable the nurses to get used to me and for me to gain their acceptance (Field and Morse 1996). While I intended to keep personal intrusion to a minimum, Berg (1988:54) warns, that the presence of the researcher in the study setting “may taint anything that happens among other participants in that setting”. He adds that the researcher’s attitude is vital in maintaining co-operation and recommends a neutral attitude which acknowledges a situation but neither advocates nor criticises. An empathetic stance, which implies neither agreement nor disagreement may also help the researcher avoid personal involvement in participants’ concerns about their work situation.

Mason (1996) suggests that because the quality and quantity of data generated depends upon the nature of the relationships established with participants, it is necessary for the researcher to consider carefully, demeanour and behaviour. I felt reassured in the knowledge that I usually enjoy amicable relationships with people, but the field worker role was new to me. I perceived that acceptance may be deterred if nurses perceived me as an academic know-it-all or if research intentions were intrusive to either the nurses or patients. On the other hand, I needed to give the impression that I had some idea of what I was doing. I therefore worked on the basis that interest and respect are often reciprocated and formulated flexible goals always checking with the staff that these were acceptable. I was on foreign territory and my intention was to adopt an non-intrusive profile with a ready willingness to participate if invited.
Hilton (1987) identifies the potential for stress as the researcher attempts to live in two different and paradoxical worlds; there is the desire to be accepted by the group being studied and involved in order to gain maximum understanding, but also, the need to remain detached, in order to maintain academic viewpoint. I found ‘entry into the field’ an anxious experience although this was unfounded. The nurses were friendly, open and proud of their practice. While I thought patients might find my presence intrusive, I was surprised by how well I was accepted. The number of voluntary visitors they receive may accustom patients to the presence of strangers and non nursing and medical staff in the care environment.

4.13 The observational vantage point and writing field notes

Only after commencing the initial phase was I able to compare the two options for observational strategy. On the first morning, I followed two nurses around the unit and found that data generated through nurse-patient interactions were being missed by being in the unit areas away from the patient bays. I also felt awkward and found that the nurses were including me in their interaction with the patients. For example, while a nurse was doing a foot massage for a patient, she made sure that I was comfortable while watching!

The following day, I placed myself at the back of the bay and found this much more satisfactory. I was able to watch nurse-patient relationships within the context of the patient’s day and experience. Therefore, the routine thereafter, was to arrive for the hand-over from the night to the day staff, decide on which bay I felt held greatest potential and to ask the nurses if this was acceptable. The choice of bay was based on intentions to observe in both male and female bays and the severity of distress and treatment being received by the patients. For example, some patients were self-caring, while others required almost constant care. These opposite extremes are also potentially the most intrusive. I therefore tried to balance the desire for data and respect for the privacy and dignity of both the patients and nurses.
Following the hand-over, I introduced myself to the four patients in the selected bay, explained the study, clarified my non-clinical role, obtained verbal consent and gave each an information sheet (appendix 2). Hilton (1987) identifies that ethical conflict may be provoked by a variety of situations, for example, whether or not to intervene or meet patients' requests for assistance. One ethical dilemma which arose involved my observation of intimate care-giving. Much of the interaction and care-giving was easily visible and if curtains were drawn I initially joined the practitioner at the bedside with the patient's consent. After a few occasions, the data obtained during observation of intimate care-giving were no richer than that at other times, such as administering drugs or negotiating care-needs, and was therefore felt not to warrant the intrusion.

At the onset of phase one, I was undecided when and where to make notes and more experimentation was necessary. Because it was decided that these would be broad but comprehensive, notes were copious. Initially I left the bay to write up notes but felt that details of interactions and patterns and sequences of activity were being missed. I was seated at a table at the back of the bay, could observe interactions clearly and I began to wonder why I had to hide away to write up notes. Nurses and patients knew the reason for my presence and did not find it problematic. I began to test responses and the impact of remaining in the bay to write-up my observations and found that it posed few problems. I took steps to avoid the impression that I was writing notes as things were being done and said, although this became achievable. There seemed to be appropriate times to write without invading people's privacy. I waited for the end of conversations and interactions and then wrote my notes. Often the nurse had gone out of the bay. I think the factor which contributed most to their growing accustomed to my note writing was that I was often writing notes when nurses entered the bay and it was therefore clear that this related to previous interactions. This also gave me the opportunity to change what I was writing about and to obtain fairly accurate transcriptions of what was said and done. Often several things occurred together necessitating later expansion of the notes and when I was in close proximity to the action, such as at the bedside, it was clearly more appropriate to write it up later.
I admit, that observing the nurse-patient dyad sometimes felt an intrusion, although this was based on my own feelings rather than any indication from them. What I found quite helpful was to appear to be focusing mainly on the patient. This felt quite a natural thing to do. The patients appeared accustomed to the attention and I sensed a kind of partnership with the nurse.

As detailed in the previous chapter, I had identified a mental observational guide (rather than schedule) and prepared myself to absorb the environment. Over the days, in order to find some structure, I referred to the major principles identified in the framework, such as synchrony, receptivity etc. Analysis of the data spontaneously occurred during writing up and particular aspects were noted for attention (in addition to the usual aspects) during the next observation session. Examples include, the use of silence and departure signals. Issues were also identified for the interview, such as how nurses balanced the needs of one patient against collective needs and how they prioritised care. These emerged as central features in both of the research settings. Importantly, the emerging data guided the subsequent data generation, rather than the data being forced into a pre-set framework.

4.14 The interviews and exit from the field

Initial plans to have discussions with practitioners following their interactions with patients were abandoned. These had been intended to identify elements of caring which are often intuitive, preconscious or concern practical knowledge such as, patient cues responded to, decisions regarding responses given and feelings experienced. It was realised that this again would have interfered too much with their care of the patients and had to be left to the main interview.

While not wishing to ask patients to evaluate care, I needed to get some idea that interaction was beneficial if this is not apparent from observation and to gain insight into their experience of being cared for. This was inappropriate and unachievable where patients were either
emotionally or physically distressed, confused semi-conscious or unconscious. However, all the patients I approached were quite happy to discuss their care. The conversations were not audio-taped and were written up as soon as possible after the conversation.

Interviews with six nurses were undertaken during the final observation week and the week afterwards. These were with the nurses who had been observed the most comprehensively since some of the observational and interview data were to be correlated.

Interviews were held mainly in a quiet room in the unit, which was prepared before the meeting. Comfortable chairs were placed at a comfortable proximity and angled to facilitate easy eye to eye contact and communication. The tape recorder was placed in an unobtrusive position and tested. After a brief résumé of what my research entailed, participants were asked permission to tape the interview and anonymity and confidentiality were assured. I gave each an information sheet (appendix 2), which represented my commitment to this undertaking. As I had found obtaining biographical information about the nurses helpful in the pilot interviews, I retained this strategy to open the interview. However, the questions had become modified in keeping with my changed thinking and understanding of the caring phenomenon. All of the nurses were asked, what caring meant to them. On occasions it was necessary to phrase the question differently, in which case I asked them about their personal intentions of caring for the patients. Subsequent questions followed up items within their responses, such as the use of models, how they achieved particular aims in practice, such as building relationship, individualising people, reducing a patient's sense of burden hood and feelings associated with being unable to reach personal, caring ideals. Other questions, which were still associated with their comments were intended to gain insights into theoretical aspects, such as patient cueing. Common issues did emerge such as partiality, prioritisation of care and, if the opportunity arose, these were utilised as a focus for an interview question. Interviews were kept to an average of about one hour, so as not to impose on either the nurses' personal or work time.
Notes were made after the interview about the informant's body language and response to the interview. I interpreted the nurses' body language as relaxed, although one or two appeared slightly nervous initially. They were positive and clearly interested in their practice and happy to talk about it.

As mentioned earlier, four additional days were identified and this resulted from themes emerging during transcription and identification of additional observational targets. However, the second phase came to a natural conclusion for several reasons. The observational data became repetitive, new staff were orientating and since they were unfamiliar with the unit appeared inhibited. Neither were these data representative of the unit practice. Additionally, following the interviews, the nurses started to include me more in conversations in the bay, which prevented me from making observation of their usual activities. I was conscious during field work of maintaining a balance between over and under involvement with the nurses and to adopt the role of researcher. But it became difficult to maintain the distance, as the nurses' interactions with me increased. This naturally led to the patients involving me also and it became more difficult to remain uninvolved with simple patient requests for assistance, such as calling for the nurse. I was pleased to have overcome personal fears of rejection and lack of co-operation and to receive the nurses' and patients' friendship and trust, but it was becoming counter-productive.

In contrast to prompt transcribing of the observational data, all interviews were transcribed once completed in the two settings. In this way, rather than being influenced by previous responses, the flexibility within the semi-structured interview format was maintained and remained responsive to individuals in the subsequent research setting.

4.15 Field work in the maternity ward setting
As mentioned earlier, I was undecided where to undertake the maternity care phase of the study because of concerns regarding the validity of the data. The decision was more easily made once the research in the palliative care setting was successfully underway. I felt that I
had gained good insight into adopting the researcher role and was grateful that the palliative care nurses and patients were so helpful. This gave me confidence (although not complacency) in myself as a researcher. Also, given a few situations in the palliative care to clarify my non-participant role, I felt I had addressed the ethical dilemma of when and when not to intervene (Hilton 1987). In addition, while I knew many of the midwives in the hospital, student midwife practice placements had been moved to the community, I felt that this afforded me some distance from the hospital based staff. I was aware however, that with greater theoretical insights into the speciality I had to guard against letting this divert my attention from caring aspects.

I decided to discuss the project with one of the team leaders and was met with a good deal of enthusiasm. I followed a similar process to the palliative care phase and visited the ward to explain the project to the midwives and left information sheets (appendix 3).

As in the palliative care setting and in order to maintain similarity of practical arrangements, sequencing of research activity and methods of midwife participation was undertaken. The off-duty roster of the dates I planned to undertake observation was utilised to identify midwives on duty on that day. Therefore introductory visits were also aimed at gaining agreement from the midwives on the planned days. The ten dates were as follows;

Phase one: 21st, 23rd and 26th May 1997
Phase two: 2nd, 10th, 11th, 16th, 19th June and 1st, 9th July

The latter days were planned, as before, in order to achieve continuity with several midwives for the purpose of obtaining more in-depth observational data and to enhance the quality of the interview.

The aims of the initial phase remained unchanged and indicated that there were many practical issues to be contemplated and decided. I enjoyed the first morning on the maternity ward, feeling it familiar. Even so, the amount of activity was overwhelming and I wondered how I
would record all the information. Neither was it possible to sit at the back of the bay due to the
fact that screens were often round the beds and care-giving interactions per woman were less
frequent. The pattern of midwife activity comprised care-giving activity, usually behind
curtains, and return to the midwives’ station to write up case notes. I therefore found it easier
to shadow one or two midwives on each day, joining them behind the screens during care-
giving. In between times, I placed myself where I could see the station and the midwives’
activity. Selection depended upon the compatibility of my field work days and the midwife’s
off-duty and appropriateness of chosen ward area on the day. For example, interactions were
frequent with postnatal rather than the antenatal women. This therefore avoided the
impression that preference was involved in the selection process. Even so, ensuring that all
staff were informed about the study was greatly appreciated.

I usually wrote up my notes in my position near the midwives’ station and found again that this
did not appear to create inhibition. In keeping with naturalistic inquiry I was unable to predict
which woman-midwife interaction I might observe and therefore obtained consent from all
women potentially involved. This was quite easily achieved and necessitated women also being
informed that I might not see them with the midwife.

There were some issues I had to address due to my educational role in the speciality. I had to
consciously eliminate the role of assessor versus researcher. In the first two days I was aware
of judging the instrumental aspects and had to remind myself of the aims of the study. In part,
this may have been because, the instrumental side of practice was emphasised in the setting.
Initially, some midwives saw me in my educator role and asked me about courses and
assessment issues. To some extent, I felt that this was their way of establishing rapport with
me and it was therefore a necessary part of becoming accepted. I was aware however, that I
had to take care not to become established in this role. Through maintaining focus on my
research activity and through a natural exhaustion of educational issues, I felt this potential
problem was averted. Unexpected to me, I sensed that most midwives were motivated by
someone paying attention to their work. This was a great relief, since I was unsure how the midwives might respond to having their practice scrutinised.

Despite the great amount of activity, I was soon able to recognise patterns activity undertaken by the women, midwives, relatives, visitors and doctors. These and other contextual details could be cognitively summarised in order to focus on what was most relevant to the study. As with the palliative care setting, the time to leave the field became clear as after a while little new or different activity was apparent.

Seven interviews were undertaken in a quiet room in the ward area and were commenced during the third week of the field work. The interviews followed a similar format as in the palliative care setting. Two midwives were particularly nervous during interview. In one such case, it was difficult to get the midwife to talk freely and spontaneously about her practice. Her obvious awkwardness meant that I ‘rescued’ her on occasions and the interview was quite brief. Afterwards, she said that she was unused to talking on a one-to-one about practice.

The other midwife was nervous about the interview being taped. I felt in somewhat of a dilemma wondering whether to encourage her since people usually get used to the tape recorder very quickly but not wanting to impose anything against her wishes. I reassured her regarding anonymity and confidentiality. It was probably her wanting to get the interview ‘over and done with’ that she consented. Afterwards, she was relieved and told me that she did soon forget that the discussion was being taped, although seeing the recorder on a couple of occasions did remind her of the fact.

I left the field and agreed to provide feedback and details of the research findings within both settings, at a later date. This was undertaken in summer 1998.

With confidentiality and the security of data in mind, all audio tapes were kept where only I could access them. Interviews were transcribed on to computer, and to maintain anonymity
and confidentiality, any information which might uncover identities of participants, colleagues, patients or study units was removed. I personally undertook the transcribing word for word, which was the start of becoming familiar with the data. (Examples of palliative and maternity care interview transcripts can be found in appendix 4 and 5 respectively).

4.16 Data analysis

The management and analysis of qualitative data, on which fulfilment of the research aims and new theoretical proposals depend, is a lengthy and complex process (Pollock 1991, Savage 1995). Pollock (1991) identifies that despite this complexity, there is little guidance on how it might be undertaken. This is problematic, since the interpretation of the data depends upon the researcher’s perceptions, based on personal experience, and cognitive processes. In consequence, the reliability of the findings and possible contribution to practice are limited if the process of analysis is unclear. It is intended therefore to make this part of the research as transparent as possible.

Authors note that qualitative data analysis is undertaken simultaneously with research design and data collection (Pollock 1991, Bryman and Burgess 1994). Groundwork for the analysis began during the conceptualisation of the caring phenomenon and clarification of the research’s purpose and aims. Understanding was also enhanced by writing a paper for publication which explored reported deficits in caring and contemporary distracting discourses (Woodward 1997). During field work, ideas and themes emerged through the combination of note and journal writing and reading through the observational data day by day. This activity was also intended to reassure myself that field notes were comprising data which would create a description of caring in practice. Initially themes were merely noted, but later these contributed to observational goals which gave the themes shared focus with the usual observation of the overall context. Sometimes goals were associated with the conceptual framework, such as receptivity to the Other and the use of silence. Other themes arose from the data, such as prioritisation of care and the choice paradigm. This motivated the writing of a further paper for publication (Woodward 1998), which again, helped to clarify my thought processes. In order
to permit the emergence of new themes, it was helpful just to sit, without the worry of keeping notes, and absorb what was going on. As mentioned earlier, some commonly observed patterns of practice were incorporated into the interview schedule as the opportunity arose. Also, interview data were not formally analysed until after all the fieldwork had been undertaken.

Once the observation phase in the palliative care was complete and prior to field work in the maternity care setting, I undertook a brief, preliminary coding of the observational data. This was to gain an overall impression while the experience was still fresh in my mind. I sensed that much of what I had seen was caring practice, but it was difficult to specify why. Neither was specification desirable, since it might then serve as benchmark for observations in the maternity care setting.

At the end of the field work, and when all the observation and interview data had been transcribed, a more focused examination ensued. (For examples of observation transcripts, see appendix 6). As mentioned earlier, the analysis involved moved between the data and theory. Mason (1996) notes that it is important to determine if data are selected to match the theoretical explanation or vice versa. Some impressions of caring which arose through a ‘free-range’ examination of the data were difficult to specify in neat thematic form. For example, it appeared that non-verbal behaviours, combined with the spoken word, conveyed to the patient a sense of not being rushed or being a nuisance, but a full description would be far too complex and speculative. In this situation, there was return to the conceptual framework which was helpful in specifying impression more objectively. As Morse and Field (1996) identify, "...established theory is used as a ‘backdrop’ to sensitise and illuminate the data or to enlighten the researcher." The framework is also in keeping with Habermas’ notion of transient hermeneutic preunderstandings:-
Theoretical concepts and systems of reference are only concretizations of a strategically successful preunderstanding that is temporarily fixed for the purposes of analytic comparison (1972:171).

Habermas (1972) cautions that the hermeneutic circle may, in fact, reap circular insights and be isolated from practice, unless the conceptual analysis is reciprocally blended with experiential data. It is acknowledged that particular stimuli would be salient and interpretations predisposed, during data generation and analysis, due to pre-understandings and the theoretical framework, which were necessary to guide the observational component of the study. Accordingly, in order for previously unidentified concepts and issues to become known, the research framework was put to one side during the initial analysis of the data. Throughout, the temptation to formulate and test hypotheses has been resisted and non-reductive themes and categories were allowed to emerge. Despite the discomfort of ambiguity and uncertainty of not knowing what would emerge (if anything), there were no intentional ends, beyond ethnographic description. Due to the abductive analysis undertaken, it is felt that the data analysis allowed a description of caring as manifest in practice rather than constituting isolated theory.

The multi-method research design had been decided upon to differentiate between practitioners’ espoused versus theories-in-use and profiling of the palliative care nurses was commenced. This involved coding the interview transcripts, extracting the observational data which involved the specific nurse from the observational data set and examining this for evidence of coded themes (appendix 4). It was intended to do the same in the maternity care setting, but when this was commenced, themes and categories appeared ‘thin’ (Denzin 1989). There may be several reasons for this perception; one being that the activity was often instrumentally based and task-focused. Additionally, themes were more easily recognised as the process of profiling had previously been undertaking and the midwifery speciality is more familiar to me. Even so, the comparison of interview and observational data was undertaken by hand and raised some minor discrepancies as detailed in the following chapters. Use of the
framework was particularly valuable, when it came to specifying the qualitatively sensed differences between the settings. It is thought important to emphasise that it was not intended at the outset to compare the two settings. However, this became compelling as it became apparent that it enabled deeper access to the caring phenomenon.

While the focus on the themes was initially related to individual practitioners, a more sociological perspective began to indicate differences in the settings’ cultural norms and values. I was aware of my impression that caring was more manifest in the palliative care setting and consciously attempted to support these perceptions empirically. I also had to remain aware of personal biases which might influence the analysis. Over time, I was aware of judging the palliative care as a potential model and in comparison, the maternity care deficient. I also became acutely aware and resisted the risk of sweeping negative cases in the palliative care under the carpet and doing very caring midwives a disservice. I admit that there was a certain amount of disappointment with some of the activity in the maternity care setting and it was important for me to explore the underlying reasons, acknowledge what was good and to be constructive.

Observational and interview material was read through on many occasions, data were explored in relation to the manifestations and meanings associated with caring. I made copious notes in an attempt to draw understanding from the mass of information. Pollock (1991) notes that the attempt to utilise all collected data may detract from achieving a description of the whole picture. She notes that in contrast to quantitative data, which are easily categorised and classified, qualitative data will often fit into several categories, which may result in a circuitous process. My feeling was that I was experiencing this first hand.

Themes were therefore collated which contributed to an overall representation of what was occurring in the settings. The following chapters, detail and continue to analyse themes both relating to the conceptual framework and those which arose independently.
Yet, despite the importance of the homogeneous features, which may provide an overall picture and description of caring in the two cultures, exceptions and idiosyncrasies which might have been disregarded were found to be invaluable. Idiosyncratic situations and differences, mainly across, but also within the settings, became the source of deeper educational and cultural explorations into why non-caring and caring cultures may be formed. These also resulted in hypotheses for future research. For example, despite espousal of empowerment, midwife O’s practice was seen on occasion to be lacking in partnership with the woman. Other findings which stimulated questions also include nurse A’s underestimation of her caring qualities, the differences between how midwife D and B handled a conflict situation and differences across the settings in terms of the adoption theoretical model and socialisation processes. The details of this continued analysis is in the following chapters and illustrate how understanding can be achieved through the hermeneutic process of travelling between the data and theory. In order to achieve some coherence and to meet the research aims, it was deemed most effective to present data under headings which reflect theoretical analyses of the caring phenomenon. Additionally, themes which have spontaneously emerged, such as use of theoretical models and conflict situations are included in the following chapters. Chapter ten, which addresses the educational facilitation of achieving caring as a central practice value, is based on a combination of qualitative differences found across the settings in relation to conceptualisation of caring and emerging organisational issues. The analysis is therefore initially, interpretative and becomes more speculative (Mason 1996) and hypothetical, requiring research beyond this current study.

### 4.17 Presentation of the data

Extracts of data derived from observational field notes provide a literal description (Mason 1996) of general activity and nurse-patient interactions and aim to make transparent, interpretations and the testing of the conceptual framework. In contrast to the often esoteric portrayals of practice, data serve as a reminder that day-to-day activity, in which caring occurs, comprises fundamental social acts on which human relationship is founded. The data are also
used to illustrate other human, social and political features of the work habitus which are discussed.

Field and Morse (1996) advocate the editing of interview transcripts, in order to reduce confusion and enhance interest in the text. While some minor editing has been undertaken, many of the interview extracts are presented verbatim and include paralinguistics, partial words, pauses etc. It has been identified that the purpose of the thematic data analysis is to build theory, but in keeping with the discussion at the end of chapter two, there are aspects of human existence that cannot be made the object of scientific extraction.

Mason (1996) identifies that the nature of the data generated depends upon the study perspective adopted and the research aims. The qualitative research method employed in this study is intended to explore how people make sense of their every-day world, their subjective experience and the taken-for granted assumptions within cultural contexts (Cohen and Manion 1994). It is believed that the presentation of verbatim transcripts, contributes to this intention. In contrast to focusing on only concrete and tangible concepts, the tacit dimension of nurses’ and midwives’ vocalisations give insights into their experience of caring. Extracts are also lengthy and this was thought necessary to ensure that the embedded meanings, which might otherwise be eliminated, would be conveyed. A ‘full feel’ of the data is important from an epistemological perspective, since it emphasises the dynamism and tacitness of knowing in practice and the experience of caring. The tentative and tacit nature of the knowledge embedded in the articulations offers a greater understanding of the caring phenomenon and stimulates a number of the discussions raised in the thesis. For example, chapter three began the process of identifying that caring for the Other as non-standard, un-predetermined activity and chapter seven examines possible explanations why articulations about caring appear unrehearsed.

Evidence, provided by the data of provisional decision-making during the acute process of care-giving, highlights the limitations of theory written in text books. Data suggest that
practice combines moment-to-moment sensed experience and knowing which is embedded and tested in action. This emphasises the difference between the doing of practice and the theorising about it and exemplifies the existence of a practice-to-theory gap as well as the reverse. The data illustrate the inarticulate nature of some areas of practice and provide a strong basis for one of the major arguments in the thesis, that is, that socialisation processes are instrumental in achieving caring as a central practice value.

The occasional inclusion of a researcher question is added, with the intention to contextualise the participant’s response and to provide the opportunity for readers to scrutinise the interview question format and technique. The key to interview and observation transcripts are given on the following page.

4.18 Summary

This chapter has traced the process of clarifying the research aims and questions and a review of previous research which resulted in my decision to study caring from a qualitative research perspective. The rationale for adopting an ethnographic design necessitating field work and a combined non-participant observational and semi-structured interview to generate the data was offered. Devising the observational guidelines was a lengthy process and while much of the information gathered for the purpose was only indirectly utilised, this provided invaluable insights and personal security. Following this, the planning of the research, the pilot interviews, access to the field and minor modifications in relation to selection and recruitment of participants and field work were explained. Thereafter, there is a description of how the data were analysed abductively by alternating between theory and empirical data. Finally the rationale for presenting interview data ad verbatim was identified.
Key to transcripts.

General notes.
Codes names are employed to preserve the anonymity of the nurses, midwives and the research settings.
The numbers in brackets at the beginning of transcripts are to enable reference to the raw data in the event of reader enquiry.

Key to transcripts.
The interview.
♦ The transcript is a verbatim record which includes paralinguistics and words which were not completed. These have been transcribed to indicate the nature of participants' thought processes.
♦ Pauses in speech are indicated (...), these vary depending on the length of the pause.
♦ Ellipses, where the transcript is abridged are indicated as ....
♦ Instances where the speaker is interrupted are indicated as //
♦ Words which were spoken with emphasis are typed in bold.
♦ Occasional clarification of a respondent's meaning is added in brackets ( ).
♦ Occasional, minor modifications of the verbatim text have been undertaken to increase comprehensibility.

Observation.
♦ Communication reported in square brackets [ ] represents close approximation to the actual conversation.
Chapter Five
The research settings compared

In order to place the subsequent caring articulations and activity within the wider socio-political context, this chapter describes the two research settings. It contrasts the tranquil palliative care setting with the hustle and bustle of the maternity care ward and identifies strong differences with regard to patient turnover, team work and inter-disciplinary relationships. Patients' and women's accounts of care support the anxiety provoked by illness and hospitalisation alluded to in chapter two and the potential and constraints of the nurses' and midwives' intermediary role are indicated. Data which demonstrate the stresses of practice are presented.

5.1 The palliative care setting

Despite the nature of the speciality, there was a feeling of peace, calm and optimism when I first walked into the unit. Patient accommodation comprises two four bedded female bays and two four bedded male bays and four single rooms. There is evidence of an attention to detail aimed at making a patient's stay as comfortable as possible. For example, windows look out into pleasant gardens with plant laden trellises and regularly replenished bird feeders. Vases of flowers on the ward shelves are tended by the volunteer flower ladies. There are patient laundry facilities, a choice of music cassettes, newspapers are supplied daily and a hairdresser visits regularly. There is also emphasis on complementary therapies which include, aromatherapy (massage with oils) and aromatherapy oil burners placed in each bay, relaxation and reflexology. Physiotherapy, occupational therapy, counselling and chaplaincy services are also provided.

Patients tend to remain at the bedside, apart from visits to bathroom, day room and occasional visits to the main hospital. Visitors, including children and pets are welcome at anytime, although there is a rest time between 1-2 p.m. There is a visitors' kitchen with available snacks and overnight stays can be arranged. The unit philosophy reads:

(name of unit) has a multidisciplinary team which provides holistic professional care for our patients, their family and friends.
We aim to ease any symptoms of disease and provide physical, emotional, spiritual and social support enabling continuing independence and comfort.

During my field work, the unit was never full to capacity and the bed-occupancy averaged ten to twelve patients per day. The patients were admitted mainly for control of symptoms such as pain or nausea, or when they can no longer cope at home, as opposed to treatment intended to eradicate the disease. The duration of stay in the unit varied from approximately five to ten days. The following extract indicates the importance given to the nature of the admission procedure as a foundation for the on-going caring relationship;

(380-94) Nurse F: I think it starts right from the minute they come through the door really, XX on the reception, you know, gives them a big welcome, brings them round, gets them in bed, introduces them to the nurses. .. the admission process here takes a lot longer, you can sit with people you know, for hours on end really, it's all spread over as many days as they want it to be spread over, so it's not (.) you know, not like an acute hospital; you get them in the bed, you do their obs, you know, ask them a few basics about their past history and you know it would be like bum bum bum, where as here it's much more of an on-going process and can take an awful lot more time.

During my observation, quite a number of patients were known from previous admissions and a later extract conveys the shared affection between staff and some of the patients.

Staff are divided into two teams with a maximum of eight beds per team. One staff nurse or sister usually co-ordinates the shift, overseeing two qualified staff (occasionally drawn from the nursing bank) and two or three nursing assistants (sometimes including a Macmillan nurse). The unit office provides personal space away, although within call, from the patients.
During fieldwork, hand-overs between shifts took place in the office where a trolley of drinks awaited. It was a relaxed affair and nurses sat on chairs, on the desk or on the floor. All staff freely contributed information about the patients. The report had a general pattern. Details of the patients included their diagnoses and how many days they had spent in the unit. A variety of items were reported, for example, the sort of night patients had spent, technical aspects, such as an intravenous pump not working, patients' physical symptoms, medications given and patients' emotional states. Care problems were identified and discussed, such as a patient who refused hygiene care or worries that patients were becoming too dependent. Following deaths during the night, the reactions of family were given to enable continuity of care.

The contribution of nursing assistants was genuinely valued and they were treated as full members of the team, although their activities were limited. They contributed equally to the information about patient well-being and their main activities involved serving meals and assisting patients with feeding and hygiene. Despite their restricted role, (or perhaps because of it), some patients developed close relationships and the more openly affectionate encounters I observed, involved nursing assistants rather than nurses. This is evident in the following extract of observational data;

(599-632) A bank nurse is tidying a new arrivals clothes into the wardrobe. They chat pleasantly. NAB, one of the nursing assistants comes in and in greeting rubs the lady's slippers and, facing the patient, crouches by the side of her chair with her arm resting on the patient's arm rest. The patient knows her from a previous admission and fondness between them is evident. They look 'en face' and there is deep, prolonged and relaxed eye contact. The patient says [I'm glad you're on, I was hoping you would be]. It was lovely to watch this; both patient and nursing assistant were relaxed and natural. MCB (Macmillan nurse) comes into the bay and is pleased to see the newly arrived female patient, she also knows her from a previous admission. She too rubs the patient's slippers and legs and sits on the bed by the patient's side. All three enjoy the 'companionship', talking about nothing in particular and the patient is the
centre of their attention and looks at home. The nurse arrives back into bay with a jug of water and a glass and continues tidying the patient's belongings. She notices suitcases behind the patient's chair and asks MCB to put them in the wardrobe and then leaves bay. MCB does so and says jokingly to the patient [you travelled light today did you?]. The patient starts to tell MCB and NAD about the difficulty she's having moving her arms...

Nursing assistants spend more of the patients' 'unoccupied time' with them and are therefore able to provide companionship. Interview data evidence the commitment of nursing assistants in the unit to get to know the patients and their preferences in order to meet their individual needs. Their role appears crucial in adding quality to the patient's experience. While this relationship building is the medium of caring, this in itself is insufficient in professional care settings, since there has to be knowledge of what may or may not be beneficial. Nursing assistants therefore need to be supervised. There was one situation I observed in particular, which suggested that they lack understanding of professional care and the need for flexibility. This was a situation in which a male patient wished not to have a bath. I felt that the reduction in the nursing assistant's autonomy and failure to understand the principle of choice, resulted in a situation where the main concern was on fulfilling the task of getting him washed and meeting perceived qualified nurse expectations. In contrast, a nurse would have been able to take the decision to modify care on this occasion. Since these carers spend so much time with patients, it is maintained that they need to be included in activities during which the underlying philosophy of practice is examined and developed.

5.2 The maternity setting

It is not possible to give an initial impression of the area since it was familiar to me. Even so, during my first morning of field work, the longest period I had spent there for along while, the amount of ward activity was striking.

The ward has twenty six beds arranged in two bays of five beds for antenatal women, two bays of six beds for mothers and babies, four side rooms, for antenatal or postnatal
women and a nursery. During the observation phase, bed-occupancy was usually ten to twelve postnatal mothers and babies, and six to eight antenatal women. In particular the number of women going home and those being admitted from home and the delivery unit made it an extremely busy environment. I calculated the comings and goings from ward documentation over a three week period and found that on average, there were ten admissions per day (range six-eighteen per day) and nine discharges (range five-fifteen per day). On some days, women had to be discharged home in order to make room for women from the delivery unit.

During the morning shift, there were either two or three midwives and two nursing assistants on duty and a ward clerk to help with paper work and answering the phone. Two midwives and two nursing assistants came on duty in the afternoon. The work was divided by negotiation and the midwives took responsibility for women either in the antenatal or postnatal beds. No midwife had overall responsibility to lead the shift.

The decor reflects efforts to demedicalise childbirth and transform hospital accommodation into a more homelike environment. Consequently, the ward is carpeted, with duvets on the beds, pleasantly patterned curtains and wallpaper. Music plays on the radio in the nursery or at the back of the midwives’ station. In the nursery there are frilly-cushioned rocking chairs to help mothers relax while feeding. The ward philosophy reads;

**Our team is committed to giving the highest quality of care in a friendly supportive atmosphere.**

**We aim to work in partnership with the woman and help her family, tailoring care to individuals needs.**

In promoting normality and discouraging sick role, women were facilitated to do for themselves, a degree of flexibility being derived through necessity, due to the adherence to ‘demand feeding’ of the babies. Women were therefore able to help themselves to meals and drinks. As mentioned earlier, the amount of activity, especially on the post natal side, was initially overwhelming. This may in part have been due to perception of two coexisting
subcultures. One had almost nothing to do with the staff. Partners were present most of the day and there were other visitors and children, in the afternoon and evening. Curtains were often drawn around beds for privacy, partners wandered into the nursery to get things for the baby, fetched vases for flowers and brought in ‘take-aways’. The atmosphere was very informal, with people, on the whole, ‘doing their own thing’, except when agitatedly waiting on the midwife or doctor to finalise their discharge home.

The parallel culture comprised hurried midwifery activity to, from and at the midwives’ station. This was situated in the centre of the ward and comprised two counters at right angles, with a lower desk top on the inner side, where midwives and the ward clerk wrote up notes, accessed data on computers, observed the security monitor, answered the telephone and security door intercom. This provided midwives with a personal space, which was open to view and which women could freely access, if mobile.

Opposite the mothers’ side of the station was the nursery. Due to the security necessary to prevent baby-snatching, if mothers had to leave their babies, for example, while having a bath, they were encouraged to take them into the nursery, where staff at the station were able to keep watch. The contrast to the palliative care setting was noticeable, as it appeared to be usual practice for women and the family to wait at the station to access midwives rather than the midwives attending the bedside. I wondered if this was a natural phenomenon, that is, a result of women being up and about or if it was encouraged. On two occasions, I observed the ward clerk orientating antenatal women to the ward and heard them being informed to attend the station, where there would usually be someone to help. Even so, this was combined with observations of midwives telling women where the call bell was situated at the bedside. For the midwives, this arrangement places emphasis on responsive rather than pro-active interaction, but at the same time, provides an enhanced opportunity for women to get their needs met in a busy environment. The hesitancy of the midwives to respond is referred to in a later chapter.

The hand-over reports took place at the station. In the morning, nursing assistants did not arrive until 8 a.m. and if it was not too busy they were given a separate report. Failing this, they sat and obtained information about the mothers from the bed state board.
During report, the information conveyed was similar to that in the palliative care setting and included diagnoses, the sort of night spent, analgesics and care given. On occasions, notable information from women's past histories, such as postnatal depression, was highlighted and sometimes concern was expressed about women's experiences in the delivery unit. Other remarks conveyed various attitudes, such as exaggerated frustration:

(1113-1128) *smilingly, Midwife C, handing over from the night shift, says about baby 8d* [This is the baby from hell, I nearly locked it in the equipment cupboard, it's awful, it's murder, it screams and screams, it feeds all the time and still isn't satisfied].

During the same report, praise of a mother's care of her baby;

... *the midwife says* [That's another hungry baby but she's coping so well, she is so good with this baby].

Other more derogatory comments;

(1915-8) *the midwife comments that that a mother asks some very basic questions and says to a colleague* [she's got a pressure sore on her finger]. *The midwife looks quizzically at her - [From pressing the buzzer].

After the report, the ward was usually quiet for another thirty to forty minutes (the reason why nursing assistants start later) and midwives chatted, put the kettle on, checked drugs or prepared notes for the morning's work. In contrast to the palliative care setting, team work was limited, depriving midwives of the opportunity to gain insights from the practice of colleagues. Midwives often work alone due to the independent nature of the women and this contrasts with the palliative care nurses who often have to work in pairs to move patients or to observe administration of controlled drugs at the bedside. Traditionally midwives place emphasis on being practitioners in their own right (Towler and Bramall 1986) which may result in resistance by some to have their work scrutinised by others.
Nursing assistants contributed greatly to care, although in a more limited way than in the palliative care setting. They helped with meals, bed-making, hygiene for bed-bound mothers, helped mothers with baby care and feeding, amongst other domestic activities. Their role is constrained for various reasons. These include the statutory responsibilities of the midwife (UKCC 1993, 1994) and efforts to maintain mother and baby as a unified pair (Maternity Services Advisory Committee 1985).

The two environments were very different as might be expected given the nature of the specialities. Due to the contrasting turnover and length of stay, there was enhanced opportunity within the palliative care to get to know the patients. As was noted in chapter four, increased contact correlates with increased relationship (Knapp 1983).

5.3 Medical power structures within the research settings

In relation to nurses’ and midwives’ intermediary role, observation of clinical activity reinforces the view that organisational structures perpetuate medical dominance. In both research settings there was limited, if any direct access to hospital beds and many traditional divisions in activity are maintained by law, such as ‘The Medicines Act’ 1968 and Nurses, Midwives and Health Visitors Act’, 1979.

Within the maternity unit, mothers on the ward were ‘booked’ with three different consultant obstetricians and together with other medical specialist teams, such as anaesthetists and paediatricians, this amounted to a large number of doctors in contact with the women and babies. Midwife-doctor relationships were variable, ranging from flirtatious to formal. Doctors arrived on the ward regularly each morning and in absence of the traditional and expected midwife escort on the medical ‘round’, frustration resulted, if midwives caring for particular women could not be easily identified.

Policies, such as mandatory medical authorisation of investigation requests placed midwives at the centre of families’ frustrations when a doctor was unavailable. Observational data reveal resistance by parents to being inconvenienced by bureaucracy. The more independent status of parents was perhaps reflected in the display of annoyance and abuse.
towards midwives and women being prepared to take their own discharge. Examples of these conflict situations will be discussed in chapter nine.

In the palliative care setting, relationships between nurses and doctors were apparently respectful and amicable. The medical team comprised one consultant, a registrar and one senior house officer (usually a trainee GP on a six month rotation) which may have contributed to the unit’s harmonious ambience.

5.4 Medical status
Abbott and Wallace (1990) argue that nurses will not achieve equality in the eyes of their medical colleagues or patients. They suggest that, if patients were given the choice between effective cure and good personable care, they would choose the former. Palliative care is generally regarded as the gold standard of nursing care, since care concerns achieving quality rather than quantity of life. Even so, in this setting, data suggest that patients give doctors higher status than nurses. In the following two extracts, despite the unpleasant side effects of medication, medical intervention was considered primary.

(706-715) Patient A was hoping to go home and was keen to engage in conversation. She told me that she and her fellow patients were not really themselves because of the drugs they have to take and that they feel [zonked] out most of the time. Because of this they are not always able to ask the nurses what they want. I sought clarification that she was able to ask for the care she needed. She said [they look after you and I always ask the doctor if I want something].

Also:-

(1467-83) During an opportunistic chat with patient C regarding his admission to the unit, he informs me that he has had several admissions for loss of appetite and nausea. I ask him what he finds most helpful about the nursing care. He tells me that they are very obliging, that they will do anything for him and that, importantly, they are cheerful; [but really its
the doctors who are the most helpful. It's the treatment that you come in for. I'm hoping they'll find something to help my symptoms. They keep trying different things, and last time they tried different drugs and found a combination that worked. I clarified that the main focus of care for him was getting his symptoms sorted out [oh, yes, it's the doctors, who'll find the treatment to help].

A further observation was striking as it revealed a major contrast in levels of patient interest and sociability during interaction with the doctor compared with the nursing staff.

(925-964) Patient D is lying on top of the bed with her eyes closed, she appears lethargic and has complained of pain earlier that morning. Nursing assistant MCC arrives at the bedside and stirs D by speaking her name. The nursing assistant leans over her, back rounded, hands on bed close to D, arms almost straight. She looks into D's face, who glances and looks down interchangeably. MCC goes out to get wheelchair (patient is going to the day centre). The doctor (new female senior house officer) comes in and sits on the end of D's bed, her torso angled 45 degree towards the patient. The doctor says [It's nice to see you dressed, how are you feeling? You look more comfortable than you did yesterday]. D appears more alert and is keen to talk about her medication. She remains lying across the bed with her head on the pillow and knees up to her abdomen while she talks to the doctor. The conversation concerns pros and cons of various medications and side effects and lasts approximately ten minutes. During this time, MCC returns to take D to the day centre and goes away when she sees that doctor and patient are busy and the doctor still needs to take a sample of blood. During this procedure, D demonstrate lively interest in the equipment, purpose of the test and asks a lot of personal questions regarding the doctors interest in palliative care work and the GP practice which she will commence in the summer. D does not demonstrate similar interest to engage in
One simple explanation for the patients' focus on medical personnel can be formulated by application of Maslow's hierarchy of needs, which identifies that physical safety and survival take priority over emotional values (Maslow 1970). It could be speculated that patients place faith in the medical profession to manage illness. Engelhardt (1982) asserts that the phenomenon of illness has been shaped by the discourse of modern science. He suggests that the physician alters the patients 'life world' to experience their lives in terms of the doctors understanding of the symptoms. In consequence, the experience of illness gives rise to certain expectations of medical intervention. Pellegrino (1982) argues that where the medical perspective predominates, appreciation of the impact on the being of the person is denied.

In the maternity care unit, while medical staff made their presence felt in terms of tradition, policy and procedures, data from observation and discussions with women failed to raise anything else of note.

5.5 The experience of illness / hospitalisation
Chapter two emphasises the professional obligation to provide a caring service because of the impact of illness / hospitalisation on individual integrity and dignity. The following extracts of discussion with patients provide insights into their phenomenological experiences.

(855-879) B, a female patient tells me that she just has no energy. She tries to relax using a tape, listens to the voice and tries to do what it says but finds this difficult. She is being well looked after, but feels that she is losing confidence to do things on her own at home. She wonders if it is worth carrying on making the effort; [what is there to live for?]. She tells me that she lives alone following her husband's death in November and relies on a neighbour to look after her bungalow and her cat; she now wishes she hadn't got the cat [bless him]. She says that she was doing
things for herself until two weeks ago, then it became difficult. She mentions that she is having radiotherapy again next week and says [I don't know what will happen after that-I don't know what it's all for].

The patient expresses her perception of loss of self-sufficiency and demonstrates passivity, dependence and conformity with medical management.

(1420-1428) During a conversation with a male patient, he comments on the amount of pain he is experiencing and I asked if his tablets are helping his pain, if he notices any difference quite quickly after he takes them. He says not really and that he finds it confusing. On trying to clarify what he means by confusing, he tells me that he is taking about 30 tablets a day and feels confused about how bad he'd been feeling over the past couple of days.

His comments suggest that he is unable to integrate his experience of illness into his life. The loss of ability to preserve personal values is apparent. The next excerpt portrays the reaction of a relative;

(1543-1578) The wife of A, an elderly, male patient who is confused and unaware of his surroundings, arrives just before he is due to have a bed bath. A is alone and she leans over the cot sides and kisses him on the mouth. She begins to weep - there is no noise, just the tears from her eyes running down her cheeks. The nurses arrive to do her husband's bed bath, one of the nursing assistants tells her what they are going to do and suggests that she goes to get a drink of tea. She is too tearful initially and has the need to compose herself. She is sitting near to me and says that she can't help being emotional. She doesn't think she'll have him for much longer. She tells me that she feels guilty that she couldn't cope anymore with him at home. She misses having a cuddle with him. She becomes tearful again as she hears the nurses with her husband behind the screens [It loses his dignity, that's the problem. I know they've got to do
I know it worried him about coming in, I used to do things for him, but that's different and it does depend who it is, what they're like.

Her last comment reveals how the skill and attitude of the nurse caring for the patient is of paramount importance in maintaining personhood and is a potential source of much anxiety. This view is also apparent in the maternity setting. Despite the contrasting nature of the settings, vulnerability was very much in evidence. Some mothers were clearly anxious about how their mothering skills would be judged and that they would be left unsupported.

(2034-41) One mother told me that despite having one child already, she had no confidence in caring for the baby and was so relieved when she wasn't treated as though she should know everything - she was relieved that the Midwife did not say [Don't you know how to do that?].

This was not a chance finding as the following extract demonstrates,

(2083-104) I ask 8F how she would describe the caring received by the midwives. She seemed disinterested initially. [The midwives showed concern for me - concerned that I was all right]. Then she began to focus on the fact that her first baby had been on the special care baby unit and she had missed a lot of experience caring for the baby early on, and this felt like the first time for her in a way. She said that she felt 'like an idiot' - and was worried that the midwives would know that it was not her first baby and would expect her to know.

Both women therefore expressed similar anxieties concerning the expectations that midwives would have and relief at the realisation that the fears had been unwarranted. This signals a positive outcome from one perspective, yet there is the question as to why mothers had these fears in the first place. It may result from media portrayals of expected parent role behaviours; or may involve the loss of a secure self-concept provided by the family and social networks, while in hospital. Also, their concerns indicate the possibility
that midwives achieve the status of 'significant other' which therefore increases the impact of their agency.

5.6 Failure of the institution to meet patient expectations

Chapter two traced the establishment of hospitals as accepted institutions for health care and medical treatment during illness. The familiarity of patients’ own homes is forfeited and exchanged for institutional life, in the expectation of intervention and the potential for health to be restored or discomfort alleviated. The following extract of data obtained during field work in the palliative care setting, demonstrates a mismatch between a patient’s expectations and experience. Kestenbaum (1982) and Fulford (1996) argue that there is growing dissatisfaction with medical management, since, despite its advancing potency to reduce disease and suffering, it fails to address the patients’ phenomenological experience.

(4632-665) I go to chat with B. Nurse BNB is in the bay and she looks over to ask him if he would like a bath or a wash. He says that really, he would like to go home and that he misses the twins (20 year old grandchildren). He says that he isn’t really doing anything in the hospital, he hasn’t seen the doctor for a while and doesn’t know what is happening. Nurse BNB tells him that the doctor will be round later and that she can put things into motion for him to go home. She states [That’s what you want] (In a way which affirms this as important). Nurse BNB leaves the bay.

B comments about the nurses; [They do very well]. He mentions that he is having a lot of tablets and that he has never drunk so much water before. He says that the tablets leave a nasty taste in his mouth. We chat generally and he comments that it is a long time from 7 a.m. until the evening and he doesn’t do anything. I ask if he likes TV or reading papers. He says he doesn’t and says that he just stays in bed all day really - [I wish they’d tell me what to do]. He says that he feels that nothing is being done, although he’s happy to stay if necessary. He says how he misses being at home - he has four children and six grandchildren who he sees at weekends. He tells me how his son had lifted him as though he was
as light as paper, when he last visited. He comments on patient D - [He’s so helpless isn’t he?] and recalls how he had called for help the night A had fallen and cut his head on the bed. He says [It’s sad that people get old, isn’t it?].
The call bell sounds in another room. B comments [That goes all day long]. I mention the time and in surprise he checks what time I have said. It is about 10 a.m. and he had been convinced that it was the afternoon. Later [It’s quiet isn’t it, you don’t see anyone for ages].

B appears willing to do what he is told and expects to be organised, which reflects Pellegrino’s (1982) stance that, imposed scientific view-points lead the patient to incorporate medical taken-for-grantedness of his state of illness and subsequent expectations of his social role. The earlier extract on page 5-12 encompasses a similar finding.

Assuming that without my presence the patient would have expressed the same concern to the nurse, and in contrast to the previous extracts, the data partially supports Fulford’s (1996) assertion of the emergence of the patient power movement. He proposes that this questions the medical model which prioritises scientific knowledge and disease theories above the patient’s central concern regarding personal values and their experience of illness. However, Fulford may be referring more to the experience of health care rather than Pellegrino’s (1982) phenomenological experience of illness. While there is some inevitable overlap, these constructs need to be differentiated, since, as the data suggest, in acute situations, patients primarily need relief and release from suffering, before other wants and considerations. Only when their distress is relieved will their evaluations of other than distress-relieving factors be valid. While the perspectives differ, the nurse and midwife are centrally placed to influence both.

In the above abstract, the nurse responds readily to the patient’s expressed desire to go home, perhaps demonstrating some insight into his experience before it was vocalised. However, ‘responds’ is the operative word and it could be speculated that the organisational structure, as discussed earlier, constrains initiative. While data give some
support for the interpretation that patient B’s expectations of medical care were disappointed, this perhaps reflects an assumption on my part. My own socialisation into nursing might exclude the possibility that nurses might proactively organise the patient’s day, in the absence of medical prescription. As mentioned earlier, the structures which maintain medical power overall, also result in nurses and midwives having prime responsibility for patient experience. The apparent professional difficulty in extending caring relationships beyond instrumentally focused encounters (Fielding and Llewelyn 1987, Salvage 1990) needs to be acknowledged and addressed. This issue is taken up again in the following chapter.

The above data, portrays B’s experience of confusion regarding what help and care was being undertaken and an expressed wish for home and his loved ones. This returns the discussion to the transfer of care from the family to the caring institution as a result of Christianity and the legacy of the moral responsibility to fulfil claims of self-professed expertise.

With hindsight, an unforeseeable disadvantage of the Christian institutionalisation of caring, concerns the medically orchestrated, social acceptance and subsequent over-reliance upon treatment in hospitals. While not through Christian intention, caring was to become exploited by the church, aspiring medical men and emancipatory women. Medically dominated health care institutions are now victims of their own success, treating illness and disability beyond all imagination. The lack of resources to meet demand is being addressed by discussions about rationing (Wells 1995) and ironically, attempts to return care to the community, family, neighbours and friends (Hugman 1991). Meanwhile, however, society has also moved on. Large numbers of elderly, chronically sick people, family breakdown and increasing individualism have become features of contemporary society, together with a taken-for-grantedness, expectation and dependence on institutionalised care.

5.7 The intermediary role: advocacy and a friend in the system

As regards the nurses’ and midwives’ role in undertaking prescribed medical care, interdisciplinary relationships in the two settings were contrasted earlier. Bishop and Scudder (1990) describe the nurses as being in an ‘in between’ situation, which places them
at the centre of a variety of intentions associated with other disciplines. According to Bishop and Scudder (1990), since nurses are in a position to promote the interests of the patient, they have a vital place in facilitating moral sense of health care. Within both settings, instrumental activity provided the main reason to be in contact with the patient. In maternity care setting, the intermediary role had two main elements; the preparation of women for medical intervention and advocacy. Both could place them as a 'friend in the system' (Page 1995:84).

(78-110) Midwife H: Erm (sigh)... being a mainly hospital based midwife, when I see ladies coming in antenatally with a problem whether it's premature rupture of membranes, a bleed, polyhydramnios so it's making sure they understand what's happened, why it's happened or the reasons why it could have happened, erm, sort of, relieving any anxiety around it, erm you know, the abnormality, or the deviation around it and erm then giving them positive foresight into how things will be managed in the future and also reducing their anxiety by, you know, future complications that might be detrimental to the baby's health. So it's a lot of it antenatally, is erm, it's just talking and going through things over and over again so they understand erm what's happening to them and why, why it's not going straightforward. So most people, I think feel that they get pregnant, have a baby and go home, they don't realise that there are hundreds of complications that could happen.

VW: Why is it important, do you think that they understand, that might seem a very simplistic question but why do you think it is so important?

Midwife H: Erm, because if they don't really understand, they'll just worry about it erm, you know, I'm sure I would and erm and if they don't understand, they might not erm understand certain measures, that we do, the certain investigations and procedures we do on them, you know. I don't feel, they should be made to feel that we just do things to them, they need to understand why we need to do them. If they understand that need
erm then they are more complying and want these investigations done. because they themselves want whatever it is, you know, diagnosed, cleared up or sorted out.. I just think ... the more you know, the better (laugh)

The contemporary medical focus on technology potentially overpowers and disregards the patient’s phenomenological experience (Kestenbaum 1982). This makes nurses’ and midwives’ insights into the individual’s day-to-day experience and vulnerability morally essential and it is crucial that they are not swept along with medical discourse. The midwife above refers to the woman’s experiences of admission into hospital. Even so, the focus appears to involve explaining obstetric management. This forms the basis of the relationship and ensures that the professional agenda subordinates the woman’s. The following extract encompasses a commitment to the role of advocate.

(567-581) Midwife O: I feel quite strongly: one of my morals is as advocate really (...). Yeah, the idea that everyone’s got their own fears, their own needs and stuff and that you actually respect that really. (softly) I think sometimes we impose so may erm ideas and err (...) things on people especially within medicine, which I don’t really think are on and I don’t know why we’re doing it sometimes, it’s not benefiting people really. Yes I suppose I feel strongly about that.

The extract suggests a sense of resignation and lack of strategy to advocate for women. During the observational phase, the opportunity never arose to determine if this, once again, was mere sentiment and rhetoric or a theory-in-use. None-the-less, the above extracts illustrate the opportunity nurses and midwives have to enhance the experience of the patient.

5.8 The intermediary role: centralising prescribed care and internalisation of resource constraints

The following extracts identify how nurses prioritise medically prescribed or orientated activity over caring relationship with patients. For example, a forthcoming doctors’ round
and drug administration routine are the cause of postponed response to patient care-giving, as the following observational data illustrate.

(310-330) I accompany nurse B who is working quite briskly this morning, taking tablets, sometimes leaving them on tables (except the controlled drugs). She ensures that patients have drinks and is generally interested and receptive to their needs. However, while taking drugs to male patient D, he stops her from leaving the bay three times - [I know I’m a lot of trouble but...]. When we are back in the clinical room she says that she did not encourage discussion with him since this takes at least half an hour for a useful, helpful discussion and there just wasn’t time this morning. She felt that it would make it worse to begin a discussion and raise involved issues only to have to leave without being able to resolve things. This morning, apart from the drugs (at least an hour’s work) she had to attend the doctors’ meeting and round.

The following extract, which also involves the drug round, illustrates how specific intermediary activities, while legitimate, constrain spontaneous caring response.

(3514-3522) Nurses E and H come to administer a controlled drug to C. A patient in the same bay rings the call bell. There is no response from nurses. They check C’s hospital number who then drinks suspension, nurse H takes the cup away. A is still ringing and nurse E tells him [A, we can’t actually come to you while we’re doing the drugs. We’ve got to come to you anyway, OK?]. A looks uncomfortable.

While medication rounds were prioritised, there appeared to be no other tensions between medical prescriptions and nursing activity. Due to the nature of the speciality, active medical management of the disease mainly involves formulation of effective drug regimes and most care-activity was therefore directed by the nurses. It appears crucial that nurses resist routine and ritual and work reflectively. Where appropriate, they need to prioritise their specific sphere of practice in order to provide response care.
In general, models of care give little attention to the care-context. In Wesley's overview of models from Nightingale to contemporary theorists (1995), the environment is identified as one of four metaparadigms. Yet, none address the constraints on nurse agency as a result of socio-political influences. Practitioners' perceptions of constraints due to the institutional structure and resources were apparent in both settings. Careful use of NHS resources is a disciplinary matter and therefore practitioners are influenced by this. From a utilitarian perspective, the preservation of resources means that more people can receive NHS attention. This presents a situation where caring for the Other and I-Thou relationship is overshadowed by utilitarian considerations.

There were occasions in both settings when practitioners identified that it was time for patients / women to be discharged home. While this was to free beds for others, there appeared a fear of nurturing patients' / women's dependence and an internalised norm regarding the length of hospital stay. Midwife H discusses what might be said to a mother when there is need to free beds for others.

(535-541) Midwife H: 'Don't you feel ready to go home now', 'you're not being discharged from hospital, you're being transferred'; that sometimes works or 'Your baby's feeding well, erm your well, and you're not needing help from us'. I think they do thrive better in their own home, although it's very difficult to go home and let go of the security of having a midwife around all the time, especially at first.

In the palliative care there was an implied avoidance of creating dependence.

(305-319) Nurse F ... we've had a lot of cases recently where there's been people who (...) perhaps haven't wanted to come here, but when they arrive they don't want to go home and we have an awful (laugh) trouble trying to, trying to persuade them that they're now well enough to go home .... they've just got so secure here they've got, you know they've found their little niche and they've got their routine and they've perhaps you know their family are quite happy coming in and out, they might have made
friends with some of the other patients and (...) you know we sometimes seem to take away the impetus of them wanting to go home because they're so happy here.

The issues of patient choice and autonomy will be discussed in greater detail in chapter seven, but the impact of doctors' responses to consumerism legitimated through the Patient's Charter (DoH 1991) and Changing Childbirth (DoH 1993b) publications appears to add to the stress of practice and workload. Fulford (1996:147) posits that "The essence of consumerism is that consumers should get what they want, not what the producers choose to offer them". Yet, midwives were powerless to resist actions of obstetricians, despite the detrimental effect on their own sphere of practice. In the following example, what limited time there may have been to develop relationship and practice, this was eroded further by adherence to consumerism.

(411-444) Midwife H: I think what's happening in the big picture is that people are getting more choice, getting more erm demanding about care, not that that's not a good thing, but they're so carried away with it that they are forgetting the strain on the resources it can cause, and strain on finances and staff. They may want it, but there may not be the money for it, there may not be the time for it and there may not be the staff for it and much as you want to strive to meet all the needs that these people want is not always physically or financially possible. People are demanding caesarean sections rather that vaginal births. Elective sections puts an enormous strain on resources and staff. It makes the ward much busier, heavier work load, longer stays, erm you know, the cost of an operation and after-care. If they need a caesarean section, they need it, but there's a lot of people now erm asking for electives, just because they don't want a vaginal birth.

While nurses were committed to providing choice for patients, the next extract demonstrates the extra psychological stress placed on practitioners as a result of the choice paradigm.
(177-183) Nurse C: it’s a bit like making a rod for our own back, bending over backwards to provide exactly what that person wants and then (...) like Patient A now, if we can’t provide that she gets extremely upset and (...) becomes tearful and then nurses feel really guilty (.....) it’s trying to get a fine balance really.

5.9 Rationing and prioritising care

Despite the focus on close, caring relationship, undivided, individual attention is a rare commodity in contemporary health care practice. During observation in both settings, patient demand on practitioners was striking and personal and collective strategies to prioritise and fairly distribute care appeared well practised. The following extract provides a good example of a midwife’s coping strategy.

(463-496) VW: Are there times when you have to negotiate with people to wait...?

Midwife H: Yes, normally erm, normally, you just have to say erm, you know, ‘Sorry, I’m just in the middle of seeing to this lady at the moment and I’ve just got to do two other things, can it wait?’ then if it can’t ‘Can I get somebody else to come and see you because I’m not free?’ and that they have to accept. Just because they visually see you walking around and you’re not locked in a room somewhere with somebody, you know, they think that they can just pull on you, all the time really, erm. You know, if you were locked in a room doing postnatal checks with somebody, then nobody would interrupt you and you would probably get things done, you know, but it’s very clinical and it’s very erm.. unhomely (laugh). It’s much better to be sat behind curtains but again that’s the privacy issue as well, but erm, people do try to, you know, you’ve got three jobs lined up in your head that people ask you to do plus, you’re in the middle of, say, trying to sort a baby out and erm, then somebody else wants you and wants to jump the queue, for nothing very important sometimes.
VW: Presumably, that’s when they get upset on occasions?

Midwife H: Yeah, especially the ladies who want to go home, they want to be home now, they don’t even want their paperwork done, they don’t even want to be checked, they just want to be out the door and it’s the, it’s difficult for them to understand, you know, for them to get good care in the community we need to make sure everything goes nicely so we can transfer them in the community with everything in order, erm, otherwise they may not get the delivery of care they want in the community. It’s often only for the sake of an hour. It is very demanding sometimes on our time and on resources, which sometimes is difficult to accept, people can’t be patient.

The above extract reflects a degree of resentment and frustration on the midwife’s part in being unable to meet demand and suggests evidence of consumerism and individualism on the part of the service-users. In the palliative care setting, the nurses response in the following extract, is more guilt-laden.

(434-441) Nurse D: I think if, if, errm (...) well obviously if a patient was in demand of your time and you’d definitely, definitely for some definite reason couldn’t spend that time with them and you had to be with someone else for whatever reason then you’d have to explain (...) that you know (..) while you understood their needs that the fact was you had to spend some time with somebody else because that was a priority.

Data support the notion that the intermediary role is associated with lack of opportunity to develop practice. While concern for the patients’ / women’s experience of health care is expressed, data suggest that the ideal of care is constrained by demands placed on practitioners by management and medical policy.

It might be anticipated that due to the slower turnover of patients, calmer environment and better interdisciplinary relationships, that nurses in the palliative care setting would feel more in command of their practice and consequently less stressed. The following extract
illustrates that this was not the case, since stress was created by the amount of support required by patients and their level of dependence.

(223-294) Nurse F: ...communicating with patient A isn’t something that can be done very quickly you have to take time and patience, which is where sometimes it is very difficult because you’re very conscious of the other patients around at the same time who you may be, you know skimping on their care in many ways because you’re spending an awful lot of time with Patient A because her needs are so great and because it’s very hard to leave someone who’s upset, you know if you haven’t just got something just exactly right and I know that that has happened on a few occasions that perhaps other people haven’t quite had the care that they deserve.

Nurse in the palliative care appeared very aware of the ethical principle of fairness in the distribution of care, indicated the high standards aspired to and a service-orientation. This is also evident in the following extract, which identifies a practical strategy to provide a solution for nurses and patient.

(276-91) Nurse F: ....the two nurses who were been looking after the (‘name of team’) end yesterday had spent most of their morning really with patient A and had felt very much that they’d neglected the other patients. Erm, so asked me to have a word with patient A in the afternoon to see if she wouldn’t mind being moved in to the middle bay, where we could share her care with the other team so at least it’s not always the (name) patients who are sometimes missing out. So, you know, it’s for patient A’s benefit as well as everybody else’s’ really. ... it’s for the patients because that’s what we’re here for.

The relentless succession of admissions and discharges in the maternity unit also took its toll and midwives expressed feelings of being unable to meet demand. The next extract
portrays this view and the frustration and guilt as a result of the perceived neglect of women and the care omitted

(334-369) Midwife F: On some of the early shifts, there's only been two of us on for a full ward and we're just, you're just not able to give the amount of attention you'd like to and it's just very frustrating. Because...you don't want to leave much work for the afternoon staff, cause the afternoons can be potentially busy as well and erm, I think it's just a case of prioritising, especially if you have a bay where the majority are going out and obviously they all want to get home as soon as possible and then probably you've got perhaps a first day section .... er, you're not physically, able sometimes to do everything..... I get frustrated if I'm not able to erm ... maintain er ... sometimes you can go off duty and feel, I wish I'd, I feel as if I haven't achieved anything I wanted to achieve, that perhaps, I know it's basic things like just the post natal checks on the mums or making sure everybody's feeding properly or oh that women wanted me to do a bath but I didn't get round to do it .. you've got to rationalise that it's a twenty-four hour service and that people are there to take over and you're not physically able to do everything that you want to do.

The impact on practice development of frustrated caring will be discussed in chapter ten where this is associated with the tendency towards routinisation and low morale. Despite the everydayness of prioritising care, the constant pressures not only demands practitioners' time but also their emotional energies.

5.10 Collective caring

While the earlier analysis of professional caring was based on individual responsibility for the Other, data evidence that practitioners are aware of moral obligation and there appears to be a growing acceptance that while it might not be achievable individually, it can be collectively. In order to overcome the problem of hurried routinisation, practitioners in both settings emphasised the ideal of distributing care over twenty-four hours and the three
shifts. The following suggests that the tradition of getting the work done in the morning is perceived as presenting a stumbling block in achieving a collective approach to the delivery of care.

(296-307) Nurse C: .... I think it's again this, what we should be achieving erm you know, most of our patients want an hour when they have morning care at least and particularly at the moment in that particular team most of those patients need that time and there's the "Oh well we should really try to get on, get all this work done before lunch time". And no matter how much the senior nurses are saying, you know, it really doesn't matter, there is no rush, it's still kind of in-bred in the nurses (laugh) that it's got to be done and you know, they're working hell for leather all morning thinking "Oh, I'm going to fail if I don't achieve this".

Midwife D expresses a similar view, advocates the role of other workers and the problems where efforts are not co-ordinated.

(559-84) Midwife D: .... But they do get a lot of care that's not midwifery input as well; the auxiliaries can help with a lot, we have these breastfeeding support workers in three time a week as well, so you can rest assured that they are being seen to, they are at least being fed and there are other midwives about to give them pain relief but erm, I know I sometimes go home feeling bad, if there's one baby I couldn't check because the others used up my time, but you know, that's what the late shift is for and if necessary the night shift, but er ( ...)

IVW: Do you sense any resentment from other shifts?

Midwife D: Definitely, definitely. if you've not got the work done that you're supposed to do on the early, I don't think they like it.
5.11 Summary

The aim of this chapter was to place the research findings within a socio-political context. Both settings shaped an environment in keeping with the underlying philosophy of the speciality, that is, enhancing the quality of life during terminal illness, in one setting and discouraging the sick role, in the other. Extracts representing patient experience portrayed illness as change associated with loss of responsibility and ability, in the palliative care unit and the anxieties provoked in response to the changed social role in the maternity care setting. Data demonstrate that nurses and midwives, as intermediaries, are in a position to contribute to the Other’s personhood. Yet, medical or managerial priorities, such as consumerism and pressure on NHS resources, which undermine this potential appear unopposed. Practitioners seem well practised in strategies to ration and distribute care and feelings of frustration and guilt were experienced by nurse and midwives alike.
Chapter Six  
Deriving values and meanings for practice

Chapter two argued that nurses and midwives are socialised into a work environment in which they are intermediaries and subordinate to the medical profession and hospital management. In the previous chapter, data were presented which indicate how nursing and midwifery goals of care interface with power structures and demonstrate that these dominant group values strongly influence agency. The position adopted in this thesis maintains that nurses and midwives are instrumentally central to ethical health care provision. While caring is a personal responsibility, idiosyncratically manifest and arguably individually sustainable, data make abundantly clear that existing theory fails to take sufficient account of the influence of socialisation processes within hospital setting cultures. It is argued that if caring is to be the essence of practice, it needs to be culturally embedded. It is therefore vital to examine the extent to which there is opportunity and capacity, within current structures, to control and develop their sphere of caring practice. While inter-professional rivalry is derided, it is argued that nurses and midwives could usefully identify, take ownership and develop a unique sphere of practice for the benefit of patients/women. The view is held that an awareness of the nature of professional socialisation and need for the transmission and legitimation of values is crucial if caring practice is to be sustained. Therefore, prior to presentation of the data which portrays the manifestations of caring and meanings nurses and midwives articulated, the sources of values and meaning are examined.

This chapter begins with an outline of these processes and discusses the extent to which individuals are formed by or can influence their social milieu. The controversy of language versus practice as the source of meaning is then explored.

6.1 Socialisation, social action and the origins of social meaning

In chapter two, the perpetuation of cultural values was briefly alluded to and it was argued that professional caring is dependent upon this process. At this juncture, it is useful to explore divergent sociological perspectives which offer alternative interpretations of the relationship between the individual and society. These involve the extent to which
individuals are socially constructed or conversely can become conscious of social structures in order to shape their social worlds. It follows, that the perspective adopted determines a conviction whether or not the individual can be instrumental and responsible for social transformation.

Durkheim’s functionalism assumes that individuals are socially constructed and that social conformity, consensus and cohesion is achieved through institutions which pre-exist them and determine their behaviour (Jones 1993). The theory utilises the concept of role (discussed again in the following chapter) which exerts constraints on human behaviour ‘in the form of cultural expectations about appropriate behaviour for the holders of a particular social position’ (Layder 1981:53). While functionalism explains societal solidarity and stability, the subsequent theories of Weber and Marx rectified its disregard of societal conflict and change (Jones 1993). From this different perspective, it is argued that individuals can influence society, albeit in the interests of economic or personal power (Jones 1993). Marx noted that:-

*Humans make their own history but they do not make it in conditions of their own making: they make it under conditions handed down from previous generations, in the form of the mode of production and its dynamics* (Burkitt 1991:194).

The concept of modernity, in which knowledge was to provide individuals with the opportunity to create the good society had to account for how social change is achieved (Jones 1993). As a result, the individual rather than the institution became the focus and created the view that humans are more than the result of the socialisation process. Harre’ (1983) argues that meaning is internally derived and human action is capable of transcending environmental, cultural or historical influences. In consequence, he rejects the notion that our social heritage is the source of our moral shortcomings and argues that individuals are responsible and autonomous in this regard and hence accountable for their moral agency. While this perspective modifies the view of the individual as being over-socialised or a ‘cultural dope’ (Jones 1993:39), others argue that this view is also flawed as it ignores the existence of structural and interactive constraints (Layder 1981).
English and English define socialisation as a process by which a person develops a sensitivity to social stimuli, accepts attitudes, values, beliefs and norms within the group, which enables cohesion and conformity with others in the group or culture (1958 cited in Krathwohl et al 1964:29-30) and maintains existing power structures (Burkitt 1991). This social learning which is often subconscious, shapes personal ways of acting, feeling and thinking (Burkitt 1991). Legitimation is the process by which the activity, beliefs, values within a culture become normative and serve to perpetuate existing structures of power (Jarvis 1992). Smith (1988) notes that individuals socialised into a profession, not only acquire a new capacity or skill, but also contribute to the maintenance of the traditions and institution of the profession itself.

Bourdieu (1990) identifies that individuals socialised into a culture are the source of regulation and reinforcement of the ‘objective condition’.

Unconsciously knowledge is acquired of possibilities and impossibilities, freedoms and necessities, opportunities and prohibitions....the most improbable are therefore excluded, as unthinkable by a kind of immediate submission to order that inclines agents to make a virtue of necessity, that is, to refuse what is anyway denied and to will the inevitable (page 54).

Bourdieu implies exposure to the norms and values within a singular culture. However, actions may reflect values derived from primary socialisation during childhood, including caring values or those adopted through subsequent secondary socialisation experience. Within a modern pluralist society, individuals are exposed to a variety of social contexts which provide alternative value options (Burkitt 1991). Schon (1983) notes the phenomenon of professional pluralism, in which there are competing views of professional practice and questions the extent to which managers are able to shape ‘turbulent’ environments created by changing, interrelated problems of modern day society (page 16). This suggests that for caring to remain central to practice over generations of practitioners, in Bourdieu’s terms, it needs to constitute a possibility and indeed necessity rather than a transient discourse.
It may be anticipated that individuals test pre-existing values with those encountered within a new habitus and vice versa. While, values central to a particular culture will be perpetuated through the socialisation process, it is suggested that other pre-existing, peripheral, personal values will coexist and may become manifest. The view adopted for this thesis is that individuals are both socially constructed and within the constraints of the habitus, hold values and meanings which could shape it.

The following interview extract demonstrates the influence of socialisation process and the pressure on the individual to conform to dominant cultural practices. This experienced midwife has developed practical knowledge of how to build a personal working relationship with ‘institutionalised’ women. She questions rather than values this capacity on the basis that it may cause trouble for her peers and resentment.

(544-604) Midwife T: There have been a few on the antenatal side who have seemed to be perfectly OK when they were first admitted, but have actually, sort of risen, as it were, to be manipulative (...) because they have been there a long time erm, and they start feeling they’re part of the team almost and feeling that it’s appropriate for them to say ‘Why haven’t you done so and so or ‘Don’t you think Mrs so and so should have her CTG put on now?’ and some midwives are sort of fuming (...) and I have felt quite responsible on some occasions, because I think I’m often sort of, quite easy going and the danger is that I sort of let these people be a bit like that and I’m sort of saying ‘Oh, don’t be so cheeky, I’m the midwife round here’. So I let it go over my head a bit erm, ‘Oh, yes, yes, in a minute’ or something, you know, whilst somebody else complains and says ‘I really don’t like this’. May be I’ve contributed to it, because I’ve accepted it as part of their institutionalised behaviour.

VW: That’s a personality thing isn’t it? Perhaps when you take that approach, it will work for you, but not necessarily for other people.
Midwife T: Yeah, but you're working as part of a team, that's the other factor isn't it? and if other people don't find that behaviour acceptable erm (......) mm, yeah, I think you've got to be aware of, you know, some midwives feel it particularly appropriate for them to be err (....) regarded at all times as professionals (...) it's never appropriate to get over-familiar, you should never get to a point where patients are suggesting their care as it were.

Perception of peers reactions and expectations resulted in lack of legitimisation for her personal strategy and demonstrates, at least in this verbal account, the power of collectivity over individuality. However, the following extract of observation data exemplifies midwife T's light-hearted interactions with the women, which suggests some disparity between her espoused and theory-in-use (Argyris and Schon 1974).

(2740- 63) Midwife T goes to 6A with the 'work box' and stands at the end of the bed. [Let's check you over. We'll do your temperature first]. She prepares the temperature machine (places nozzle on the end) and kneels on the floor at the top of the bed. Her head ends up on a similar level to that of 6A. She places the hand set on the bed and carefully places the nozzle in 6A's ear until it beeps. [That's fine. Pulse next]. Midwife T remains kneeling and takes 6A's wrist and is silent while she looks at her watch. Midwife T asks when her intravenous canula was last tested (that is, flushed through). 6A tells her that it was about 3 days ago. [BP now. I've been left with the big cuff this morning, it will go round your arm twenty times] She gets the cuff out of the box. 6A [that will go round both arms!] Midwife T (jokingly) [Put both arms out (....) I don't mind stopping the drip]. 6A doesn't take her seriously and leaves her right arm down by her side. The midwife starts to pump up the cuff [It's me whose got the blood pressure pumping this up]. After this, she asks 6A again about what she is eating. 6A says that she has had some Lucozade. Midwife T [Well that's a

6-5
She goes to the end of the bed and writes in the findings [Let me know if you want anything].

The previous interview extract raises several points: methodologically, the data suggest the midwife’s desire to make an impression demonstrating a commitment to team cohesiveness. Alternatively, she might have been seeking validation from myself. Either interpretation evidences the need to take account of researcher effect (Polit and Hungler 1995). Professionally, in denying her personal approach, she risks portraying the sacrifice of a warm, spontaneous strategy in favour of ‘professionalism’, which may serve midwives’ rather than women’s interests. It also suggests that current discourses of empowerment, choice and partnership (DoH 1993b) are denied purchase within the established ‘habitus’ in order to perpetuate the status quo. As it is, the interaction is kindly, the midwife utilises humour to build friendship and indicates her availability.

Krathwohl et al (1964) distinguish between the terms socialisation and internalisation of values, which is described as being broader and which is defined as the process of: “incorporating something within the mind or body; adopting as one’s own the ideas, practices, standards, or values of another person or society” (English and English 1958, cited in Krathwohl et al 1964:29). While values are available for transmission within a culture, the need to internalise them in order to be motivated to act upon values, need not necessarily occur.

For educational application, Krathwohl et al (1964:30) have proposed an affective continuum which addresses the internalisation and commitment to values. At one pole, the individual’s responses are ‘controlled’ by environmental or internal influence. The next stage identifies that inner control directs attention but response is dependent upon ‘external authority’. At the opposite pole, which represent higher levels of internalisation, the responses are under internal control and are produced consistently despite ‘obstacles and barriers’. Despite her awareness of peer views, this latter description appears to represent midwife T’s commitment to her personal way of caring. Based on preceding discussion which considered the extent to which the individual can ever be totally free of social influence, it appears unlikely that the latter is frequently accomplished.
Krathwohl et al (1964) point out that education concerns developing persons as individuals who can think for themselves, challenge conformity and act as change agents. Even so, caution is required since, education plays an important role in legitimation of values and behaviours and may unwittingly serve to perpetuate the status quo and interests of those in positions of power (Jarvis 1992). In the case of professional caring, this raises the question regarding how caring values, if they exist, can be preserved, and if non-existent or rudimentary, how they can be transmitted and internalised in order to motivate agency.

Examples in the previous chapter of nurses' and midwives', concern for resources and the length of time patients / women remain in the hospital, illustrate the taken-for-grantedness of values which place organisational values above the construction of sufficient autonomy to facilitate concern for the Other and caring agency. This stands to restrict the development of nurses' and midwives' caring practice if values embedded in existing power structures are allowed to undermine their influence over patient experience.

While not sought, data identify little incidental evidence of value conflict between nursing and medical staff. Conversely, interview data provide numerous examples of values espoused by practitioners which contrasted with those reported of nursing and midwifery colleagues. Again, the potential wish of practitioners to impress and to demonstrate awareness of certain discourses is kept in mind. But this aside, these data suggest that practitioners consciously evaluate values and meanings embedded in practice and are frequently independent thinkers. Finding the motivation to openly influence the situation in order to fulfil their own moral values, is another issue. Data suggest that practitioners are more likely to compensate perceived moral deficits through personal action rather than verbal confrontation of peers. The following example suggests that equality is a salient ethical value which the practitioner is motivated to maintain when she perceives shortcomings in peer activity.

(688-699) Nurse B: .... I know there are some staff that definitely avoid the issue of the patient they don't click so well with. erm but I think it's wrong cause we don't get to pick and choose who comes in. It is quite funny to see when people delegate within a team who gets to look after.
perhaps the labelled patient, the difficult patient and quite often it's the same person. But if I can break that routine and say 'Well it's going to be me', or 'I want it to be me' and you know, that's a fact and I'm going to work with it, you know, I think it's important.

In the relation to provision of a moral service, this once again raises the issue of obligation being fulfilled through collective rather than individual moral practice, mentioned in the previous chapter. This example highlights the organisational complexity of such a system since, the crucial question in this case is, what happens on nurse B's day off!

In the next example, the practitioner generalises colleagues motivations and utilises these to evaluate and validate her own practice values.

(134-193) Midwife O ... I think also, a lot of people who come in to the caring professions .... tend to be wanted to be cared for and I think erm that a lot of people in midwifery as well, about midwives in general, erm tend to want to be needed, I don't feel that so much for myself.

VW: ... you mention this business of midwives needing to feel needed, do you find that in everyday work at the moment?

Midwife O: I think that most people need to feel needed anyway regardless of whether its midwifery or any other job, you want to feel valued, I think that's just a trait of any human being, but I think within this type of work, because people are vulnerable and therefore you give of yourself because of their vulnerability, they need something. I think sometimes, people get upset if they don't get back what they've given out. Well I think within er the sphere of midwifery because it's quite an emotional big life changing episode for a lot of people and obviously people tend to pinpoint labour and delivery, the amount of effort you put in, not just physically but psychologically as well, that I think that people feel that, you know, they're not owed something but I think they feel that
They, they get upset if people don't carry out the expected erm reactions like 'Oh thank you very much for delivering me' or 'You were so wonderful' or whatever. I tend not to feel that I don't need that, of course it's nice but I will actually feel quite happy if people say nothing because that actually means that they have done quite a lot themselves you know. I feel it's quite interesting how people feel they want to gain something from that person, give back to themselves as a professional that's quite interesting I think.

While opportunity to compare theories-in-use never arose during fieldwork, midwife O demonstrates an awareness of patient vulnerability and personal altruism.

Within interview data, there are instances when nurses and midwives identified the value of patient feedback. It was sought by some to evaluate the acceptability of care. For some, expressions of patients' appreciation made them feel valued and more motivated. This is not to say, that the primary intention of agency was to obtain a patient's gratitude or in Kant's (Blum 1980) terms, as a means to an end. Building relationships with strangers day-to-day involves facing the risk of misunderstanding and rejection (Hinde 1979). A patient's appreciation, freely given, is probably important in maintaining self-confidence.

These opposing perspectives indicate the personal nature of caring agency and the power of discourse to provide values and meaning in order to question, develop or divide approaches to practice. Conversely, the earlier midwifery example of the influence of social conformity (page 4) indicates the potential of practice to modify personal meaning.

In order to satisfy both the descriptive and educational intentions and explorations of this thesis, it is necessary to examine the role of both language and practice in the transmission, reiteration and legitimation of caring meanings and values. In nursing and educational literature there is also this dichotomy in the form of proponents of nursing conceptual models as source of nursing knowledge and meaning (Bryar 1995) and alternative theorists such as Benner (1984) and Schon (1983) who argue that knowledge and meaning are
derived from practice. These reflect similar dichotomies such as the theory to practice gap and the rhetoric versus the reality of practice.

6.2 The source of meaning: language or practice?

As referred to earlier, Berger and Luckmann (1966) place emphasis on there being objective means within institutions to provide accessibility, transmission, reiteration of a shared body of knowledge to others, not necessarily having the same experience and for the identification and legitimation of normative behaviours or 'practical imperatives' (page 111). In this way institutions standardise values, knowledge and behaviours. Berger and Luckmann note that theoretically, this could be based on activity, but is more likely to be linguistic.

Other philosophical and sociological perspectives suggest that language rather than activity is the foundation of the social world (Burkitt 1991:191). According to Saussure, 'meanings of words derive from structures of language, created internally within language, not by the objects in the world which we refer to by means of them' (Giddens 1989:698). Action theorists, in accordance with the view of the individual's potential to construct social change, argue that language demonstrates the possession of human consciousness which can transcend social influence (Jones 1993:102). Foucault argues that discourse has immense power over individuals; they determine who we are, what we think, know and talk about; social life consists of activities promoted by discourse (Jones 1993:106). According to Usher and Edwards (1994) language is not only a means to label experience, it also orders and creates it.

However, Foucault also argues that the emergence of particular ways of knowing and talking about such areas of social life depend on the prior existence of specific organisational and institutional arrangements (Jones 1993). This leads the discussion towards the opposing view, which holds that meaning is embedded in and derived from practice. Wittgenstein (1953) argues that language pre-exists individuals and that words get their meaning from use rather than having independent meanings of their own. Both Mead and Marx contend that humans become conscious of the world through activity.
rather than mental activity alone (Burkitt 1991). They concur that it is the way people act in the world that determine human consciousness.

Mead explains that thought, and in consequence, the development of the self-conscious, depends upon the acquisition of language. Language and the meaning of social phenomena are learned in tandem (Mead 1934). Rather than a simple stimuli-response, the self-conscious mind mediates social stimuli and information is exposed to cognitive processing. Stimuli are interpreted according to its acquired social meaning and response is shaped by the store of social knowledge in which it has been constructed. Symbols, signs and language only become meaningful because they are lodged in the practical, social activity of the group. From a phenomenological perspective, Husserl and Merleau-Ponty suggest that individual meaning depends on the contextual features the person finds salient within the situation (Cooper 1996). In contrast to Saussure and Foucault therefore, objective meaning is embedded in practical and social activity.

Mead identifies that aspects of experience, whether taken-for-granted or self-consciously reconstructed, slip out of consciousness to become habit. However, he asserts that patterns of conduct can be drawn back from pre-consciousness and be open to reconstruction. The following extract represents how discourses about patient autonomy and choice, theoretically change practice, permitting flexibility in care. But it can be seen that implementation in practice creates doubts as to the validity and appropriateness of these values.

(575-620) Nurse E: I mean we have a big thing here about, you know, patients are pretty much in bed all day, having a blanket bath everyday, when, in actual fact, does the patient need it? Does the patient want it? .... There's a lot here makes you think, who am I doing it for? Are you doing it for yourself or are you doing it for the patient? Erm, I think each time it has to be for the patient and not for ourselves .... If you're working with another team member erm (....) again (...) you know, if a patient said to me 'No, I really don't want to have a wash' and there was nothing I could do to negotiate with them, to persuade them to have a bit of one, you
might go and tell a member of the team and they might turn round and say 'Well no, go back insist upon it'. But I think that's when you run into the problems, erm, not so much from the patient's point of view, but from with other team members.

In this case, once again, the constraining force takes the form of traditional structures of practice and peer pressure. Even so, language enables us to label experience and develop shared understanding with others. Authors such as Mead (1934) and Kuhn (1970) argue that if there are sufficient people who perceive and respond to a common problem, major social transformation may result. This process necessarily depends upon individuals being exposed to discourse and it will be seen in chapter seven how team leaders in the palliative care setting facilitate this. Language therefore, also contributes to practice, since meaning derived from discourse become embedded in practice. Rather than a dichotomy between practice or language, both inter-relate.

11.3 Summary
This chapter has argued that practitioners' practice values and meanings derive from a combination of socialisation into current practice, pre-existing socialisation and encountered discourse. Data evidence, that while peer pressure is a powerful influence, practitioners differentiate between cultural and personally-held divergent values which suggests that practice holds and fulfils personal meaning. This raises the question regarding how the values which come to motivate agency are determined. The dichotomy between practice and discourse as the source of values and meaning was explored leading to the conclusion that both are necessarily instrumental.

As regards the quest for educational strategy to facilitate caring practice, the foregoing suggests a necessary inter-relationship between practice, discourse and practitioner unity. It will be shown that findings of this research support this analysis. This is based on data which demonstrate that while similarities within participants' descriptions of the meaning of caring and agency are apparent, there are qualitative differences between settings in both linguistic expression of practice and agency. These are described and discussed in the next three chapters.
Chapter Seven
Practitioners’ descriptions of caring

Extracts of data, which represent practitioners’ descriptions of caring and given meanings are presented. Factors which may constrain articulation and caring epistemology are discussed.

7.1 Difficulty in articulations

One noticeable feature, when asked about their personal meanings of caring, was the difficulty some practitioners experienced in articulating their knowledge and descriptions. In applying an ethnomethodological view, one has only to notice the erratic, sentence construction, frequency of the ‘errs’ and pauses to appreciate this. The following nursing and midwifery extracts illustrate this finding.

(108-117) Nurse A: I think it’s difficult to describe really isn’t it? Erm, I suppose you’re sort of looking after, that’s not the right word, you’re sort of trying to, I can’t think, I can’t think of the, I can’t describe it (laugh). It’s sort of emotional and physical needs isn’t it and you’re trying to erm, mmm (....) I can’t think of the right word, but I mean, everyone, I think has certain needs and it’s the process of trying to sort of resolve them or finding a way of looking after those needs really.

(40-47) Midwife D. Erm (..) erm (.) What caring means to me? (..) erm (....) erm (....) I suppose the first thing that springs to mind is that I, you know, that I’m looking after their physical well-being because that, it’s not the most important thing, but it’s one of the most important things, because physically I’m looking after them, that’s what caring means to me. That’s the thing that springs to mind first.

(74-82) Midwife B: Tt, meeting women and their babies’ needs, tailoring individual care, just being a person that they can sort of get advice and reassurance from and err, as, as a leader, a guider, someone they can talk
to ermm (...) it (...) caring (...) erm, I can't think really, it's er (...) a very
difficult question (...) no I can't think of anymore.

(34-47) Nurse F. Well (. ) I think it's, it's about erm (...) it's about
sympathy and empathy and erm (...) putting, well trying to put yourself
into the other person's shoes and think about how they're feeling really
erm (...) I think that's, that's the best way you can care for someone really
to try and, I mean it's impossible to completely understand, but to try and
understand how they're feeling (. ) uhm (...) it makes it a lot more real (. )
uhm and that, well, helping them to do things, helping them to do things
for themselves and helping them to do things they would do for themselves
if they could (...) erm (...) yeah (. ) well I think that's it really, sympathy
and empathy more than anything.

Cognitive elements of nursing and midwifery may be easier to articulate than the feelings,
values, attitudes, beliefs, intuitions and personal and tacit ways of caring. As identified in
the methodology chapter, this difficulty was anticipated to some extent. Even so, additional
explanations were sought. For example, the difficulty with which practitioners describe
caring suggests that the concept is infrequently discussed. Language, as identified in the
previous chapter, is crucial as an objective means to share values. It also comprises
discourse which provides theory to inform and develop practice. This finding therefore has
major implications for socialisation and educational activity. Factors which may impede
articulation of caring meanings and values were therefore sought both within the literature
and by personal reflection upon the research approach adopted. In the case of the latter, I
was in the field for approximately six weeks before undertaking interviews and felt that
participants had become accustomed to me. While Freire (1993) suggests that language
used by educators may not be meaningful within the context of day-to-day practice, caring
is a commonly-used word.

The notion mentioned in an earlier chapter that caring in nursing and midwifery is merely
rhetorical was discounted by the data which demonstrate caring effort and commitment and
which will be presented throughout this thesis. Some explanations may be rooted in the
nature of nursing and midwifery and the processes of socialisation and legitimation described earlier.

Information about personal values and meanings may be considered a private rather than a public matter (Krathwohl et al 1964:18) and this can be supported by personal teaching practice. In facilitating a discussion of caring with student midwives, discussion appeared constrained and students identified that talking about caring for patients causes embarrassment, or sounds too clichéd. It could be speculated that previous paradigms which involved the distancing of emotions, advocated prior to introduction of the humanistic and counselling ideologies (Kitson 1993, Bradshaw 1994) plays a part.

Opportunity to openly discuss and articulate work activity may be restricted by nurses’ and midwives’ involvement in intimate care-giving which contravenes social norms and taboos (Lawler 1991). In her review of nursing literature, Lawler identifies lack of guidance regarding the possible sexual connotations of intimate care-giving compared to instrumental activity. She concludes that it demonstrates the failure to provide language for articulation regard caring concepts other than instrumental ones.

Hart (1991) suggests that organisationally, nurses are conscious that caring is undervalued by more powerful groups, such as NHS managers and medical staff who place emphasis on quantification. She suggests that this results in a reticence to articulate the emotional, intuitive and creative aspects of their work.

Within day-to-day social life, actions become habitualised and routinised in order to be reproduced with economy of effort (Berger and Luckmann 1966:70-71). These processes enable interpretation, choices and decision-making to be minimised and result in an acquired taken-for-grantedness of practice. Also, according to Bourdieu (1990:58), ‘the unconscious’ nature of practice and “habitus makes questions of intention superfluous”

7.2 Caring, cognition and practice

Jarvis (1997) describes caring for Others as a universal moral value which is learned pre-consciously through a child’s own experiences of being cared for by significant others.
Later cultural moral values may be more consciously adopted through socialisation within wider society. Blum (1980) argues that an individual's 'being-towards-others' cannot be understood cognitively as the result of rational decision, choice or deliberate will. Neither can it be regarded behaviourally as a disposition to act in a particular way. Blum describes caring as a moral emotion which involves experience and feeling which transcend cognitive capacity and language.

While caring values can secure receptivity through the saliency of stimuli related to the weal and woe of the Other, caring agency is both particular and situational. To avoid negative (Wilson-Barnett 1994) or overzealous forms of caring (Campbell 1984), practitioners need to continuously appraise the impact of their actions on the Other and make judgements based on experience of optimum response and agency. This knowledge derived through practice is referred to by Polanyi (1958) as tacit and personal knowledge.

The structure of tacit knowledge is based on Gestalt psychology and refers to the different levels of awareness of an object (Polanyi 1959:28). Subsidiary awareness concerns peripheral awareness of particulars when we observe something as a whole. Focal awareness refers to fixed attention upon the particulars themselves. The whole can be seen as a whole only by seeing the particulars, but conversely, the particulars can be seen without seeing the whole. While explicit knowledge refers to focal awareness on the particulars, tacit knowledge represents the subsidiary awareness of particulars while seeing the whole. To explain this, Polanyi (1959) uses the example of reading a letter, when we can recall the overall meaning, but not the individual words and actual text.

Similarly, practical knowledge involves a level of mastery when the minutaie of an activity often focused upon by the less experienced become secondary to the overall activity. We learn to comprehend an entity, without getting to know, or know clearly, the particulars that constitute it; we cannot tell what they are, knowing them only in practice as instrumental particulars, and not explicitly as objects (Polanyi 1959). Within this process, the details of the performance cannot be clearly articulated and therefore have to be learned in practice by social transmission rather than by explication.
Bourdieu (1990) suggests that articulations can only be representations of meaning in that an individual may be able to achieve practical mastery,

*But he is no better placed to perceive what really governs his practice and to bring it to the order of discourse, than the observer, who has the advantage over him of being able to see the action from outside, as an object, ..... And there is every reason to think that as soon as he reflects on his practice, adopting a quasi - theoretical posture, the agent loses any chance of expressing the truth of his practice...* (page 91)

This analysis makes clear the limitations of discourse as an educational strategy to promote caring knowledge and values and emphasises the importance of practice-based approaches. Notably, Polanyi (1959) also maintains that tacit knowledge is pre-articulate and therefore not amenable to personal reflection. This not only has implications for educational strategy but also moral agency. Even so, as Blum (1980) argues, it is agency for which we are morally accountable. While we may not be able to articulate know how, it is possible to reflect on agency and the impact of this on the Other. Drawing on hermeneutic theory, it is argued, that theoretical application is required to achieve this. Based on this understanding, this thesis continues on the principle that caring agency and educational strategy involve mutual dependence of an embeddedness of caring values in practice and caring discourse. Data presented in the following section reiterate this view.

### 7.3 Constructed meanings

While articulation presented some difficulty, participants none-the-less shared personal insights of what caring means to them. During immersion in the interview data, there was sense that these were richer in the palliative care setting. Initially it was unclear what gave this impression, since many concepts mentioned by participants in the two settings were similar. This section reflects the spiral process of data analyses from the more superficial descriptions to a sense of a deeper 'lived experience' of caring described by Denzin (1989:87) as thick description. Practitioner identify elements of various nursing theories which borrow aspects of nursing models from Henderson needs-based model in the 1950s to existential phenomenology emerging in the early 1980s (Wesley 1995). It has been
argued earlier that professional caring necessarily involves a concern for the Other’s experience and accordingly practitioners’ references to patients’ phenomenological experience are interpreted as having deeper meaning. Even so, the validity of this assumption will be explored. Also, this does not undermine the importance of other need-based philosophies, since meeting need is also fundamental to caring agency.

The difficulty in the articulation of meaning, just discussed, is constantly kept in mind as a limitation in achieving true representations of practitioners’ meanings.

7.4 Meeting needs
The following extracts were found to typify responses to the request to describe what caring meant to them.

(26-36) Midwife L: I would describe it as caring for mothers while they’re in labour, their emotional needs as well as physical needs and mental and also postnatally helping them to care for their babies really erm, there again, their emotional, physical and helping them cope with their babies.

(49-62) Nurse C: I think it’s, looking at somebody as a whole, it’s not just physical only, it’s being there to provide the emotional support and encouragement really, erm, social needs. (It’s) meeting their needs, what they perceive as their needs. Well care is very much dictated by the patient ‘Well, what is it you need, what do you want me to do for you?’.

With the exception of one midwife and nurse, meeting physical, emotional or holistic needs were the response most readily provided. These derive from Henderson’s needs-based and Orem’s self-care deficit models (Wesley 1995) and also demonstrate the synonymous meaning given to the words caring and care. Savage had similar findings in her study in which her nurse participants’ notions of care involved response to patients’ physical, psychological and spiritual needs (1995). They do, however, contrast with studies identified in chapter three, where caring sub-concepts, such as compassion, support and empathy, comprised data generated.
The responses within this research, also reflect the major day-to-day activity of practice. Observational data demonstrate that meeting needs is the most tangible aspect of the work and the main means of identifying, prioritising and allocating work load. Managerially, resource restrictions necessitate that physical needs are met first. Professionally, the Code of Conduct (UKCC 1992b) is based on non-maleficence and professional accountability tends to be interpreted as primarily meeting patients' physical needs. Even so, the above responses also include notions of helping, being 'there' and being of service.

It is also suggested that the conformity of views reflect the socialisation process and represent Bourdieu’s (1990) 'habitus'. However, while most midwives implied a preference to be a separate profession from nursing, they vocalised conventional nursing principles. Also, the one 'direct entry' midwife identified meeting physical and emotional needs, suggesting that at least in her case, this mode of preparation for practice fails to fulfil hopes of eradicating nursing cultural values (Robinson 1996). While models may appear to have limited application to practice (Kitson 1993), these extracts suggest that they provide the language with which to describe practice. That midwifery has yet to establish a specific theoretical base (Bryar 1995) will be discussed later.

7.5 Nursing/midwifery specific meanings

During data analyses, it became apparent that one category of articulations arose specifically from the nature of the practice. While on first impression the specialities of palliative care and midwifery could not be more polarised, theoretically, strong similarities in caring potential are evident. In contemporary health care, the quality of the childbirth experience itself and its relationship to the future psychological well-being of the woman and her family is emphasised (Page 1995). Care of the dying or palliative care aims to optimise the quality of time remaining (O'Berle and 1990). Central and instrumental to both specialities is the vital role of patient autonomy, control and choice which facilitate self-esteem and expression of human value.

7.6 Midwifery specific

Within the midwifery data, intentions were primarily to provide practical support. Many of the midwifery participants perceived their role as being a resource for the women.
variety of concepts were identified and included: educating, supporting, helping mothers / parents to acquire skills of caring for the baby, preparing for and giving information about birth and parenting, instilling confidence and nurturing self-esteem, encouraging women to find time for themselves to rest before going home. The following extract illustrates this perspective.

(VW) I'm looking at professional caring and am asking people to describe what caring means to them. What would you say caring is?

(36-56) Midwife F: Erm, I think, in midwifery, it's different to what I would say in general (nursing), in midwifery, caring is (...) it's more to do with, it more educating and supporting and helping the mums and parents to acquire skills to deal with, obviously the baby, and preparing them and, and supporting them, through their pregnancy and labour. Erm, Whereas on the general side, it's more a hands on caring as in a (...) erm (...) their physical needs(...) so erm, it, yeah to me that's what caring is, not sort of caring as in going 'aaaaaah' but in supporting and educating them and ensuring that they're confident in what they're doing and, their education that they're getting antenatally and in labour really.

Midwives expressed the intention to optimise outcomes, in the sense that childbirth and parenthood should be a safe, positive experience. Midwives also appeared particularly aware of women's hopes for a 'normal' birth experience and the negative impact of medical intervention on women's aspirations.

(186-198) Midwife F: I think sometimes (...) people have got very erm, high expectations, they perceive it as a normal physiological event and erm, then when things don't go like that they, they're quite devastated, they think they've failed, you know, they do and (...) and erm (...) pregnancy probably is normal. it's something that the body's made to do. Then there are cases where it's upset, it's, the body, not rejects, but just can't cope with it and people with raised blood pressures and people with problems

7-8
and things like that, and erm, people get, they don’t expect, they’re not prepared for things to go wrong, well not go wrong but things deteriorate from the normal.

7.7 Nursing specific

The palliative care nurses had a similar desire to contribute to the patient’s quality of life and time in the unit since this was seen as functional in ameliorating symptoms of their disease or medication regime.

(151-183) Nurse B: (....... ) my personal intentions are to, if it’s a one-to-one interaction obviously, patient-carer, whatever situation you’re in, is obviously to provide comfort and dignity for that person, and without erm causing them too much distress to, to help them with any activities or things they’re not able to fulfil themselves and not comment on how dependent they are or may be how, what a nuisance they are, you know if things re-occur regularly and it’s just giving them the time and making and making them feel erm that they’re not a burden just that, just be easy going, just give them the opportunity to talk if they want to talk, just to sit and listen, I mean, silence, you know is caring but it’s, you know, it’s giving them the space and someone actually is, taking the time to sit there even if it is in silence, it’s the listening part is just important as well and just making sure obviously, at the end of the day that all their needs are met erm, you know, and a friendly, a friendly shoulder to cry on if that’s what they (sigh) need and just support them erm to sort of, allay their anxieties and fears about things and situations that they might have to go through and erm just to generally be there for somebody and be attached, not as a relative, spouse or whatever just as a third party and make that person not feel a burden to anyone I think.

During interviews, after practitioners had been asked to describe caring, in order to extend the discussion they were asked what their personal goals of caring are.
(247-66) VW: so when you’re interacting with someone, whether it’s just talking or a particular procedure what would you say your personal goals are?

Nurse E: (.................) That’s a difficult one, that.
(joint laughter)

VW: These are difficult questions

Nurse E: (laugh) erm, I think giving them security, it is quite important you know, a lot of our patients have been through an awful lot by the time they get here, erm in terms of procedures and having seen a lot of people, and I think it’s really important that you give them security, make them feel safe erm because a lot of them will feel quite vulnerable, erm, you know, it’s naturally a difficult time in their lives and a lot of them know that the time that they have might be quite short and therefore they need to know that that time is, is safe, so I think providing them with (...) with safety is quite important.

7.8 Individualised care, choice and empowerment

Patient choice and autonomy established a foothold within the paradigm of ‘individualised care’ introduced in the UK in the 1970s. This sought to remedy the dehumanising practices inherent in routine and task orientated approaches. As Wilson-Barnett (1994) identifies, it requires nurses to centre care on the patient’s particular needs, views and preferences and to acknowledge the individual’s unique experience. King (1968) also notes that individualised care introduces the ideal that the person’s existing level of independence and self-esteem should be optimised.

Since the 1980s, ideologies which potentiate patient choice, empowerment and autonomy have become widely adopted (Jenson and Mooney 1990) and are embedded within The Patient’s Charter (DoH 1991) and the Changing Childbirth report (DoH 1993b). Both documents emphasise patients' rights to explanations about health problems and treatments
and to participate in decisions about care. It is been suggested that support for patient autonomy represents a challenge to the authority of health care experts and is currently espoused as protection against professional paternalism (Jenson and Mooney 1990).

Commentators draw attention to the potential for nurses to fall short of the caring ideal. Campbell (1984:42) asserts that in contrast to the opportunity for nurses to offer support in times of need, it may be used instead to control and perpetuate helplessness. In the palliative care setting, choice and individualised care was utilised therapeutically and seen very much part of giving the patient control.

(513-25) Nurse E: *I think that choice is important (.) I think that patients have often lost a lot of control and giving choices gives back a bit of that control. You’re able to say “look it’s your life and actually you still have the ability to make choices and make decisions for yourself.*

(495-503) Nurse D: *I think it’s important to give people choice, especially if they are terminally ill and quite poorly. A lot of what they’re coming to terms with is losing the control over their lives and facing lots of uncertainties. And so if you can give them some sort of choice, however small, it’s empowering them in some way.*

There is also evidence that the choice paradigm offers mutual benefits. Practitioners indicated that the increased flexibility provides the opportunity to utilise their knowledge and experience to determine individual patient choice options, for clinical decision making and for practice development. This appeared to contribute to the sense of professional autonomy, responsibility and job satisfaction.

Unrealistic work loads and the deeply embedded tradition of routine and task orientation present the major threat to facilitating choice and individualised care. Garbett (1996:33) notes that “considerable investment in staffing, education and organisational development” are still required to establish individualised care. As mentioned earlier, there is a tendency to routinise care and especially when demands place pressure on available
time, "sameness and predictability in our daily experience help us to maintain control" (Campbell (1984:91). The following example illustrates the dichotomy of preserving patient choice and autonomy and pressure to get the work done.

(495-510) Nurse E: I think when patients have come from a busy hospital environment, erm, perhaps the routines, regimes on the ward is more regimented than it is here, erm, I mean some of the wards in (hospital name) have to be up and dressed by a certain time. Erm (sigh), so I think from that respect we are very relaxed here erm and if we go to someone in the morning and say "Do you want a wash?" and they say they don't want one...then that's fine (Gentle laugh). But I think that we sometimes end up then having an argument with ourselves, because part of us would really desperately like to get that person washed and done, so we can get on with other things, but on the other hand, you know that, if they're just not feeling up to it and want a rest, then that's best for them.

The above extracts demonstrate practitioners' determination to facilitate patient autonomy. As identified in chapter two, Pellegrino (1982) identifies that in essence, the moral necessity of protecting a person's autonomy is grounded in an understanding of the experience of illness. Consequently, it is the helper's responsibility to preserve the person's moral integrity by providing information about their health status and the available options for care and to act in accordance with the patient's values, concept of health and the kind and quality of the life he holds as worthwhile. Pellegrino (1982:161) cautions that:

The patient must be assisted, to the extent he wishes, to make conscious choices, and thus to act as a human person rather than become the object of technical manipulation.

The following section illustrates the nurse's commitment to prioritise the patient's values over both routine and personal values.
Nurse B: It can be quite difficult to get out of routine, but if someone doesn’t want to have a specific routine and doesn’t want to wash regularly and doesn’t want to have intervention, even if it may be beneficial to them, you have to stand back and respect that (...) and erm you know, I think as nurses, people find that quite difficult sometimes, because we assume that everybody wants to be comfortable and everyone wants pain killers to get rid of their pain and whatever else, but that’s not always the case. And it’s important to listen then because that is part of caring, listening to what they actually want and standing by that (...) Everybody reacts differently and we should treat everybody as individuals and although you may have a feeling about something, it should be in the back of your mind and it should be, you know, the patient expressing themselves that you’re listening to and not your own personal feelings cause you want to care for the person that they are and you know, their feelings can be completely different to your own personal ones, so, I think it’s important to pick up from the patient exactly what their feelings are and not try and cloud them with your own, may be.

The nurse’s views demonstrate an awareness of Campbell’s (1984) concern that humans have a tendency to make generalisations about people based on persons previously encountered. As Campbell states "The knowledge which love seeks is a more costly encounter" (1984:91). He identifies that getting to know what is best, demands the time and attention to learn about the person’s individuality. Similarly, Bauman (1993) in applying the ideas of the existentialist Martin Heidegger, proposes that only when one looks beyond what is ‘taken-for-granted’, is knowledge about the person perceivable. This is the essence of caring and the optimum balance of beneficence and promotion of autonomy is based on the knowledge of particulars obtained through the practitioner-patient relationship and not purely on ethical assumption. As Pellegrino (1982:162) identifies, the health practitioner “must strike the right balance for this patient between freedom that might be self-injurious and coercion that would impair a human decision”. This includes acceptance that a patient’s autonomy need not be expressed to be respected.
and valued and that it is on occasion appropriate to accept a patient's dependency (Campbell 1994).

Childs (1995) asserts that once patients are informed, they should be trusted to make responsible decisions. This view epitomises the current discourse which rejects paternalism (Jenson and Mooney 1990). The following extract demonstrates the expectation that patients must take responsibility for their decisions.

(145-54) Nurse C: If a patient doesn't want to do something, if they compromise care and there's an omission, we are accountable for what we're actually doing then that's where one of the grey areas arises. But again, at the end of the day, if they're able to make a decision and we're actually giving them information so that they can make an informed choice and if legally we're actually documenting that all this has been discussed then, (...) we're all capable of making a decision, why should the patients be any different?

Provision of choice may create tension between beneficence and autonomy. Due to the preoccupation with the preservation of the patient's values, it may be overlooked that over-emphasis on autonomy may represent the antithesis of caring. Fulford (1996a: 13) states:

*It would be wrong to say that in each and every case, the patient's express wishes should prevail. This would not genuinely be patient-centred care. It would be a consumer model of health, in which the supplier of goods has merely to flatter the customer with what she wants. But the health professional has an obligation to care.*

While Fulford does not specify how serious the consequences of the patient's decision may be, he implies that, on occasion, moral agency demands that beneficence overrides autonomy. Implicitly, his perspective conveys that health care should concern covenant or love of neighbour and not only contract (Campbell 1984).
In cases where the choice made will clearly adversely affect the patient, Pellegrino (1982) counsels that practitioners need not be so neutral that they cannot indicate what they consider to be the best choice and proposes that no effort at persuasion is tantamount to abandonment. From an Aristotelian perspective Oakley (1992) argues that, in order to be moral, rather than just doing good acts, these should be performed out of good motives and for good reasons. Following this line of argument, promoting patient autonomy for its own sake, does not necessarily constitute moral agency. Pellegrino (1982) advises that dialogue between patient and professional with choice based on shared perspectives best fulfils the moral sense of benevolent concern for the Other.

Sorrell (1997) points out that in order to make an effective choice regarding care and treatment patients require an understanding of specialised information which is beyond many people. In the maternity setting, this risk that choice may undermine safety was an evident consideration.

(575-82) Midwife F: *I think giving informed choice is part of your care, cause, you’re giving them the information, we tell them the pros and cons and we allow them to make a decision. Obviously if you’re not happy with what’s going with the baby, perhaps the baby’s not doing well, especially in labour, then you’ve got to be able to explain that to the mums and explain why you think this may be a better option than the other one.*

The following represents a midwife’s argument that patients may require guidance due to the lack of women’s understanding.

(337-55) Midwife H: *I think choice is good that erm, in some areas er. I’m not sure, at the moment, in some areas, what I am concerned about is erm,(....) we’re giving women lots of choice about lots of things when they’re pregnant erm and they’ve got a lot of adaptation to pregnancy: body change, life style change, work changes, family, home life, and then we’re giving them all these choices in pregnancy and no matter how much reading they do and how much information we give them as a*
professional, they are still going to have a basic knowledge. And I think we are in a bit of danger here of, (...) of people who want to make choices on issues in childbirth, making them without any real, erm, understanding. We say informed choice, but they can only be informed to a certain level, because they're not midwives or obstetricians, and erm, so I think we still have to guide them in to their choices.

Midwives expressed a variety of factors which influence the provision of choice and individualised-care.

(137-56) Midwife O: I feel that I am there to support somebody but not there to facilitate their everything, so I would like to be able to create er independence and autonomy for each person ..... I like to think that I actually support people to be able to take on their own (. ) their own independence and their own ways of creating optimum outcome, really, so I'll support people to achieve their own outcome rather than support them to create stuff for me to be, to be more involved.

VW: So I suppose part of that is identifying what their intended outcomes are?

Midwife O: Yeah and I think that most people can identify their own, if they actually think about it and lots of people erm would like to feel that, because the way they've been brought up or the way they run things that people should have the same outcomes as themselves, but of course everybody's different, so I think, if you can identify what women want for themselves, then you can facilitate or support them to be able to gain that. That's what I feel I would like to be able to achieve.

Most of the midwives were quick to identify the potential problems of giving choice rather than the benefits to the woman thereby constraining women's choice. There appeared to be an acceptance that the pressure of work and constant need to prioritise activities.
rendered individual care unrealistic. Despite the current discourse conveyed within the Changing Childbirth Report (DoH 1993b), which advocates woman-centredness, empowerment through partnership, implementation in practice teeters, as individuals constantly refer to and pragmatically shape activity in keeping with the perceived resources and constraints (Layder 1991). It appears that discourse or ideology will fail to motivate agency if resources are strained. Instead, it is likely that practitioners’ tendency to adhere to what they know rather than strive to achieve the unattainable.

(156, 237-250) Midwife O: I don’t know if we do actually achieve it (individualised care) because there are lots of frustrations about time or irritated staff and paper work and all those things........ I think I’ve learnt that along the way being much better at realising that you can’t achieve everybody’s needs within your own time, within your own shift, and I think, as I’ve got more mature in myself and seeing how those things are not feasible and also, not things that I should try to achieve sometimes, you can’t meet all the needs of all the people all of the time. But I do feel that there are particular aspects that I feel are important, whether it’s the needs of the group and the individual and I sometimes think that the needs of the group over ride the needs of the individual, especially within this sort of environment because obviously we have pressure on beds, we have pressure on, you know, getting things done, like drug rounds and those sort of things and obviously, you know, individuals have to fit in to that sort of schedule.

Contrary to empowerment, the next extract shows how the midwife firstly vets the parents’ expectations in order to make these fit the professionally focused reality.

(306-22) Midwife O: ..... when I’m talking to people I try to see what their expectations are before their expectations are met because, and try to be realistic, because obviously if people say ‘I’ve got to be in at half past 8 because my husband’s coming at 9’; I’ll say that my reality is, I have three people to see and have things that are very, very important to me
now, if I can't meet those expectations what's going to happen? If I can’t meet them then you’re going to be angry with me because I can’t meet them but if I tell you I can’t now then may be we can have a solution to it whether you go without medical discharge or you say OK my husband will have to rearrange it or whatever, but I think, I think if we discuss things with people (...) most people tend to be quite (...) erm ....

VW: So do you find yourself saying things like that?

Midwife O: Oh, all the time, everyday.

While midwives referred to bolstering women’s confidence through providing information and guidance, there was little evidence of strategy to achieve the principles of current discourse. On the contrary, midwives allowed the organisational structure and ethos to disempower women. While midwives shaped aspects of work over which they had influence, they themselves appeared disempowered to provide flexible care provision. Potential reasons become clear in the following sections.

7.9 The place of models of care

Wesley (1995) outlines seventeen major nursing models and a further ten which are given lesser acclaim. The purpose of the models is to offer an ideal representation of an approach to practice (Ford and Walsh 1994). Ford and Walsh (1994) identify that while rigid implementation of models can stultify practice, in certain circumstances, they can be empowering, can be adapted by staff in the light of real experience, or staff can develop their own model. They can also give clear structure and intention to practice and facilitate the development of nursing rather than medical values. Dennis (1998) provides an example of how a team of nurses formulated their own model of practice and resulted in a positive outcome. The activity resulted in a more cohesive and confident team, with a clearer direction of practice.

It could be speculated that due to the nature of caring ‘knowledge’ and limits to verbal expression, that models and frameworks of practice offer a means to build visions of and
evaluate practice. While it is acknowledged that caring is individual and based on tacit, practical and personal knowledge, it would seem reasonable that a profession, accountable to the public and professing to care, could be explicit about the scope and goals of practice.

Ford and Walsh (1994) identify that models are rejected by some or problematically, one model is exclusively adopted. Levine (1995) also argues that there can be no one universal theory that fits all situations. Based on Benner's novice to expert model (1984), Ford and Walsh (1994) suggest that more experienced practitioners are less likely to base care on models. This latter assertion was not supported within this study. In the palliative care setting, three of the more senior nurses referred to models to support their rationale for practice and appeared enabled to lead practice as a result.

The Burford and O'Berle's and Davies' model (1990) had been modified by the lecturer practitioner and had been implemented in the unit for about a year. The first model was developed by nurses in Burford Community Hospital, and focuses on goals compatible with the conceptual framework of caring devised for this thesis. The Burford model advocates the importance of nurse-patient relationship and emphasis on the patient's experience and therapeutic use of self, being totally present for the person, validating the patient's experience, identifying deficits intuitively and through 'subjective feeling' (Kitson 1993:35). The O'Berle and Davies model (1990) combines the following principles; valuing, connecting, empowering, doing for, finding meaning and preserving the nurse's own integrity. As already seen, interview data provide ample evidence of vocal legitimation of respect for patient autonomy and empowerment. Examples of observation data, presented in a following chapter, strongly support the view that this value is internalised and manifest in practice.

The following extracts demonstrate the use of models in the palliative care setting. Below, nurse C has just identified building patient confidence and encouraging independence within the patient's capabilities as part of what caring means to her.
VW: Does that tie in with any other concept that you have, as to what caring means to you or what you’re trying to achieve in your day to day interactions with patients?

Nurse C: Well, I mean, obviously it ties in to (...) the nursing models that we’re using and our philosophy of care, we’re trying to (...) we’re using those and what we try to achieve in those. We’ve done a lot of work on that (The Burford model).

VW: What are the elements in particular?

Nurse C: It’s er, it’s really looking at (...) the, well, the patient’s perceptions of what’s needed erm and also trying to trying to avoid us making judgements, like this person has got pain therefore they must want tablets for it. Does that make any sense? Not assuming that that patient wants a wash everyday and that may not be, you know what they normally do, that they wash every morning.

VW: How do you feel about that model. Does it sit comfortably with your own personal philosophy?

Nurse C: Erm, it does but I think there’s also the, the degree of this inbred nursing, nursing philosophy, that says ‘we must “do” the patients’. Erm there is a tiny element of that, I think, certainly within nursing staff that varies erm as to how much they really think about what we’re doing and what we’re doing here.

The unit’s team leaders appeared to utilise the model in an attempt to challenge the traditional structures of practice and provide positive role-modelling and philosophical direction for other staff members.
Nurse C: *Erm I think it’s again this, what we should be achieving? Erm you know, most of our patients want an hour when they have morning care at least and particularly at the moment in that particular team most of those patients need that time and there’s the “Oh well we should really try to get on, get all this work done before lunchtime”. And no matter how much the senior nurse are saying you know, it really doesn’t matter, there is no rush, it’s still kind of in-bred in the nurses (laugh) that it’s got to be done and you know, they’re working hell for leather all morning thinking “Oh, I’m going to fail if I don’t achieve this”.*

As the extract above illustrates, the more senior staff in the palliative care setting were also empowered and cared for other team members. During the last week of my field work, a nurse who had never worked in palliative care before was being orientated to the unit. Although her newness would account for some behaviours, others, such as talking over the patients, were noticeably different. During field work, nurse A, who had worked in the unit for eighteen months, explained to me how her values had changed compared with when she started. She noted how focused she had been to get all the care done in the morning and how anxious she was when this wasn’t achieved. In the maternity care setting, there is no such support or clinical leadership in evidence.

Kitson (1993:30) argues that personal understanding comprises personal experience, both negative and positive, education and a variety of historical, social, political and psychological factors. Kitson argues that although conceptual frameworks and theories exist, it is necessary to personally blend the information derived from these sources with personal experience of the world. This implies that it is not only a case of knowing but of clarifying values which can be internalised in order to motivate agency. The primary step of internalising values which will sustain purposeful agency is not an insignificant one (Krathwohl et al 1964). Taken that this is achieved, as seen earlier, the translation of values into practice may conflict with existing organisational structures and objectives.
In contrast to use of models and philosophy of care in the palliative care setting, midwives reflected the view that models may well be rejected and be seen to have little usefulness in practice (Ford and Walsh 1994). The following extract of my interview with Midwife O illustrates this.

(538-56) VW: Just before we finish, you obviously feel quite strongly about the care that you provide, are there any other values that you can identify that you incorporate in your caring or //

Midwife O: // Values, in what way? Moral values do you mean?

VW: Yes

Midwife O: Erm (........)

VW: Or any aspect of models that you have worked with or work with, you know, important aspects or things that are important to you.

Midwife O: I think, (sigh) at the end of the day I haven’t had, I know in nursing they’re always talking about models and stuff and I don’t know if they’re good, bad or indifferent. I sometimes hate things like that because they’re so rigid and you don’t think about the actual person, you just think fulfilling the model, the criteria and I don’t know If I actually agree with that.

This midwife identifies one of the potential drawbacks as previously mentioned. As identified in the methodology section, field work was undertaken in the palliative care setting first. Data as exemplified above, suggested to me that team leaders play an important role in creating a tangible vision of implementing caring values in practice. Therefore, I deliberately included a question about use of models during my interview with midwifery counterpart, as follows.
(739-801) VW: Just as a final question. Are you familiar with any particular models of caring?

Midwife H: Yes, the erm, the one that erm as a midwife is Orem's, is the nearest that we would apply (....) there is no real midwifery model of care designed (..) I think it would be very difficult, it is so diverse, the subject

VW: So from Orem's that you mention, do you think there is any influence at all on your caring from that model?

Midwife H: I don't know, you read about these things and you don't know if you're doing it without your knowledge, you know, but it's not a conscious (.) it's not a conscious way of practising, by someone's model, you just do it, because that's what you do as a midwife, you know that's, it just comes naturally do it like that, whether it's somebody's model or not I wouldn't know. ......... it's quite difficult to define the caring side of it because, because, we do it everyday, day in, day out, it's just, it's not like coming into work and turning the word processor on and working away on it and then turning it off and going home, you don't turn caring on and off, it's just in your nature, most of the midwives, it's just in there, you just do it....

This extract may just illustrate the difficulty in articulating caring knowledge. Alternatively, it may support the sociological perspective that humans are passive rather than intentional and purposive (Layder 1991). Professionally, while the midwife identifies the nursing model considered to be most compatible with midwifery practice, the potential benefit of theoretical application to practice is not acknowledged. This supports Bryar's (1995) identification of the lack of theory development in midwifery compared to nursing. Bryar notes a period during the 1980s when an interest in models was provoked by the topical attention being given to individualised care, consumer pressure and the under utilisation of midwifery skills. Bryar identifies that this initial interest involved the use of the nursing /
midwifery process, birth plans and was followed by adaptation of nursing models to midwifery, the development of philosophies of care, development of local models and quality assurance models.

Although the interview concerned caring rather than midwifery, there was no vocal or observed evidence of an underlying framework for practice. Apart from initial reference to meeting needs which may derive from Henderson’s need-based model, care appears to be based on individual values and meanings. Interestingly, while one midwife had difficulty in identifying caring within the midwifery context, she identified that she would be well able to describe caring in her former role in an intensive care unit. This may illustrate more defined scope of practice and stronger sense of role.

There appears to be resistance in midwifery to the implementation of a collective approach to practice, which became manifest in other ways, to be discussed later. Most of the midwives interviewed, spontaneously differentiated between nursing and midwifery and it may be that innovations, such as individualised care, the nursing process and models of care originated in nursing. An alternative explanation may concern the individualistic and independent approach to practice, which again implies difficulty in collective working. In a later chapter which aims to portray the overall work and caring ethos within the research settings, it is suggested that further phenomena within the midwifery context reflect Durkheim’s concept of ‘Anomie’ (Burkitt 1991). This refers to a situation in which people alienated from one another’s thinking, there are multiple moral positions and it is impossible to find a system of values to guide actions.

7.10 Qualitative differences between settings
The above section dealt specifically with nurses’ and midwives’ views and application of conceptual models. This section identifies deeper expressions of meanings, which embraced a concern for the Other’s experience and which this thesis argues is central to caring agency. Data from the two settings are now contrasted.

Interview data obtained in the maternity care setting, gave an overall impression that midwives managed women rather than developed an appreciation of women’s individual
experiences. All midwives’ articulations conveyed a primary combined physical and verbal instrumental function.

There was also evidence that standard expectations of women’s capabilities and the medicalised context were permitted to undermine contemporary ideals referred to earlier. For example, in one case, the disruption to a woman’s expectations of childbirth, due to medical intervention, was normalised.

(270-302) Midwife F: .... with the initial caesarean, they’re not able to do it (care for the baby), cause they can’t get out of the bed to do it, erm, but once they’re up and mobile, then you’ve got to remember, Well, it’s their baby, they’ve got to look after it .... I know we have one lady whose been here for four days and has never changed the nappy and you think (laugh and louder) well that’s a bit too much. You know, at the end of the day, once they’re up and able to do things, you don’t want to over do it, something as simple as changing a nappy and things like that they should be getting into themselves. .... may be you’ve got to draw a line as well, where they’re able to do it and where they’re not able to do it and some people will say ‘Well I’ve had an operation so I can’t to do it’ and you think, well you’re going to have to do it when you get home. Lots of people think they can’t lift the baby because they’ve been cut, and lots of people say ‘Well can I lift the baby’ and you say ‘Yeah, the baby’s OK to lift’.

Three midwives expressed intentions to be with women and extracts will be included in the discussion of care relationships, presented in the following chapter. Another midwife articulated rhetorical concern for the growth of the other (see interview data Midwife O above, pp 16-17). The following extract suggests the midwife’s resignation that agency motivated by concern for the other was secondary to other aspects of the work. The midwife identifies that this aspect of care is was not valued by the doctors and therefore is not a priority. She describes her care of a woman requiring close monitoring due to serious pregnancy complications.
Midwife D: I think you can lose sight, I have done, I must admit, you lose sight of the fact that women can be just as frightened as anyone else, about what’s happened to her, but erm (....) most of the time, when they’re on the protocol, they’re sleeping which is, you know, that’s different obviously, but then, when they wake, it’s you know, you try to chat to them, but it’s not easy, especially if they’re that unwell, they’re really not going to feel like talking and you come away from a shift thinking, well, I’ve met her physical needs perfectly and I’ve done all her obs. and then you wonder, you know, all the things you didn’t do, you never did have a chance to talk to her about how did she feel about the delivery or anything (....) really.

VW: Is that because the shift is full of doing all the physical things?

Midwife D: Probably, yeah, it is very, very demanding looking after someone off the protocol, it’s very intense ....

VW: What about women after caesarean section? How would you compare their needs or the aims of your care for those women compared to someone having had a straightforward normal delivery?

Midwife D: Down here on the ward, do you mean, and they’re otherwise quite well, they’ve just had a caesarean? Again, there’s more physical care involved because they’re going to need help getting out of bed and you have to monitor their fluid input and output and pain relief and everything, they’re going to need more, but erm no, I try. I do try and sit down and chat to them as well .. about how everything went and I meet all their needs other than physical ones (....) The thing is, what I was going to say, going back to the protocol, it doesn’t carry any weight with the doctors, is the other thing. If you wrote in the notes erm, have not done Mrs X’s observations for the last hour because we’ve been chatting, that
In this scenario, there may be an over-reliance on chat as a therapeutic, caring response. A lack of insight into non-verbal, expressive means to convey empathy and concern or awareness that instrumental and expressive elements of caring can be combined. While not advocating that monitoring of the woman's physical well-being can be delayed, the perceived requirement, at least verbally, to placate obstetricians, misplaces caring agency. The extract also evidences the perceived lack of midwifery control over midwifery practice.

The content of four of the palliative care nurse interviews conveyed a more 'lived' concern with the patient's experience and included vocalised intentions to avoid patient perceptions of burdenhood and imposition of one's own values. Extracts presented earlier during the discussion of choice, autonomy and facilitating patients' perceptions of control (pp10-18) support this interpretation. During the interviews, these meanings pervaded the discussion and were consistently returned to (nurses E, B, F, D). While never referred to as such, existentialism and phenomenology have been incorporated into nursing / caring models (Kitson 1993) and are evident within the two models implemented in the unit.

The philosophies of existentialism and phenomenology were exemplified by the expressed intentions to 'get to know' the patient and to preserve the patient's identity, achieved by denying him or her the status of the proverbial disease or condition in a bed. Practitioners also mentioned strategies to maintain the patients' usual social context as much as possible. These included ensuring that they had messages from family, friends and community carers, encouraging and listening to life stories and seeing photographs of them in bygone years. Bradshaw (1994) suggests that the covenant perspective recognises the patient as neither dependent or independent but interdependent, that is, 'as a person within a framework of relationships that make him what he is' (page 315).

The overall approach in the unit appears to represent a progressive form of individualised care, as it looks beyond the empirical-rational and cognitive experience of the patient.
Bradshaw 1994). The following extracts, were intuitively interpreted as representations of practitioners’ deeper meanings which create salience and guide practice. However, as will be discussed in the following chapter, ‘knowing’ that this is the case, is impossible to establish.

In the following extract the nurse emphasises the need to preserve identity.

(172-84) Nurse F. It’s about their security really. When it’s somebody like her (patient A) who erm (...) she can’t do anything for herself at all she has to rely on people to do things for her and you don’t want to take her control and her independence away completely you know, just make her a number in a bed or whatever, you want to try and keep her individuality erm (...) and that’s what it’s all about basically (...) listening to them, you know the way they do things at home and the way they prefer things to be done and try to carry on doing that as near as you possibly can.

This extract illustrates ‘being with’ and ‘for’ the Other (Bauman 1993).

(120-136) Nurse D. Erm, well, I think it’s very difficult, but I think, I think, erm...there’s like some aspect is just the being with, the being with people and going, you know, going through or going along with them whatever it is they’re going through, their time of change or (...) or their experience erm (...) and (...) some, something (...) sort of, another aspect of it is kind of enabling people really to be (...) empow, you know, enabling them by empowering them to be able to deal with whatever it is they’re going through and, and to be ..be themselves through it, if you get my sense..erm, you know, helping them to, to bring out strengths within them rather than (...) so that, so that erm their resources come from, from, you know, they’ve got resources rather than anything that we’re doing for them. it’s actually enabling them to (...) to (...) grow through whatever change it is they’re (...) does that make sense?
In three of the interviews the emphasis on caring values was balanced with organisational considerations, namely, relieving team members' stress due to 'heavy' patients, solving problems associated with equal distribution of care to patients and the tension between patient choice and professional accountability (nurses E, F and D). As in the case of reference to conceptual models, these three were more senior members of staff and therefore in a position to influence care-delivery. The commitment and leadership provided by these nurses cannot be discounted as a central cause of the differences between the two settings. It was clear that all the nurses interviewed were exposed to caring discourse, which possibly provides the language to share deeper meanings. These articulations may indicate how the models utilised within the palliative care setting, created the means for sharing, legitimation and perpetuation of rich, more esoteric meanings.

The above returns the discussion to the issue of team cohesion and practice and the notion that this, as well as individual virtue, is central to caring practice. Also relevant, is the discussion of socialisation, discourse and education and the appropriateness of legitimated and perpetuated values and whose interests they serve. As argued in chapter two, discourse is dynamic and while some may complement caring others may deter it. Anticipation of the impact on caring of novel values and meanings is therefore crucial. To develop this point further, it is argued that the above interpretation is based on the assumption that existential phenomenology with its focus on individual human experience may protect individuals from the reductionism and dehumanising perspectives of the scientific approach to care (Bradshaw 1994). From this view, the deeper meaning represents potential beneficial and qualitative differences in care-delivery.

However, Mezirow's process of 'conceptual reflectivity' (cited in Boud, Keogh and Walker 1985a:25), requires that utilised constructs are examined and evaluated, in order that negative and counter-productive consequences of action are identified. In chapter three, Bradshaw's (1994) reservations regarding the appropriateness of existential theory to nursing were detailed. These are revisited and expanded in the context of the research data.

As regards contextual appropriateness, it can be argued that theoretically, there is a place for existential phenomenological philosophy in both settings. In palliative care, where the
inevitable fatal consequences of the disease are acknowledged, emphasis on existential perspectives may provide spiritual benefit. In maternity care, while pregnancy and birth are not disease processes, efforts to achieve some recognition of psycho-social and growth aspects of childbirth, could help to shake the powerful grip of the medical model.

Conversely, as identified earlier, Salvage (1990) argues that practitioners need to recognise that patients may not want an intimate level of relationship and need to be cognisant of the potential, inherent intrusion in patient’s experience. Merleau-Ponty considers the body as a mere existential tool (Bradshaw 1994) which may detract attention from physical health concerns. Kitson (1993) also identifies that focus on psychological and experiential dimensions of care may undermine physical needs and the encouragement of the patient to develop positive coping strategies to manage the situation. The experience of pain, as referred to earlier by nurse B can be used as an example of a means to achieve personal growth by testing willpower and physical tolerance. The difficulty this poses for nurses and midwives in deciding how much encouragement to give a patient to either accept or delay analgesic medication, is clear.

An emphasis on patient autonomy as a means of personal growth may stigmatise paternalism and deny the patient’s choice of dependence on care-givers (Woodward 1998). Based on the assertion that dependency during illness and distress is a fundamental character of human life, Campbell (1994) warns that over-emphasis of autonomy stands to dehumanise health care and suppress moral agency.

A further question involves whether existential phenomenology is realistically compatible from a professional perspective. Bradshaw identifies that existentialists assert that experience is the ‘ultimate authority’ in guiding agency. For the practitioner, a focus on individual experience may lead to tensions between one’s own self-fulfilment and the collective, service orientation to others. As identified earlier, discourse can also be used for personal gain. Bradshaw (1994) points out that Bevis who propounds existentialism in her theoretical writings appears more concerned with it supporting the argument for increased nurse rather than patient autonomy.
The above application of Mezirow’s reflective principle emphasises the need for constant appraisal of practice against a framework of what constitutes moral and caring agency. The discussion, however, disregards the principle that, despite theoretical discourse, practitioners constantly refer to what is or what is not possible within the habitus (Layder 1991, Bourdieu 1990). The following data suggest that in practice the ‘truth’ and practicality of discourse is challenged. A more pragmatic approach is evident in which acquisition of knowledge does not guarantee utilisation and tacit understanding of what is appropriate for the patient is cardinal. The following scenario demonstrates the balance of discourse of existential phenomenology with the reality of practice.

(281-99) Nurse D: Erm (...) Well I suppose (...) recognising that there just isn’t always anything to say. I mean there’s just a man just now (...) who was (...) who was kind of quite restless and ermm (..) and looked quite, quite disturbed and there was something not quite right, but he wasn’t wanting to really say and it was difficult to know what to say to him really, so I, so I just sat down on the bed next to him and, and and didn’t say anything. Errm so, and, I suppose and that’s part of what I see as caring, is just being with people and that a lot of the time here there isn’t you know its either not appropriate or there just isn’t the things to say erm but, but I think (...) you just have to, you have to realise that there actually some value in you just being here and it’s how, it’s how you’re being as much as (little laugh) as what you’re saying or what you’re doing.

In the next extract, the nurse admits lack of adoption of the theoretical perspective in line the recognition that the issue is controversial and conflicts with existing personal values.

(761-73) VW: How do you feel about actually discussing deep issues with the patients, say if they feel afraid of dying and this sort of thing // do you encourage them to talk about it?

Nurse B: // Erm. We don’t not encourage it, but I wouldn’t say that I was one that made them express their feelings. I think there are some nurses
who ask more questions than others erm ... I find it, one, quite difficult anyway as an issue and two, I always think it needs to come from the patient, I don’t really think it should be prompted.

The following nurse expressed intense lack of confidence in what she perceived as palliative care skills, and is not comfortable in the role.

(180, 467-74) Nurse A: ..... they’ve (the patients) been told they’ve got cancer and a lot of people when they’re told they’ve got cancer they think they’re going, their life is limited then really don’t they? So there’s probably lots of emotional, but not everyone wants to discuss that, not everyone wants ter (.) have nurses and everyone sort of going into their deepened personal thoughts. .... I think, one of the things I sort of have to tell myself is that not everyone, no matter what job, would be good at everything and that’s one of the areas I hate dealing with this real deep emotional stuff, I don’t feel I’m very good at it and I don’t feel I ask the right questions and have the right answers.

This latter example also illustrates the potential for models of care and discourses to alienate practitioners from practice and one another if they are too rigidly implemented. They may also isolate the individual’s self. The extracts do however pose the question as to what determines which discourses are promoted and why.

In an attempt to answer this question, attention is drawn to data presented in this chapter which relates to patient empowerment, choice and respect for autonomy. These are discourses common to both settings, yet were espoused more readily and positively in the palliative care setting. While it is acknowledged that other variables such as individual motivation, may be influential, data suggest that the characteristics supporting exemplary rather than pragmatic practice include, language to enable articulation of day-to-day practice aspirations and difficulties, clinical example, empowerment and leadership and realistic staffing levels.
7.11 Summary

Interpretations of the interview data, suggest that caring as a concept is little discussed in practice and it was identified that this may be due to some extent, to the personal, pre-conscious and intimate nature of caring practice. It was suggested that this limits the role of discourse and theory and places emphasis on practice-based educational strategies. In contrast, contemporary concepts of individualised care, patient choice, autonomy and models of care were espoused with greater commitment and purpose in the palliative care setting. In this setting, there was also more reference to phenomenological and existential aspects of patients' experience. A guiding framework based on the goals of practice was advocated in order to evaluate the compatibility of changing discourse. Finally, it was argued that realistic resources and clinical leadership are pre-requisite for transforming theory and theoretical values into practice.

So far, interpretations have been based mainly on interview data and it is now necessary to present observational data to determine if practitioners' espoused meanings, values and theories were evident in the reality of practice.
Chapter Eight
Representations versus manifestations of caring

This chapter begins by addressing the difficulty in interpretation of behaviours in relation to caring agency. The purpose of a combined data generation strategies of observation and interview was meant to enhance the validity of data, in particular, to differentiate between espoused versus theory-in-use (Argyris and Schon 1974). In reality, it has to be acknowledged that practitioners, due to epistemological issues addressed in the last chapter, were perhaps unable to say all they know (Polanyi 1958). This casts doubts upon the capacity to cognize and articulate meanings and values attached to practice. Alongside this, the interpretation of behaviour / agency also presents a methodological difficulty.

Benner and Wrubel (1989) suggest that non-caring can be recognised at a glance, but it is suggested here that the same cannot be said about caring. During the study it became clear that manifestation of caring is as unique as every individual interaction and the existence of multiple, potential interpretations of actions makes it difficult, if not impossible to establish the source of motivation. In attempting to interpret behaviour, it is hard to know the extent to which, the expressivity is real, symbolic or comprises role behaviour. It is this very ambiguity that creates the greatest difficulty for this exploration of professional caring.

It is argued that the ambiguity of observed actions or dialogue, leave little hope of arriving at ‘facts’ and ‘truths,’ as attempts to specify definitive caring behaviours creates a simplistic and false portrayal. In view of the point made earlier, it is agency for which we are morally accountable, and for this reason, the above issues limit rather than disqualify exploration.

The previous chapter identified diverse meanings practitioners attach to caring. These reflect approaches practitioners adopt in their interactions and relationships with patients. Brown et al (1992) identify the following dichotomous choices; involvement versus distancing, therapeutic use of self versus self-protection and authenticity versus manipulation. Importantly, as they acknowledge, the quality of these encounters depends upon the involvement the patient chooses to enable. Alternative interpretations of observed behaviour are now discussed.
8.1 Professional and therapeutic relationships

The term the 'professional' may be defined as 'one who endeavours to have mastery of and to apply effectively that knowledge upon which his occupation is based' (Jarvis 1983:28). Jarvis notes that emphasis may be placed on proficiency rather than practice ideology. In earlier extracts, midwives control the care given, making it unnecessary to base practice on relationship-building. Indeed, the use of the term 'professional' in nursing and midwifery literature suggests little ideological focus, such as commitment to caring values. In contrast, the use of the term is associated with an instrumental concern with the rights and wrongs of practice (Brown et al 1992) and consequently, the relationship with the patient is superficial and detached. Jourard (1971:180) argues that a professional bed-side manner, which is perhaps intended to promote patient confidence, may have dual purpose and serve to protect the practitioner's self and maintain control. He argues that the professional exterior may alienate appreciation of the patient's experience, deter authentic patient disclosure and desensitise the nurse to her own experience.

Morse (1991) undertook a study utilising a grounded theory design to explore types of nurse-patient interaction from both nurse and patient perspectives. She identified four categories:- clinical, therapeutic, connected and over-involved. The study involved forty four primary interviewees and fifty nine secondary informants who validated the emerging theory. Patients' perspectives were provided by nurses who had themselves been patients rather than non-nurse patients. This therefore undermines the validity of some of the data. Morse (1991) describes the clinical, 'professional' interaction as entailing brief contact sufficient make an assessment of the patient and implement treatment performed by 'rote'. The relationship with the patient was polite, superficial and impersonal. Morse (1991) appears to reject the place of caring in nurse-patient interaction; she states, “In the emotional sense, caring has connotations of 'fondness' or 'love', neither of which may be present (or desirable) in a professional relationship” (page 467). In her discussion of therapeutic relationship, Morse (1991) also suggests that instrumental activity is prioritised over patients' concerns. The concept of therapeutic relationship may create some confusion since it could be assumed that all nursing is therapeutic. Yet Hockey (1991) identifies Florence Nightingale's concern over the debilitating effects of poor nursing technique. Admittedly, nursing was very different at that time, but it is maintained that
poor care in modern-day health services is as physically and psychologically detrimental. Consequently, therapeutic nursing is meant to imply positively assisting the patient towards health. Within this thesis, this is considered a fundamental obligation of NHS health care provision and an assumed expectation of the patient. McMahon (1991) offers a broader definition of therapeutic nursing than Morse implies in her study. He adds that therapeutic nursing is based on holism and proposes six therapeutic activities: - creation of a therapeutic environment, information giving to relieve stress and anxiety, providing comfort, application of complementary techniques and treatments with proven efficacy, in addition to the development of therapeutic nurse-patient interaction. This is based on Peplau's counselling paradigm (1952, cited in McMahon 1991) and reciprocal relationship. As will be seen, elements of this type of relationship are apparent in some practitioners' articulations in the palliative care setting.

Campbell (1984) and Bradshaw (1994) reject the idea that interpersonal responses such as listening, talking and touching can be learned as a technical skill to be applied in a predetermined manner. In chapter three, this was identified as incompatible with caring agency. Bradshaw (1994) argues that this objectifies the person and transform Buber's I-Thou relationships into I-It interactions. Jourard (1971) warns that techniques aimed at enticing patients into greater self-disclosure may become manipulative, insensitive and oppressive. From an alternative perspective, in the absence of caring, predetermined strategies may well benefit practice and are certainly preferable to non-caring behaviour.

While values underlying observed agency are difficult to determine, it may be theoretically possible to distinguish caring versus professional and therapeutic approaches. Where the approach to practice is primarily strategic and/or instrumental, the nurse-patient interaction will be linear, the practitioner being focused on completion of her goal and less receptive and responsive to the patient's cues signalling additional or alternative agency. In contrast, interaction model of communication (Argyle 1979), described in chapter four, involves receptivity, responsivity and synchrony with agency unfolding harmoniously with patient cues. Observed interactions which meet these descriptions will be presented later.
However, contextual details, such as workload, require consideration in order to exclude alternative explanations of brief, task-focused nurse-patient encounters. It is even more difficult to assess confounding interpersonal variables, such as the precise history and nature of previous nurse-patient encounters. During field work, some of this information emerged spontaneously, but it was clear, that to profile each practitioner-patient relationship, would be too disruptive and potentially alienating.

8.2 Caring Roles and symbols

There are other examples of nursing and midwifery activity such as role behaviour, which might be labelled as a representation of caring rather than being ‘real’. The stability of all social systems depends on their members to conform to certain roles (Jourard 1971). Socialisation causes individuals to develop certain dispositions by learning what emotions and behaviours are appropriate in which contexts (Burkitt 1991). On this basis, social order and being accepted as ‘normal’, relies upon the individual conforming to the expectations of others (Jourard 1971).

Goffman (1959) offers a means to analyse social life based on roles and an analogy of theatrical performance, often referred to as ‘dramaturgy’. Holmes (1992) provides examples of how Goffman’s dramaturgy can be applied to nursing. He suggests that the clinical setting can be identified as the metaphorical stage, uniforms represent costumes, the scripts and performances are equivalent to Parson’s sick role and nurses play dispassionate professionals.

Berger and Luckmann (1966) suggest that role behaviours perpetuate professional identity and also symbolise traditional, social relationship between practitioner and the patient. In addition to role behaviours, nursing and midwifery employ multiple verbal and non-verbal behaviours which symbolise caring. Firth (1973:226) suggests that the body is the first and most natural instrument of man and is used symbolically to good effect. Symbols, such as touch and eye contact, embody and transmit complex values, beliefs, attitudes to the other over and above what can be articulated (Firth 1973). Once again, this diminishes conscious awareness of meaning.
While specific details will be presented later, observation in both settings identified that nurses, midwives and other health care personnel, such as physiotherapists and doctors enact similar patterns of non-verbal behaviour. For example, facing the patient with an open posture and increasing proximity by sitting next to the patient or leaning forward were common observations. The following interview extract demonstrates predetermined approach to interaction, found in discourse on communication and counselling advocated by writers such as Burnard (1992).

(343-57) VW: ....... You said about establishing relationship. How do you go about establishing relationship ?

Midwife B: Well, good communication is always essential for good practice, I think that er, it starts by just maintaining good eye contact perhaps by sitting moderately close by to somebody and just listening, just, obviously saying 'Hi, how are you?' and just listening to what's going on. I think that you just need to have a good listening ear and be able to sort of converse pleasantly and, and you actually are on a good trail to a nice relationship erm, it's all about posture as well, it's all about good eye contact, isn't it? and just being there for them and getting the women to er trust you and er you being honest with them. I think that's just a few first things we should think about when we're starting to form relationships with women.

Berger and Luckmann (1966) note that the ability or inability to perform typified activity, socially differentiates the knowers from the non-knowers and as a result controls and legitimates the group's behaviours. The following extract in palliative care indicates the nurse's wish to conform to cultural norms as she expresses frustration with her non-verbal communication skills. This supports the argument that behaviours are socially transmitted.

(406-430) Nurse A: .... it's like yesterday, I went and sat down on a patient's bed and he was really crying and at that precise moment he didn't actually want to say what the problem was, he was just sat there
crying, he just wanted someone there, and I just sat on the edge of his bed, and, and immediately, the first thing I did was cross my arms. I thought about it ‘Oh God that looks horrible’ and so I then uncrossed them, do you know what I mean? I think how you’re doing with yourself can obviously affect them and I just think, you know, listening to them and just, touch is very important/

VW: // So how did you position yourself then?

Nurse A: .... to look at him, he was sitting on the edge of the bed, so I was sitting on the edge of the bed, I was turning to look at him and I just sort of had one of my hands on, on his hand and I was looking more at him, rather than sort of, do you know what I mean and I think that sort of, to him obviously looked I suppose, I don’t know, I think that’s just more of an approach that looks more better than someone sitting with their arms crossed and, it’s those little things isn’t it, like touch.

This perhaps supports Campbell’s (1984) and Bradshaw’s (1994) concerns about attempts to learn elements of interpersonal relationships as technique. There is also evidence of provoked emotional discomfort through trying to conform to a theoretical ideal. Clearly in this example, the nurse’s attention is on her own performance rather than the patient’s experience. This indicates that over-reliance on socially constructed notions of right and wrong can inhibit caring agency. Benner’s (1984) ‘Novice to Expert’ model, in which unfamiliarity with the task distracts attention from other factors, provides a further possible explanation.

According to Goffman, the fully socialised self acquires a number of techniques for creating a believable performance by giving the impression of sincerity (Goffman 1959). There are opposing views regarding the conscious awareness and acceptance of this process and the emotional impact on the individual (Hochschild 1983). For example, Goffman (1959) suggests that people unconsciously sustain role and hence may be distanced from meaning and emotional consequences. Holmes (1992) suggests that Goffman’s theory stresses the
artificiality of social relations and portrays a 'cynical view of human interactions'. Hochschild (1983) too is critical of Goffman's view which implies that individuals are emotionally passive and that feelings accord to the stimulus-response principle (Layder 1981) rather than on inner values. As discussed in chapter four, one view of role, is as a concept in keeping with a functionalist perspective which projects humans as oversocialised and holds that normative values override alternative individual interests and values (Layder 1981). From a perspective of power, the question was raised then regarding whose role expectations are met. If applied to contemporary nursing and midwifery discourse, role expectations depend upon the perspective held regarding the nature of optimum professional practice. That is whether this views practitioners as "techno-academic", expressive specialists in psycho-social dynamics and therapeutic relationships (May 1990) or caring. Conversely, phenomenology asserts the intentionality of persons since humans consciously interpret their world and act in it in terms of the meanings it holds for them (Layder 1981). An extract in chapter six (pages 7-8) exemplifies how the meanings embedded in practice motivate agency. There, a practitioner is determined to action personal values when these were perceived to be unmet by colleagues.

Agency depends upon a person's ability to construct or conceal emotion (Hochschild 1983) and while an individual personality may be perceived by others as 'normal', it may be compromised, if role jeopardises the integrity of personal values (Jourard 1971). Hochschild (1983) suggests that individuals can become alienated from the part of the self 'used to do the work', since in effect, they mentally detach themselves in order to follow 'feeling rules'. He refers to this process as 'surface acting'. In contrast, 'deep acting' concerns finding the means to authenticate the emotions deemed socially appropriate.

Various authors differentiate between role motivated by social conformity and authentic agency motivated by internalised values. Jarvis (1992) identifies three interpretations of authenticity and notes that is a value-laden concept. One meaning, is individualistic, self-differentiating and promotes spontaneous self-expression. Jarvis discounts Carl Roger's self-actualisation and authenticity since this implies that self-centredness is held as the ideal and argues that reciprocal relationships are the source of authenticity. Drawing mainly on Buber's work, an opposing view is presented which maintains that authenticity and self-
discovery reside in interactions and relationships which enable others to achieve personhood. Authenticity is denied when relationships are impersonal or deny the person’s individuality. This appears to suggest that authenticity has transferred from the expression of one’s own true self to enabling this in others. In this sense, authenticity is aligned to caring, since caring as relationship offering mutual growth in being and becoming is suggested by a number of authors (for example, May 1969, Mayeroff 1971, Roach 1984). This is explored in relation to interview data at the end of the following chapter. Being authentic versus authentic caring is a related issue. Bauman (1993) asserts that, it is not truly caring if this serves ourselves rather than the Other.

The discussion at the beginning of the chapter, regarding the extent to which individuals passively perpetuate role or determine practice, is also relevant. Bauman (1993) argues that where practitioners undertake expressive activity, in order conform to cultural norms, this represents undertaking a role and socially constructed actions rather than agency motivated through internalisation of caring values. Bauman therefore rejects the notion of caring role and appears to contradict his espoused view that caring is pre-cognitive and a-rational.

Bishop and Scudder (1990) and Roach (1984) identify that in contrast to role, authentic practice involves practice becoming part of the nurse’s being. Within practice, there is an integration of the mandates of practice and one’s particular way of being with Others as persons rather than patients (Bishop and Scudder 1990). The final extract in the previous chapter perhaps exemplifies the logistics of this transition (chapter 7:32). Similarly, Holmes (1992) identifies Arendt’s distinction of three human activities: labour, work and praxis. Praxis enables the individual to overcome the problem of meaningless generated by the instrumentality of labour and work by engaging in activities which are good in themselves. Praxis means confirming the humanity and uniqueness of the actor in relation to others. While role as a determinant of behaviour emphasises the force of socialisation, Layder (1981) identifies the opposite stance of existential phenomenology, which he argues, ignores social constraints on the individual’s agency.
The next piece of interview data, illustrates concealment of the nurse’s, true feelings through respect and concern for the Other.

(497-535)VW: There’s quite a lot of (...) intimate care isn’t there, bed baths and things like that (...). How do you help to maintain dignity through these intimate procedures?

Nurse F: I think the longer they’re in a hospital situation the less they worry, actually, well that’s not the same with everybody but, you know, quite often when they’ve been here for a while they’ll just throw the clothes off or I mean you see patients doing it all the time don’t you? But erm (...) I mean er (...) uh, how to put it, how do I, how do I ?, I think it’s very much through your, you know, your facial expression as much as anything and they can just tell by the way that you work and you know the look on your face. Like if you’re dressing a, I don’t know, a fungating breast lesion or something, I think they, well I know a lot of the ladies look at you very carefully to see whether you are sort of disgusted or, or horrified or whatever by the way that erm, you know, by the way that your face looks or whatever I think you have to be very careful erm to sort of guard any feelings that you might have. But then saying that, you know quite, it’s not that you get used to it but you know you have seen it before so it’s not so horrifying each time. Well it is to them because its theirs... you do have to be very careful by the way that you look and what you do and the way that you act. Just act, you know, very sympathetically and professionally really, just sort of keep a bit of a cloak over you know, if you do feel unhappy about what you see or whatever. It’s quite important for their confidence and their security really, it’s getting their trust isn’t it?

In an example in the maternity care setting, the midwife deliberately adopts a way of relating in order to control the woman’s experience of fear.
Midwife D enters the bay in response to 8C’s buzzer [*Is someone buzzing*?]

8C [*Me, my wound’s bleeding*].

Midwife D draws the curtains round, she covers the mother’s legs, starts to lift her nightie [*I’ll have a look, is that all right*?] She stands at the side of the bed and leans over the mother, angling her head to look at the mother’s face. She is gentle and moves the clothes away slowly in order to see the dressing....

Midwife D [*It really needs to be taken down and redressed*] [*We’ll change your nightie*] [*I’ll get Midwife T, she’s your midwife for the morning - all right*?].

Midwife T arrives at the bedside .... She stands half way up the bed on the mother’s left, looking at the mother’s face. While the midwife tends to the dressing, 8C looks frightened- her head is unsupported and she moves her head back, breathes out of her mouth and looks up to the ceiling from time to time. She comments on how much it has been bleeding and asks anxiously [*Has it bust open? I’m sure it’s bust open*].

Midwife T standing on the mother’s right hand side half way up the bed, speaks calmly and works slowly and gently. She angles her head as she looks at the mother and explains what she is going to do...

The mother is very anxious and as the dressing is removed, blood trickles over the mother’s thigh on to the bed....

The interaction continues for some time, the doctor is called, the husband arrives to see what is happening, the mother is upset and tearful. Later midwife T tells me that in such situations when women are so distressed, she finds it best to work deliberately calmly.

These two examples illustrate the possibility of multiple interpretations and the difficult task of deciphering caring practice. In the above extracts ‘real’ emotions are concealed and may represent insights into the patient’s experience and values of respect for the dignity of persons, putting one’s own spontaneous responses aside in the interests of the good of the Other. They may represent professional, therapeutic or caring agency and comprise
potentially symbolic actions conveying conventional, representative and metaphorical rather than authentic meaning (Firth 1973). The latter extract may indicate manipulative responses aimed at containment and denial of the mother's fear or conversely concern for the distress of the Other.

Based on the above discussion, it is argued that observation can provide descriptions of actions but cannot reveal whether these constitute role or 'lived' agency. Motives can only be known to the practitioner. Accordingly, it has to be acknowledged that the initial aim of the research to describe caring practice is almost certainly unattainable. Even so, if caring is undertaken professionally, it is argued that the difficulty in differentiating the representative from the real is insufficient grounds to deter practitioners from developing a framework for practice. Therefore, despite the above impasse and limitations of a logico-rational approach, the analysis is continued. Observed agency is presented and discussed within the context of the caring framework developed for this thesis. While validity cannot be directly addressed, the data presented will enable readers to test the interpretations and consider the proposed qualitative differences between settings for themselves.
Chapter Nine
Further observations and practitioners' explanations of practice.

This chapter begins with a brief summary of the main findings in relation to the caring framework and then continues to present the data and descriptions on which the interpretations have been based. While a single channel approach to communication was not adopted for observation as explained in the methodology chapter, initially, for ease, some of the features of observed interactions will be described in that format. Where appropriate, interview data are presented to give deeper insights into the practitioner's rationale for agency.

9.1 Summary of similarities and qualitative differences between behaviours in the two settings.

Common organisational characteristics, such as perceived busy pace of work and the need to prioritise care, were presented within chapter five, which describes the two settings. Also, some typification of non-verbal behaviour was referred to while discussing role behaviour in the previous chapter.

Factors unrelated to caring attributes accounted for some nurse and patient behavioural idiosyncrasies, such as, height and agility of practitioners. Patient conditions also influenced proximity, posture and eye contact. For example, one patient who is frequently featured in palliative care data, due to her unusually long stay, was unable to sit up straight due to mobility problems caused by her disease. As expected, women in maternity care were very different from ill or elderly ill people. They were more mobile, sat or lay on beds with legs tucked underneath them or lay more on their sides. One nurse and one midwife were pregnant, which reduced their mobility.

Observational data obtained within the two settings, reflect the differences found within interview data. For example, nurses were committed to supportive provision of choice, had knowledge of patients' biographies and individual preferences which contributed to enhanced relationship-building. Combined observational and interview data portray greater representation of caring agency, as identified within the research conceptual framework, in
the palliative care setting. There was greater focused attention on the patient, sensitivity and consideration during instrumental activity and receptivity and responsivity to patients’ needs. Even so, evidence of institutionalisation was observed in both settings. Practitioners in both settings expressed perceptions of inadequate time for care-giving and the desire to establish caring relationships. Both groups openly admitted patient preference and demonstrated emotional labour in maintaining care-giving relationships. Conflict situations between midwives and women or their partners were observed in the maternity care setting on several occasions.

9.2 Face to face ‘contact’.
Within both settings, practitioners were seen tilting their heads when looking into the patient’s face. However, the greater amount of time looking into the patient’s face in the palliative care setting was striking. This is not described as eye contact since it often occurred and was sustained even while the patient looked down or away, for example while in pain or discomfort, or eyes were closed. If nurses were working together, this was seen as a shared behaviour on several occasions. This activity appears to be utilised both symbolically, to affirm the person, and functionally to convey receptivity and willing responsivity and to detect patient cues.

(31-38) Nurses A and B administering drugs to distressed male patient D. When patient cues are intensive, that is, crying, both crouched down. Nurse A’s arm is placed on the chair with forearm touching the patient’s arm, her hand is placed on patient’s fore-arm, towards the end of the discussion. Nurse B was crouching, watching the patient’s face, head angle 90 degrees, Rare eye contact with patient who was looking straight ahead and wiping tears from eyes.

Even when the nurse was unable to do anything to help, and the patient was unresponsive, the look expressed concern and empathy. (The nurses use of touch will be referred to a little later).
A remains agitated, nurse E returns with prescription sheet and drugs. A is lying on his right side, she leans low over facing him (over cot sides), her face facing his, she strokes down over his back and the back of his hair and straightens the hair above his ears and side of head with her fingers. Refers to him by name [what's the matter?]. His hands are 'stroking air', she takes his hand and says that she has some tablets for him - can he manage them? Does he want to sit up? He remains agitated and unable to communicate. His right eye is closed and his left eye, staring, nothing seems to be registering. Nurse E looks at him, leaning low over him with her face only a few inches away form his. She gives him sips of water from a beaker and places one pill at a time gently into his mouth, helps him to wash these down with the water, She holds the beaker in one hand and his jaw in the other, he coughs and splutters once. She looks into his face for a while without doing anything. Straightens his bed clothes and leaves.

Interview data helps to elaborate the meaning given to this communication as follows:-

(213-235) Nurse E: *I think it is (...) it is an individual thing, but as long as .. as long as we maintain eye contact with them, if they choose to look at us then that's very much up to them, but at least if we, if maintain eye contact with them if they happen to catch our eyes at least they know that we're interested and that we have some concern for them (...) I think eye contact is a good way of saying it's OK you're safe erm and it's like as trust and a bond that can be built up, so if they're not making eye contact I still think it's important for us, because if they should happen to make eye contact with us because it shows that we're interested in what they've got to say erm and that we're interested in them , as people, not necessarily as patients as such.*

It can be seen that caring fundamentals such as interest and concern are spontaneously alluded to. Izard (1979) describes the face as a major source of social stimulus, as it
displays emotion and as a result motivates thought and action. The next interview abstract demonstrates how looking into the patient’s face is used functionally to guide care. This reflects the model of communication incorporated into the research conceptual framework, in which caring, responsive action is synchronous and dynamically determined by the interactant’s cues.

(442-8) Nurse B: ..... there are all sorts of non-verbal cues. Some, sometimes, erm, I think people miss them because they don’t look at the patient when they’re delivering their care. It’s all very well to go in to someone and saying I’m going to do this for you, get themselves organised and go and deliver it but if you’re not actually looking at how that patient reacts.

In the maternity setting midwives achieved good eye contact during conversation with mothers, but attention was shared between the mother, baby and hospital notes. Very rarely were women given total attention.

During observed abdominal palpations, and other care-giving activity, midwives often focused on the site of examination, and missed facial flinches and cues of well-being or conversely, distress. A possible explanation is related to the speciality and frequent intimate examinations, for example of the breasts and genitalia, of young healthy women. While it may be a strategy to reduce embarrassment for the woman / partner and the midwife, Kitzinger (1997:89) notes that, tactics to “desexualise” midwifery and obstetric intervention, “such as a lack of eye contact or the isolated focus on a woman’s genitals” during intimate examinations, depersonalise and objectify the woman. It is suggested though, that alternative strategies may be as problematic.

Argyle (1979) identifies that gaze may be mutual or involve share joint focus on an object. Whereas the baby was often the shared attention of the midwife and mother, focus on the hospital notes tended to be unilateral. Argyle’s research (1979) reveals that when a task relevant object is introduced, attention paid to the other is reduced from seventy seven to approximately six percent. In relation to the concepts of receptivity and responsivity to the
Other, this is prohibitive. The following extract is presented to portray the perceived impression that the frequent attention to hospital documentation formed a pattern of behaviour within maternity setting interactions.

(520-40) 07.58 I go into a bay to shadow Midwife M. 7C is sitting in a chair parallel to the bed, between the bed and next to the wall. Midwife M (on the same side of the bed as the mother) is stooping over the notes which are spread over the bed, checking what care is needed. Her focus travels between these and the mother. ... (interaction interrupted by care assistant asking advice) .... She returns to look at the mother’s notes, asks her if she has any problems or pain. The mother asks if she could have something for pain (rather tentatively, stating, if the midwife has time). Midwife M answers positively, looks at the prescription sheet and says that 7C hasn’t had any today, so she can fetch them now. She says she will do the daily postnatal examination later, closes the notes and puts them on the table at the foot of the bed.

The organisational structure, pressure of work and ‘turnover’ may result in the tendency to routinise and abbreviate activity in order to cope. This compares with the palliative care setting in which, reference to paperwork during patient interaction was usually restricted to the prescription sheet during the administration of controlled drugs. Interestingly, attempts were in progress for the nurses to complete notes immediately following care-giving, to discourage nurses from staying late after their shift to complete these.

The attention given by midwives to the baby was an interesting phenomenon. While with the mothers, midwives talked to the babies, admiringly stroked their faces or straightened clothing. It was almost as if the baby was the instrument of connection between the midwife and the mother. The observation may reflect the adaptive appeal of babies which contributes to their receiving attention and hence survival (Hinde 1979). Admiration of the baby may also be a means to validate the mother. Focus on the baby, as in the case of hospital notes, may also be a means to keep any interaction with the mother, superficial.
This superficiality may be associated with the tendency within institutions to routinise and generalise in order to spare effort, as mentioned while discussing the preservation of patient values in chapter seven. As argued, caring makes it necessary to consciously 'see' the Other, not only to discover individual values, but also to convey caring and fulfil moral agency. From a sociological perspective Mead (1934) suggests that self-perception and self-esteem is constructed by awareness of the impact of the self on the other. As nurse E above suggests(page 11), actively giving attention can affirm the value of the Other. Denying attention arguably has the opposite effect by conveying disinterest.

Toumishey (1989) describes the patient’s experience of hospitalisation as that of the dependent stranger, who, in need of health care, is required to rely upon strangers rather than family. Toumishey identifies how the patient enters an unfamiliar, pre-existing culture, in which the nature of the practitioners’ responses encourage conformity. Unless practitioners appreciate and take compensatory action, the patient remains a stranger and identity is never acknowledged and validated.

On a common theme, Bauman (1993) coins the term “mismeeting” which represents a similar concept to Buber’s “Vergegnung” and Goffman’s “civil inattention”. These terms are used to describe the social status of the stranger, who enters our personal space to create a situation in which there is no knowledge of the other, no rules of interaction or guarantee of outcome. The term mismeeting refers to a situation in which reciprocal politeness exists to maintain social order, while each person seeks their own goals. As a result, the ‘being’ and uniqueness of the Other remains unnoticed. There is absence of personal engagement and meeting the other as ‘face’, as described in chapter three. Levinas (1991 cited in Bauman 1993:48) attaches moral meaning to the concept of ‘face’; “Morality is the encounter with the Other as face”. This relationship is asymmetrical and concerns an unconditional being-for-the-Other. Similarly, while Buber’s (1958) caring I-Thou relationships take no account of identity, this rejects partiality and prejudice rather than the person.
9.3 Posture and proximity

In the palliative care unit, occasional use of cot sides restricted contact and nurses frequently moved obstructing furniture or equipment to one side in order to achieve closer proximity. If patients were in bed, carers went to the head of the bed and leaned over them to achieve facial contact. Often, if the patient was sitting in a chair by the side of the bed, nurses would crouch, leaning on the arm of the chair, or kneel on the floor while giving care or communicating.

There was generally less proximity achieved in the maternity care setting as midwives spoke from the end of the bed or middle of the bay, unless directly involved in examination. Equipment such as the Cardiotocograph equipment, side tables and cots were made functional, being placed between midwives and women and leaned on or used to write up notes. Babies in cots were often placed in the centre of midwives and mothers or parents. Midwives sat on the woman’s bed during discussions of well-being, and procedures. Three were seen to kneel while giving care or information. Two had more relaxed posturing, not seen in palliative care, sitting back on legs, leaning on the woman’s pillows while assisting with breast feeding.

Savage (1995) concludes in her ethnographic study of the therapeutic use of self, that in addition to strategies, such as touch and humour, nurses deliberately utilise kneeling and relaxed posturing to achieve ‘closeness and disclosure’ and to symbolise a homely environment. While Savages describes postures more relaxed than those observed in either of the two research settings, she suggests that nurses were contesting nurse stereotyping. Atypical postures contributed to the redefinition by nurses of the context of care. Savage suggests that this shaped an environment more allied to female authority rather than the traditional, doctor-led clinical area. Hence, Savage undertakes interpretation of observational data from a political perspective. Not until I attended an update on “manual handling”, required by the hospital health and safety policy, did the potential for misinterpretation of posture and proximity become evident. Due to the high incidence of nurse sickness and attrition through chronic back problems, this training encourages practitioners to adopt closer proximity and optimum position to prevent back strain. This could be an alternative interpretation of apparent unconventional postures.
9.4 Touch

The role of touch in the provision of comfort, became well established in Canada and America in the 19th century (Tutton 1991). Concern regarding the dehumanising effects of hospital admission and the adoption of holism and complementary therapy in nursing, has provoked a renewal of interest. Within the literature, the benefits of expressive or therapeutic touch have attracted a great deal of focus although more recently, a more critical approach is emerging. This perhaps explains why touch was observed less frequently in the research settings than I expected.

Tutton (1991) argues that touch is more than skin to skin contact. It is potentially therapeutic and contributes to well-being, permits the transference of feelings and energy and communicates acceptance of the person and concern. Similarly, Perry (1996) notes that nurses’ touch is an important and powerful means to communicate what words cannot convey. The following comment demonstrates the view that expressive touch is an essential part of care. While summarising her study’s findings, Perry states; ‘touch was important in the care given by exceptionally competent nurses’ who ‘used every opportunity to touch their patients in a variety of ways’ (Perry 1996:9). Similarly Bottorff and Morse (1994), in an ethological study of nurses’ interactions and types of attending, assume greater amounts of touch linearly correlate with higher levels of ‘engagement’. These authors therefore appear to assume touch to be a beneficial nursing intervention and only in one passing statement, does Tutton (1991) allude to the possibility that touch may make some patients feel uncomfortable.

In contrast to the research findings presented in this thesis, Savage (1995) found that touch was commonly utilised. In one of her research wards, touch symbolised closeness between the nurses and the patient. However, her research informants remarked that junior nurses tend to over-use touch and that more experienced nurse use it in a more discretionary way. These nurses reported that they were conscious of selectivity, but not consciously aware of how they judged the appropriateness of the use of touch. This suggests that the judgement was intuitive, tacit and responsive to patient cues.

Estabrooks and Morse 1992 define cueing as.
the process by which, through symbolic interaction with others, one determines the need for and the appropriateness of touch, and anticipates the response to, and evaluates the effect of touch. Cueing is a life-long learning process that is culturally mediated, and it has both personal and professional dimensions; it is critical to understanding the process of touch (page 452).

The following interview extract reflects Savages' findings that there is a growing cautiousness that some patients find touch uncomfortable.

(276-290) Nurse E: Well I think touch obviously comes in a lot, there erm, but touch isn't something that you can do straight away, touch is a very personal, very intimate, even touching someone's hand can be quite intimate especially if they've not been used to having a lot of physical contact... they might not actually respond positively to being touched, they might actually be threatened by being touched, erm, but touch can often be a way of providing them with security.

Davidhizar and Giger (1997) attempt to address the need to recognise that touch may be inappropriate and counter-productive. They note that while some practitioners can intuitively sense when touch may be inappropriate, it can also be learned. They advocate that it 'must occur deliberately and with careful assessment of the reaction of the patient in order to determine an approach that is most acceptable to the patient' (page 205). The authors identify various groups based on characteristics such as gender, age, culture and socio-economic group and provide such guidance as: 'Thus, the health professional who anticipates using touch with a patient from a higher socio-economic group should be alert to the possible negative reaction' (page 205).

Viewed positively, the suggested framework acknowledges individual response to touch and therefore promotes individualised care. Conversely, it provides a clear example of a proposed pre-determined response to individual condition applied in a reductionist way. It
can be argued that guidelines, protocols can enhance the patient's experience of the professional encounter, but over-reliance upon categorisation is naive and constrains the development of the art of caring spontaneity and the skill in determining patient cues which guide response.

As mentioned at the beginning of the chapter the research participants' touch appeared idiosyncratic, since it mediates expression of personality and depends upon context. For example, nurses E and BNB were more tactile, utilising gentle rubbing or small circular movements on patients' hands, legs and shoulders. Generally, touch was used to signal departure and applied more when the patient was distressed, or confused. This supports Estabrooks' and Morse's view that when a patient is unable to cue, nurses assume that touch is appropriate (1992). The extract which describes nurse E's care of a confused patient (page 9-3), illustrates how, in cases of intense patient dependency or inability to respond, patients are given, perhaps unthinkingly, an almost child-like status.

In contrast, it may be the well and independent status of most women in the maternity setting may be the reason why, expressive touch, except in the case of babies, was rarely seen.

9.5 Personal ways of caring
As conceptualised in chapter three, since each caring relationship is reciprocally responsive, caring manifests in unpredictable and unique ways. Throughout the extracts presented in these four chapters, practitioners' personal ways of being towards the Other are evident, both in what they say and do. For example, in the maternity setting, there were midwives who focus on caring relationship and others for whom the prioritisation of problem-solving represent caring. Another midwife cares by resisting the temptation to take over from the mother and instead stands back to supportively watch. As proposed by Savage (1995) and Estabrooks and Morse (1992) above, ways of developing relationship are grown into, as the following extract shows.
VW: I noticed when I was following you around that day in the antenatal bay erm, how you position yourself. Do you think plays in establishing interaction.

Midwife H: I'm not sure, I do it everyday.

VW: Well let's say, from non-verbal communication point of view, how you might perhaps enhance your interaction with people?

Midwife H: Just, I don't know, I smile at them erm, I give, you know, I sit on the bed or sit next to them or erm .. you know, rather than standing up over them I try and get eye contact, you know.

VW: Are you conscious of doing those things?

Midwife H: Erm, no I'm not actually anymore.

VW: You say anymore?

Midwife H: I suppose that .. initially it was, I found that I got a better response when I did do that so I started doing it more often and now I just do it all the time.

VW: So you remember the transition almost do you ?

Midwife H: I don't remember it, I'm just aware of it, it's a vague recollection of thinking, well this works and this seems better and sort of, but I don't remember when I went from thinking, this is better and then doing it all the time, I can't say it was three years ago last October. Erm, I can vaguely remember.
Even so, it appears difficult to differentiate between practical knowledge and a sensation of achieving role.

Similarly, in the palliative care, there were caring actions which come to comprise the nurse's personality, while other caring strategies remained latent and only elicited when needed. I noticed nurses who exude selflessness, were thorough and kind, relaxed, affectionate, daughter-like, bustley and jokey. Another was more serious, adopting a more critical, theoretical approach to practice aimed to bring about the best for the patients. There was the nurse whose smiling face and gentle ways epitomise caring and affection. Caring adopts a multitude of faces and disguises.

9.6 Instrumental activity
Literature on nurse-patient interaction and relationship have identified that contact is often initiated as a result of routine care-giving (Kelly and May 1982) and this was observed in the two settings. In both sets of interview data, practitioners espoused the intention to meet patients' / women's physical and emotional needs. The main opportunity to identify additional needs were identified during routine activity.

The main component of instrumental activity differed between the settings. In palliative care, agency involved 'doing for' and 'doing to'. Nurses assisted the patient with things they would have once done for themselves or independently, such as washing or mobilising ('doing for'). In addition, there were treatments, such as dressings to pressure areas and injections ('doing to'). Nurses often conscientiously persevered to ensure that patients had all their needs met and were comfortable. On occasion, this required immense patience as it took some time to achieve.

Since women in the maternity setting were usually able to meet their own living needs, the focus of interaction was on 'doing to' and usually involved the monitoring maternal health. Other activities included removal of wound sutures, dressings and injections.

While instrumental touch is very much a part of nursing and midwifery practice, it may embody concern for the other or merely portray routine task. In the study outlined earlier,
Perry (1996) presents an extract of observational data which describes how one of the nurses touched during the procedure of examining an intravenous site; ‘...he did so gently, not rushing to pull up the patient’s sleeve....’ Perry interprets the manner in which it was undertaken as communicating concern and respect for the patient. The following two excerpts of observational data, contrast touch and synchrony between the two settings. The first describes an observed scene in which there was lack of sensitivity, concern, synchrony and responsivity to signs of distress.

(1293-1310) Midwife L returns with a tray of tape and cotton wool for the removal of the Intravenous canula and to give a suppository for analgesia. She explains that the analgesia will be given rectally and says that it is often very effective given that way. The mother moves slowly up the bed. One leg remains tucked under the opposite thigh. Midwife L [You’ve sort of got that caught haven’t you] laughs and takes hold of 7F’s ankle (fairly gently) and helps her to untangle it. The mother screws her face up as she moves. Midwife L is on the mother’s left hand side, leaning forwards over the mother’s arm not saying anything. Without warning, she starts to remove the elastoplast which is securing the canula in the left wrist. The mother screws up her face. The midwife makes no response to this, either to look at her or to talk. She starts to talk about the mother’s delivery [You went to theatre, did you have a spinal or GA?]. The mother replies. Once all the tape is removed and canula out, a pressure dressing is applied.

Midwife L then says that she wishes to examine the mother’s breasts and immediately begins to undo a button on the mother’s pyjama top and attempts to pull it this open. The button above is still done up, so this is unsuccessful. The mother then undoes this. Midwife L asks how the baby is latching on the breast as she looks at these. The shirt is then closed. [Can I just feel your tummy? Can you just slip down the bed- (laughingly) now you’ve got up there]. As the mother moves she screws up her face. Midwife L palpates the abdomen and says [I think a lot of that is bladder] the mother says that she hasn’t been able to pass urine....
While for the ultimate benefit of the woman, examinations were performed in quick succession, task-orientated and practitioner rather than woman-centred. As time in fieldwork elapsed, there was a growing sense of midwives' denial of childbirth intervention. This may reflect current discourse which emphasises childbirth as a physiological event and aims to decentralise the medical model, legitimated and officially sanctioned by the Changing Childbirth Report (DoH 1993b). This perspective, while not personally rejected, has perhaps clouded midwives' empathetic insights into the reality of women's experiences. This perhaps also explains why caesarean section, which accounts for approximately twenty percent of births in the research unit, has achieved such taken-for-grantedness (for the midwives possibly, but not necessarily for the women), which was suggested by all the generated data.

In the palliative care setting, there were instances when care-giving caused discomfort. On one occasion, a nurse took insufficient time to apply a wrist splint and at two other times, lack of co-ordination between two nurses resulted in an awkward lift. Newly appointed nurses, unfamiliar with patients and equipment used to move them, caused patient anxiety and discomfort. These situations clearly demonstrate that caring necessitates not only a concerned attitude but also, instrumental skill and practical knowledge. Generally however, care-giving in the palliative care was gentle, synchronous, skilled and centred on the patient.

(1113) D was a 56 year old man with cancer of the prostate gland and metastases. He had been in the unit frequently for pain management. NNB helps D out for breakfast. She moves slowly, speaks very gently. She stands to the side of him while he swings his legs over the side of the bed give him plenty of time, she brings the chair closer to him again gives him plenty of time to move into the chair. She is very gentle and makes encouraging sounds through out saying [Well done, you're doing well this morning]. He asks if he can have a pillow behind him, which she gets for him and asks if he wants it lengthways and places it behind him. She leans over him looks into his face although he is looking down, he has his hand up to his head, his head is bowed. She asks him if there is anything else she can get him while she is there. He shakes his head. She says that she's
going to tidy round for him. She gives him my information sheet and places his glasses on the side table within his reach. She says she's going to put the main light on soon and to read the sheet in his own time. She gets his dressing gown out of the wardrobe. She gently places her hand on the top of his right hand and spends a few more minutes tidying round before leaving.

9.7 Receptivity and responsivity
As extracts of interview data in the previous chapter portray, nurses in the palliative care setting were protective of the patient's self-esteem and were careful to eliminate a patient's sense of burdenhood. These intentions rely heavily on being in touch with the patient's experience. Leave-delaying tactics, such as those just described, were often observed and interpreted as achieving caring principles. These include, being there for the patient that is, providing presence and the willingness to be of service, giving opportunity for the patient to express fears, which may be suppressed if interactions are brief and instrumental and increasing the nurse's opportunity to gain insight to the patient's experience. The following extract describes how a nurse interrupts routine task in response to patient cues of distress.

(1137-46) Nurse E comes in serving breakfasts notices D sitting in chair with hand on head, [Have you got a lot of pain?]. D mumbles. The nurse goes out and quickly returns and reassures him that staff are doing his tablets [It won't take many minutes to count them out]. She crouches down and puts her hand on his hand resting her elbow on the chair arm, and looks into his face. She gets up and carries on with breakfasts (drugs arrive via nurses B and D about five minutes later).

If patients felt sick or anxious, nurses sat and spent time with them, until their equilibrium was regained. This receptivity and responsivity was common-place in the palliative care setting with occasional exceptions. For example, nurses appeared to become habituated to noises associated with certain patients' illness, such as laboured breathing and moaning. When lengthy care-giving had just been completed and patient comfort was unexpectedly
very short lived, response was delayed. To some extent, this appeared to occur through necessity, since other patients required attention and care.

In the maternity care setting midwives missed opportunities to express concern and to offer support.

(111-7) 07.40 A woman (from day room, who is having Caesarean section today) comes to the midwives' station and says to midwife H, who is doing paperwork [Have I got to take my iron tablet this morning?]. The midwife says that she'll need other things because of the Caesarean section and that drugs would be done at 8am. There was no attempt to ask her how she was feeling or acknowledgement of what lay ahead. The woman backed and turned away from the station desk and walked up corridor to antenatal bay.

Kirkham's (1989) exploration of midwives' communication identifies midwives' strategies to punctuate women's expression of anxiety and desire for information. The next extract is a further brief example which suggests a midwife's lack of insight and willingness to engage with the woman.

(4863-8) A mother who has been on the ward antenatally, had pre-eclampsia and required an emergency caesarean section. Baby is on NICU comes to visit someone on the ward. She knows Midwife D (sitting at the midwives station) who cared for her when she was poorly. The mother expresses surprise regarding how quickly everything had happened. Midwife D says briefly and cheerfully, [That's how it is sometimes]. She continues to write her notes.

On occasions, individual midwives failed to follow-up information the women gave them, such as abdominal pain and dysuria which could indicate problems. In one case, the response observed was a check to see if the mother had Paracetamol at home.
Helpful behaviours and anticipation of patients' needs varied across the settings. As an example, during drug administration, nurses in the palliative care always ensured that patients had a drink to accompany this. In the maternity care setting, the independent status of mothers made this unnecessary on most occasions. There were occasions when midwives were observed helping mothers with drinks, such as women who were hospitalised with conditions requiring attention to fluid intake, such as persistent nausea and vomiting. But again, need was not always anticipated as the following extract illustrates.

Midwife M gets the requested analgesics for 7C from the drug trolley in the clinical room behind the midwives' station and returns. She hands these to the mother in a pot and signs the prescription sheet. Midwife M [All right then?] The mother shifts in her chair and glances to the bedside table on the other side of the bed. Midwife M doesn’t offer to give her any water for the tablets and after she leaves to see the mother opposite. 7C gets up from the chair to get this. 7C is two days following a caesarean section and postpartum haemorrhage.

Discussions with women identified that midwives successfully achieved a non-interventionist approach which women appreciated. Four of the twelve women interviewed, alluded positively to the non-intrusive and supportive nature of the care, particularly during labour, where midwives guided rather than told the women what to do. Three women expressed anxiety about their knowledge-base and skill in baby care and were relieved when midwives were non-judgmental. Conversely, the emphasis on childbirth as a physiological process, may, in addition to challenging the medical model, eradicate spontaneous helping behaviour and concern in the face of need for medical and nursing intervention. At times, the apparent rejection of nursing activity, discouragement of the sick role and medical model resulted in loss of quality interaction, insensitivity to women’s experiences, lack of receptivity and responsivity to cues signalling the need for physical and psychosocial support and an unwillingness to be of service. ‘Throwing the baby out with the bath water’, may be a fitting metaphor! During a conversation with one of the mothers, an awareness of the lack of receptivity to women’s experience is evident.
I have a chat with 8C she is six days after a caesarean section, which was followed by a pulmonary embolism. I ask her about how things were in labour. She tells me that her labour lasted 23 hours which also happened with a previous labour; the cervix dilated to 6 centimetres and then stopped. She said that she didn’t remember anything then until she came round from the general anaesthetic. I explored her perception of her care a little more. She told me, [*I don’t think they realise that I am in as much pain as I am. I’m frit, I’m frit to move around, they don’t realise*].

While personal observations suggested a lack of insight into the experience of women following caesarean section during the day, the mother ‘8C’ above, mentions a contrast between day and night staff.

8C says that the past two nights have been bad (midwives unhelpful). I ask her a little later who she sees during the night. She comments about the auxiliaries; [*They’ll do anything for you. They are very good, they’ll take the baby, do anything. It’s the one’s in the blue uniforms, they have a lot to do I suppose. They treat you as though you’ve had a normal delivery, rather than a caesarean. They expect you to do as much*].

In both settings there was evidence that care-giving was less sensitive during the night. In the palliative care setting, a female patient complained about being hoisted in to bed without the screens being pulled round. She commented that the patient opposite would have been able to see everything and she felt embarrassed. Later in the day, the patient opposite told me what had happened and that she felt embarrassed for the other patient. Patients also said that they felt disinclined to call the night staff, for fear of disturbing them.

9.8 Privacy

Interview data evidence the espoused value of preservation of privacy and dignity in both settings. Lawler (1991) maintains that privacy is a fundamental principle in nursing practice, being preserved to avoid embarrassment and to maintain personhood. Such agency implicitly concerns an understanding of the distinction between private and public.
Apart from the situation just described, privacy appeared central to palliative care nursing practice.

There was a different perspective in the maternity care setting. One observation involved a midwife undertaking a postnatal examination of a mother which included discussion of the extremely delicate issue of vaginal scarring from a previous birth, subsequent sexual dysfunction and postnatal depression. Screens were not completely closed and a paediatrician undertook an examination of the baby during the mother-midwife interaction. There was no advocacy, in terms of obtaining privacy for the woman, arguably due to lack of empathetic appreciation, and no apparent validation of the mother's traumatised experience.

Clinical procedures were undertaken in public places. For example, an intravenous canula was removed at the midwives' station with the antenatal woman standing. Another midwife took blood from a mother in full sight of other women in the bay. This relaxed approach to clinical procedures may have a variety of possible explanations, although it may just reflect the busy environment and taken-for-grantedness of routines and lack of insight into the impact on the women. Since the 1980s there has been attention drawn to the under-utilisation of midwifery skills (Maternity Services Liaison Committee 1982, Royal College Of Midwives 1984, Association of Radical Midwives 1984). Public performances of clinical procedures and authoritative information-giving, described later in this chapter, could be interpreted as intentions by midwives to promote their role.

Additionally, there has been a change in status from private to public and vice versa of some childbirth-related activities in recent years. In the absence of clearly identified practice values, this may have created confusion. For example, birth has become a public event with friends, birth partners and family members being present. What was once an event shared by the woman and midwife, later to be joined by the father in the 1970s, is now shared with a great number of others, including more and more often, the obstetrician. It may be possible that, because the woman has given up her private space during childbirth, this is extended to other activities.
Conversely, breast feeding which was the traditional means to feed the baby, has become socially inhibited (Royal College of Midwives 1989) which is perhaps, in part, due to current sex symbolisation of women's breasts. Screens were often drawn around the bedside and when asked why this occurred, midwives explained that due to the continuous presence of other women's partners on the ward, it afforded privacy while breast feeding.

9.9 Response to requests for help

One of the major differences between the settings was the staff's responsiveness when patients / women used their call bells to request help. In palliative care patients' calls, which occurred on regular basis were responded to almost immediately. There was only one occasion observed when a nursing assistant appeared a little frustrated at a patient's constant demands for attention. The interaction was none-the-less, respectful.

In maternity setting, call bells were infrequently used, since most women were ambulant and when admitted to the ward were socialised to seek attention at the station as mentioned in an earlier section. Even so, when women used call-bells, most responses were reluctant. Midwives were observed sitting at the station chatting to one another and often failed to acknowledge women passing by. Conversations covered topics such as holidays, wedding plans and moving house. Women were sometimes left waiting at the station for some time as midwives finished conversations or as on one occasion, finished looking at wedding photographs.

The following mother was delighted at her excellent childbirth experience only to be disappointed on the postnatal ward. The data suggest that the problem with standards of care of women following delivery (Ball 1994) which resulted in postnatal care being described as the Cinderella of the maternity services (House of Commons 1980) continues.

(5232) The mother said that she had come to the ward at about 6 p.m. and had been expected to just get on with things. This was difficult because it is her first baby and she had no knowledge of feeding, changing the nappy or anything. On one occasion she had gone to the midwives' station to ask about completing the baby's feed sheet. The midwives had been chatting
amongst themselves, one had answered her abruptly and then continued to talk to the other midwives. The mother said that she wasn’t expecting one-to-one care but she had expected more support.

Mothers perceived midwives had restricted time for care-giving. During a conversation with a mother, she noted that the midwives could be very busy with some mothers who required a lot of attention but said [I was very lucky because I didn’t really need much]. The mother’s comment illustrates the finding that, while patients were concerned with their own state of health, they were also demonstrated caring towards other patients who needed more attention than themselves.

A mother told me that she had been told off by a midwife for leaving the baby on her bed. The midwife had walked off without giving the woman the opportunity to explain that she had taken the baby’s safety into consideration. Another couple said that they were reprimanded for their care of the baby’s umbilical cord, when they had not been aware of what they should do.

These reports and observations suggest a lack of friendship, empathy and validation of women as individuals. Hochschild (1983:167) refers to ‘shadow labour’, a term coined by Ivan Illich to describe emotional work or ‘niceness’, which enhances the status and well-being of others. This work involves ‘small and large gestures’ which convey support for the well-being and status of others, facilitates social interactions and encompasses the moral and spiritual sense of putting others above the self.

In the face of being unable to fulfil one’s caring encounters with women due to the rapid turnover and heavy work load, the midwives may have been engaging in distancing behaviours concerned with self-preservation mentioned by Hochschild (1983:186). This results in a dimming or numbing of inner signals and the loss of access to feelings and the capacity to interpret clearly the Other’s experience and caring context. According to one current nursing discourse, this is the very faculty on which caring and expert practice depends (Benner et al 1996). One challenge for practice development and education is how the values which sensitise the perception are revitalised.
9.10 Institutionalisation

Goffman (1968) has referred to the deliberate aim of institutions to bring about desired manipulations of an individual's identity. By the strict regulation of all aspects of life, the 'inmate' is deprived of his or her self-image in exchange for one more convenient for institution. Goffman calls this process, 'institutionalisation'. This indicates an organisational ethos in which there is disregard for the values and experience of the individual, which are cast aside by the dehumanising routine and ritual. Situations which could be interpreted as representing this phenomenon occurred in both settings. In the palliative care setting, this rarely involved permanent qualified staff and mainly involved nursing-care assistants. As referred to in chapter five, the need to address professional caring principles within the preparation and continued development of nursing assistants appears to be overlooked.

(2390-2509) Two nurse-care assistants, NAA and NAB enter the bay where beds are to be made and female patients need assistance with morning hygiene. NAB puts the main light on with no negotiation. NAA knows that a patient has made a request for these lights to be switched off - she looks at me. NAB picks up that there might be a problem [Is that all right ?]. NAB looks at A, A says that she doesn't want the light on. NAB says to leave them on while the wash is being done.

NAB goes behind the curtains to D (A 74 year old lady who dies five weeks later) [Shall we give you a wash? Are you going to sit in a chair afterwards?] [What are you going to put on?] Responses are mumbled. The patient identifies what she wants to put on after her wash. NAB [You don't want a clean one on, OK, fine]. NAA fetches bowl of water. NAB [Let's put a fresh nightie on, because you've slept in that haven't you?]

D-[OK then]

NAB [Do you want to sit and wash yourself or do you want us to do it?]. [we'll do the bits you can't reach]

9-22
D- [You'll give me a towel won't you?]

NAB leaves her to get on with her wash and goes to make C's bed (a 78 year old lady who dies three weeks later)

NAA and NAB make C's bed, NAB is very cheerful and jokey - talks quickly to husband, comments on C's earphones, and when she finds this is a hearing aid she says [I thought you were wired up for sound- having your own little head banging session in the corner]. NAB encourages C's husband to go for a drink out of the way, NAB and NAA talk quietly while doing the bed about domestic things.

They return after a while to D - NAA says to me [She's fallen asleep while having a wash]

NAA to D [Are you tired?] [Let me wash your back for you] [Can you just lean forwards?]

NAB talks about what NAA can make for tea - pasta/pie [How does that grab you?]

NAB to D [It's tender is it?]

D [There's a red sore there]

NVQB [Have you washed under your arms- have you any deodorant or do you put talc on?]. Patient indicates she has. [Oh, all right]

NAA is called out, returns to check if NVQB can manage alone

NAB asks D if she can stand up with frame for a while for her to wash her bottom- [Doesn't matter if you can't, I'll get round another way].

D says how hot she is.

NAB [My mum used to say that while she was in hospital]

NAB to D [Have you got some slippers?] [Oh, you have those little blue things don't you, oh, there they are] [We've got to find your frame]

D [Be careful because I've got a sore]

NAB [I know, I know]. [which chair do you sit in, is it the recliner? I'll put it nearer]. NAB comes out from behind curtains, she talks to me about the flowers on the window cill.

D says she wants the chair facing out of the window.

9-23
NAB returns to finish D's wash behind the curtains.

[I'm just going to get some wipes rather than use your flannel]

NNA wants to borrow her

NAB says to D [Are you all right for a few minutes, I'm just needed, won't be long]

She soon returns.

NAB to D [Shall we get you out then? You've sort of literally got your knickers in a twist haven't you?]

D- [Be careful]

NAB [No I'm not pulling you- in your own time] [I'm just going to give you a little wash now] [OK, are you all right. Excuse me for washing round here, when you've been in bed all night you do tend to sweat a bit]

[As my mother said- cleanliness is next to godliness- I don't know what it meant but it sounds good]. [You've got a bit of a red bottom]

D- [I hadn't yesterday]

[Well you have today. You'll have to get up and about a bit. I'll put a dressing on, that will protect it].

D [I have been rather a long time without much exercise].

NAB [Try not to sit on the same spot all the time]. D-agrees.

NAB [Hang on then, you can sit on the bed again and we'll put on your knickers on -right?]

D- [Thank you]

[Lift your feet up for me, wonderful]

NAB says that she'll put D's knickers and nightie in the laundry and guaranties they will be back before tea time.

[Now stand up my love- that's it. Now if I pull the curtain back- get a bit of daylight.

NAB [Do you like your chair like that?]

D- [Facing out of the window a bit more]

NAB [All right?]

D- [A bit more]
NAB [Do you want the window closed?]
[No, don't, I'll have to have the fan on again]
D feels cold - [I see what you mean about the window]
NAB [Do you want your neck pillow?]
D [I'll probably need more than that]
D spends quite a while deciding if a small cushion is better. Then has a large pillow put behind back. D tries this and asks for it to be lifted higher. She tries it again, and requests again for it to be lifted. NAB [Higher?] and raises it.
D [Are you going to close that window?] [She'll get round to give me my dinner all right will she?]
NAB puts a knee tray on D's lap
D- [Excuse me, before you go, I'll need an alarm]

While the nurse care assistant directs the care-giving and some comments give the patients inferior status, the patients showed no negative responses and hygiene and comfort needs appeared to be met. During interviews staff indicated that a variety of strategies, such as humour, were employed to maintain patient dignity while undertaking intimate care and these interactions are therefore difficult to interpret.

In the palliative care setting, patients were encouraged to maintain normal routine for as long as possible. However, in the following extract the nurse assumes that a very independent female patient would use a beaker for her drink of tea.

08.25 Staff nurse NNA with breakfasts to DD [do you want some breakfast sweetheart? what would you like poppet?] She asks the patient about sugar on porridge, hot or cold milk. Sorts the side table to enable patient to get the food [You'll need some help with this]
DD- [No, I'll be able to manage]
NNA- [Are you sure?]
DD- [Yes]
NNA-[Do you have your tea in a beaker?]
DD- [No in a cup please] She must pick up surprise from the nurse and D apologises [Sorry].

NNA [I’ll come back and see how you’re getting on, all right ?]

While nurses and midwives (including assistants) usually used patients’ Christian names, pet names such as ‘my sweet’, ‘poppet’, ‘darlin’, ‘good girl’, which may reduce the dignity of patients, were sometimes heard. These names were more likely to be used with helpless, semi-conscious and frail patients.

(2357-67) MCD comes in response to A’s buzzer (A is a 76 year old female patient with chronic lung disease. She dies about a week later) [Are you all right A ? Are you cold ?] [I’m going to get something to put over your shoulders. Let’s put your lovely cardigan on], [Is that better A ?]

A [Thank you].

MCD [That’s all right my sweet, you don’t want to sit there and be cold].

And

(2369-80) MCD in response to A’s next call [Are you ready to get back into bed now ?].

A [Shall I have a new pad ?]

MCD [Yes, certainly].

MCD [Well done, well done, good girl]. [You’ll need two of us to get you back to bed].

Comes back with BNB

MCD [OK, here we are] [Can you lift your bottom up for us- Oh you are good]

BNB [Do you want to sit more upright ?]

MCD [I’ll come back and give you a wash darlin, OK?] [I’ll give you a minute or two to get your breath]

A [You take your time there’s no rush]

MCD [I’ll give you a few minutes to get your breath back]
In the maternity care setting, only one midwife was heard, with light hearted subservience, to call women ‘madame’ or rarely ‘Honey’ which appeared to add empathy. Use of the terms appeared to be a part of her personality and means to build a friendly rapport with women. While being exposed personally to discourse that terms of endearment are patronising, this latter example emphasised to me, the unique nature of individual practice and relationship building.

9.11 Building relationship

Relationship and ‘being with’ are fundamental to caring for others (Jarvis 1996, Bauman 1993). Bauman (1993) also asserts that caring is without pre-determined purpose and is an end in itself. It is acknowledged that in the context of professional caring, caring relationship, in addition to being a moral imperative, may be regarded as functional or instrumental.

Research data identified that in most cases, contact and relationship building appeared to be purposeful in both settings. For example, it was a means to identify needs, rather than naturally arising or as an end in itself. Within the conceptualisation of caring in chapter three, it was identified that professional caring has relative aspects because of the experience of illness and NHS obligations. Rawnsley (1990) has used the expression ‘instrumental friendship’ as a metaphor to characterise caring relative to the professional nursing context and to some extent this encompasses the interpretations of the observational data. Time restriction may account for the apparent routinisation and superficiality and be justified on the premise that the experience of illness and / or hospitalisation is central to the patient’s concern (Halldorsdottir 1997).

Although the term ‘building relationship’ is used frequently within nursing and midwifery literature, there are few details of the practical ways in which this is achieved. A central necessity for relationship is spending time or ‘being with’ patients and it was anticipated that the reduced time available for midwives to spend with women, due to work load, would detrimentally affect their relationships. Observational data indicated that this was the case, yet tacitly, neither time spent with patients or ‘closeness’ appeared to be the differentiating feature. On exploration of the data, the main qualitative difference was the
practitioner's expression of interest in the patient as a person and their experience, using silences to listen and demonstrating knowledge, however simple, of the Other.

Two midwives voiced intentions to spend time with women to enhance the opportunity to receive and respond to women's anxieties. While in the first extract the midwife intends to give the woman opportunity to express any anxieties, it is suggested that the norm of giving information rather than listening, is implied.

(363-389) Midwife D: I think, it's just, I try and find a time where I haven't gone to see this woman to do something to her I've just gone to see how she's doing, which is not easy, but on shift like today, when it's so quiet, I should, hopefully be able to do it, but erm, because sometimes, they are so quiet, but if you start them talking about how you know, if they want to talk about how their labour went, they might have, they might have a lot of things that they want to talk about, things they don't understand what, what happened, that want clarifying. I'm thinking of postnatal mainly but erm, I try to do that if I can, it's not easy especially if it's like, say, one of these women that's not really interested. I mean some women, if you went and sat down and said you know, do you want to talk about your labour, that's an invasion of privacy to some women. The majority here, they're a pretty chatty bunch, you know, especially at the moment.

VW: So some people you just get a blank response/

Midwife D: Yeah, my lady in 6E, my little Chinese lady, when I do her traces, that's, I'm doing something physical, that the medical staff require me to do, twice daily at least half hour traces of her twins, and it requires, well it doesn't really require me to stay with her constantly to hold them on, but I always do when I do her traces? with other people I wouldn't necessarily do that but she is so quiet and she never talks to anybody and I sit with her when I do these traces and try to get her talking, but it's not easy.
This situation was explored with the midwife to identify why the mother was so non-participatory. It was not a language problem, since the mother was quite conversant with her English husband when he visited. It could be speculated that the expectation or acquired perception of the patient role as submissive and powerless is a causative factor.

A good example of an activity with embedded values and attitudes and used symbolically is provided by Midwife T who likes to ‘plonk herself down’ to build relationship with women. Notably, this midwife also conveyed her willingness to be available at the end of interactions (chapter 6:6).

(132-151) VW: Do you sit down first or is it something about them that you think, I need to spend some a bit of time with them?

Midwife T: Erm, I try to plonk myself down on the bed fairly automatically because I think it gives them less of a them and us situation, you know. If I'm standing there in my little nurses’ uniform with my stethoscope round my neck I am then the midwife, who, they hopefully respect and they know is doing their job, but erm (......) it's the midwife, and is there to help them, but maybe they don't think is there to chat to them, whereas, if you plonk yourself down on the bed, you're almost making a statement, ‘Look, lets’, you know, ‘Let’s have a chat’, may be. Having said that, I also think (laugh) sometimes when I’m busy, I know this in the back of my mind and I actually stay standing (takes breath in), you know, ‘OK temperature’s fine, pulse is fine, your blood pressures is fine, oh that tummy’s going down nicely, every thing fine then?’ because, I am aware that time is constrained and I’ve got to get on to the next lady and er, and err, I think she hasn't got any problems, but you know, er.. you miss problem, I think you do miss problems, of course you do.

VW: So your ideal is to sit and.

9-29
Midwife T: //Yeah, my ideal would be to sit every time, you perhaps do the obs. standing up and then plonk myself down, check their tummy, check their rear end and make myself available to talk, that's my ideal, but that's not necessarily always what happens.

VW: What, can you describe what your aims are, say when you do sit down and plonk yourself down on the bed, what are you hoping to achieve by that part of the interaction?

Midwife T: I think that, that you are achieving interaction as opposed to you're just caring erm... that you're actually, you're sitting down and you're saying 'I care, is there anything I need to care especially about' erm 'is there anything that worries you, I've got time', I'm saying that I've got time by sitting down, even if I haven't (laugh). Erm, I'm actually sort of sitting down and I'm saying 'Look, you know, I'm not just doing this as a job (laugh), erm, I'm here because I care and if you've got a worry that's what I'm here for'. I mean I sort of trot round saying 'that's what I'm here for'. Erm, because that is what I am there for, difficult though it may be at times and it is (...) erm (...) and it is difficult to balance one patient's needs with another, it is and that's one of the challenges, I think, because, erm we've all got ideals and we all know that those ideals slip.

Both of these extracts add to the views conveyed during interviews and noted in chapter seven, that intentions to provide comprehensive, individualised care are problematic and unrealisable. Midwife D remarks that women may be unresponsive and disinterested, while midwife T identifies lack of opportunity. As interpretation of the data progressed, there was a growing sense of midwives' perceived helplessness in achieving personal and professional ideals.

While nurses perceived similar constraints of time limitation and the need to balance prioritisation with distributive justice, nurse B's response below suggests that specific
factors which consume time are identified and goals of practice are rationalised and prioritised.

(285-309) VW: How do you enhance or increase the opportunity just to be with people (.) is there any strategy for that?

Nurse B: Personally, I try and avoid erm, answering the telephone and writing notes because I find I benefit and I hope the patients benefit more from time spent together with the opportunity to interact if that's what the patient wants. Erm, it's not always possible, I mean if you're co-ordinating the shift sometimes, I find it frustrating that patient contact as far as I'm concerned isn't enough, it's something that has to er, sometimes take second place to running the shift and making sure that the care is delivered over all as opposed to a one-to-one but any time I am given the opportunity or if someone specifically says I've got pain or something, If I've got the you know, the time to go and see that patient, obviously I utilise that time as best I can. Erm and that's why I sometimes I find I'm writing notes in my own time at the end of the shift because I'd rather be interacting with the patients than not being by the bedside or available to them or their families while they're here.

Midwives spent much of their time at the station on the telephone or dealing with hospital notes. This confirms Fielding’s and Llewelyn’s (1987) view that administration tasks are given priority over interaction with patients and may provide a way of avoiding involvement with patients (Campbell 1984). However, this work space may offer peer contact, protection, privacy and control within a stressful, disempowering work environment. Midwives appeared to approach practice at the level of getting through the work compared with nurses in the palliative care setting who appeared to be actively working towards their vision of relationship and practice. Arguably, nurses gain their energies and motivation through their relationship with patients. While there has been emphasis on the emotional labour of building and sustaining relationship as a cause of potential burnout and professional dysfunction (Smith 1992, Hochschild 1983, Jourard
Ramos (1992) analyses sixty seven critical incidents in which clinicians reported their closest personal relationships. Participants were recruited from medical-surgical settings excluding paediatric, psychiatric and obstetric practice where ‘specialised bonds’ may bias findings. The findings are therefore extrapolated with caution. Three categories of relationship are described; level one comprises an instrumental level mirroring the ‘professional’ relationship outlined in the beginning of chapter eight. Notably, one participant reported that she felt able to disguise the superficiality of the interaction. Level two included a balance of emotional and cognitive involvement in which nurses noted an ‘active psychological process’ (page 502) aimed at gaining insight into the patient’s experience in addition to physical needs. This was therefore purposeful as information was used to enhance nursing care. Level three involved emotional and cognitive identification with the patient and achieving what participants called ‘understanding’ with ‘emotional bracketing’. Within these relationships nurses felt that they were able to provide optimum care and noticeably nurses reported that these relationships were effortless, rewarding and motivating. While perhaps portraying a behavioural perspective, it may be that the satisfaction gained from deeper relationships with patients may result in the desire to perpetuate such agency.

In addition to organisation of the workload, there was further evidence of a commitment to relationship-building in the palliative care setting. Moreover, the espoused values and meanings articulated during interviews were embedded in much of the day-to-day practice. As mentioned earlier, Wittgenstein (1953) holds that words find meaning in use and observational data support the notion of a reciprocal relationship between discourse and practice. Concepts identified within theoretical models can become lived and in consequence, legitimated and perpetuated. In the palliative care setting, the unit’s theoretical frameworks appeared to be becoming realised.

In keeping with existential phenomenology, nurses actively pursued the intention to gain insight into the patient’s experience by constantly asking patients about their perceptions of
progress, the effectiveness of treatment strategies implemented and demonstrated knowledge of patients’ personal likes and dislikes, and took time to do the ‘little things’ (see next extract). The espoused commitment to provide choice, in order to provide patients with a sense of control expressed during interview was observed in practice. Patients were given more opportunity to influence the interaction and care received and the matter of fact way in which choice was offered, eliminated any notion of the patient being a nuisance (or that researcher presence was changing this aspect of care).

The following extract intends to portray many of the principles just outlined and to illustrate that care-giving and relationship building are unified rather than separate activities. At the same time, the limitations of language to comprehensively describe interpersonal relationship is acknowledged; as Habermas (1972:168) states: “Ordinary language .... becomes complete only when enmeshed with interactions and corporeal forms of expression.”

(3821- 3934) Nurse A helping D with a wash. D is an 82 year old female patient with chronic lung disease and breathing difficulties,

Nurse A comments on a sore on the D’s skin. D thinks that it is due to the steroids she is taking.

Nurse A [Is it sore or itching or anything ?]
D [No]

Nurse A [What cream do you have on it ?]
D mentions the names of a couple of creams for it. [You take your pick which you use]

Nurse A is turning pages, checking the prescription sheet.

Nurse A [We’ll use this one I think]
D [That’s the one that’s usually used]

Nurse A [Is your husband coming in today ?]
D [Yes, he comes in everyday] She explains how he comes in the morning goes home for lunch, returns in the afternoon. He doesn’t like driving in the dark and his son brings him if he visits in the evening.

Nurse A [I’m just going to wash my fingers, I’ve got cream all over them].

9-33
Nurse A goes out from behind the curtains and washes her hands at the hand basin and returns to D.

Nurse A [Right. Nightie, does it matter which one?]
D [No. One's cotton, one's polyester]
Nurse A [You haven't got a preference then?]
[Can I just pop some of this cream on this spot here?]
D [Yes do]
Nurse A [It's quite dry isn't it?]
Silence
Nurse A [OK. Do you need to slip your nasal cannula on?]
D [That's it].
D [Thank you]
Silence
Nurse A [OK. I'll just give your hands a wash]
D is grunting softly-silence
Nurse A [Do you have some days better than others?]
D [Well not very often. Well I do have some periods better than others]
Nurse A [Have you been using you relaxation techniques?][Do you find them useful?]
D [Yes, I do]
Nurse A hums briefly [Do your hands feel dry?][Can I just take this away for a moment?](sheet covering part of D)
They talk about D's legs. D says that as they are scaly they're often just creamed.
Nurse A asks D if she wants them washed or just creamed. D just wants them creamed and says that they were washed yesterday anyway.
Nurse A [You have to be so careful don't you?]
D [Yes, they come up in all spots and bruises]
Silence .... The bedbath continues and after intimate care-giving, is complete. Nurse A tidies round and the screens are opened.
D [Will you pass me my brush and comb?]
Nurse A passing them [Can you manage to do that on your own?]
D-[Yes I can]

Nurse A cleans the table [Do you want any music on D?]

D-[Eh ?]

Nurse A [Do you want any music on ?]

D-[No]

Nurse A [Where shall I put your nightie for your daughter ?] ......

Some patients took full advantage of the nurses’ willingness to be of service and one nurse expressed frustration during the interview when she felt the patients made insufficient effort to help themselves. This provides a reminder of the judgement within human perception and its impact upon the willingness to be responsible to the Other. Research has indicated that nurses’ motivation to be of service may be conditional upon their perception of the patients need, severity of illness, patient’s behaviour and deservedness (Kelly and May 1982). While in this thesis, caring is taken as a universal value, it is held that caring agency is contextual (Leininger 1981, Watson 1985, Benner and Wrubel 1989). It is acknowledged that the terminal nature of the patient’s illness and more dependent status of the patients in the palliative care setting, may well result in greater emotional motivation and opportunity to demonstrate service compared to the maternity care setting. While birth is to be celebrated, evidence of parental vulnerability elicited during fieldwork necessitates that caring should be of as much concern to midwives as nurses. This discussion of deservedness serves as an ironic reminder of the Christian belief that all are equal in the eyes of God, which motivated the institutionalisation of caring. Since then, modern discourses derived from humanism, individualism and feminism have emerged to deify personal status and power, the conscientization of and retaliation towards oppression and exploitation. Arguably, these contemporary anxieties present the major barrier to achieving Levinas’ moral ideal of meeting the Other as ‘face’.

In the maternity care setting there are very few examples of midwives utilising knowledge of the woman and their childbirth experience to develop relationship. In contrast, antenatal women knew about midwives personal lives. In one observed interaction, roles appeared to be almost reversed as one woman expertly encouraged a midwife to share information about herself and family. With reference to Bauman’s (1993) mismeeting mentioned
earlier, it is suggested that utilising particular knowledge of Other, gives the person identity and worth. Data clearly demonstrate that midwives separated relationship and task and the focus during interaction involved the identification of problems, such as neonatal jaundice, problems with the mother’s health and administration of prophylactic treatment.

The following extract, represents an hour long interaction and while abridged is inserted to illustrate, that despite the busy context, time for interaction and relationship building is available. Within interview data in chapter eight, the midwife espouses empowerment as fundamental to her caring goals. The theoretical framework supporting this contemporary discourse has included amongst other things; increased information-giving, choice and autonomy. The midwife-mother interaction fits the earlier description of the professional relationship. It is superficial and enables minimal participation of the woman. Commentary is made throughout in order to identify information which is misleading and which may increase rather than alleviate maternal anxiety and undermine self-esteem.

(790-1042) I shadow Midwife O while she organises 8D’s transfer home. 8D is a multiparous woman two days following a normal delivery. The midwife tells the mother who I am and checks with the mother that it’s is OK for me to be there. Midwife O explains that she will see to the mother first and then the baby. She explains that since the delivery was normal, 8D didn’t need to see a doctor.

The mother is sitting up in bed, facing forwards, the midwife sits on the edge of the bed, on mother’s right hand side, facing the mother, legs 35-45 degrees from parallel of the bed, the notes are placed between herself and the mother. Intermittently, she obtains information from the notes and looks at the mother while speaking. Midwife O leans forwards throughout most of the interaction and the midwife and mother achieve frequent face to face contact.
Midwife O asks the mother if she has any questions or concerns about the labour. The mother says that the delivering midwife has seen her since the delivery.

Midwife O identifies from the notes, the length of labour [2 hours 17 minutes. Do you agree with that?]

Midwife O comments that the labour had gone well. She mentions the amount of blood loss - [150 mls, about a cup full] and indicates with her thumb and forefinger, the height of a small cup. She says that this is not a large blood loss and it shouldn’t affect her level of iron. She checks from the notes what the pre-delivery level was [That was 11 and treatment won’t be given unless it goes below 10, so yours was a lot higher than that].

She discusses post natal care, emphasising that the mother is not being discharged but transferred to the community midwives and explains the visiting schedule.

Midwife O says that she would like to examine the mother’s abdomen, and asks if this is all right. She gives the mother time to lie flatter and to lower the joggers herself to expose her abdomen. The midwife stands and turns to be at 90 degree approximately to the mother, she places her left hand on the mother’s fundus, takes the mothers hands a gets her to feel [Can you feel that hard lump?]. She tells her to feel this if she bleeds at home - to get on the bed and feel this and get the midwife. Midwife O explains that the womb will contract down and will take about 6 weeks to go below the pelvic bone.

**Comment:** This is inaccurate, it should be no longer palpable after about ten days. The purpose of advising the mother to feel the fundus is unclear and should she bleed, this would probably not be palpable. There is evidence of the need for the midwife to revisit the text books and think about the impact on advice, while well meant, on the mother’s anxiety levels / even if she understands what to do.
Midwife 0 sits again on edge of bed when not physically examining the mother. She explains the blood loss, that it is red now because it is fresh but will become like an old period. She says that she needs to tell the midwife if the loss gets heavy or smelly. This may happen if something has been left inside after the delivery.

The midwife mentions analgesia and suggests that the mother takes these if she needs them. Although this might be the case, her breasts may become engorged since she is not breast feeding and the breasts might produce milk none-the-less. She advises the mother to leave them alone. [Just put a tight bra on with a couple of breast pads]

**Comment:** This could be taken to mean not touching the breasts at all, for example while washing.

Midwife 0 sits back on edge of bed at 35-45 degrees to the mother and starts to go through the information in the transfer home pack e.g. birth registration, cot death, contraception: [Do you feel all right about that? Are there any questions?]. She briefly looks at mother before going on to examine the various results in the hospital notes (to check if any treatment needs to be given). She asks the mother if she is immune to Rubella, the mother says that she thinks so. Midwife 0 finds the result in the notes and shows it to the mother. The same approach is adopted for the haemoglobin result. She also asks the mother what blood group she is, the mother doesn’t know. The midwife finds the result, shows this to the mother, [This is your blood group, you are rhesus positive so we don’t need to worry about anti-D]

**Comment:** Much of the care a midwife gives entails giving information and advice rather than emphasis on physical care. This style of interaction above, could be intended to encourage the mother to take responsibility for her own health, and concerns partnership. It could also be threatening and undermine the woman by emphasis on her lack of knowledge compared to the midwife. The last piece of information about anti-D appears
irrelevant to this mother has no rational basis, is potentially confusing and may make the mother more anxious. It appears that the midwife has little insight into the impact of what is said on the mother.

Schorr and Rodin (1982) note that for some patients, the negotiation model of interaction may not be expected and being handed control may be stress-inducing, depending on personality trait, adequacy of the information and perceptions of self-efficacy. While information may enhance control, information needs to be understandable and relevant and without concurrent strategies to enhance perceptions of self-efficacy may be counter-productive.

Midwife O then says that she is sorry that the baby is dressed but that she does need to check the baby over. There is something in the midwife’s manner which creates expectation that the mother will undress the baby. It may be the relaxed manner, there appears little physical rush, although information is given fairly quickly. The mother gets off the bed and picks the baby up out of the cot and places him in the centre of the bed with his head at the foot end. The mother and midwife sit either side of the baby, both facing the foot end of the bed. Midwife O admires the baby’s outfit. She then shows the mother the baby’s notes, [This is his number in case he has to come in to hospital again].

Comment: again this could cause anxiety.

Midwife O goes through all the paediatrician’s examination of the baby and notes that everything was found to be normal. The midwife examines the baby. She speaks quite slowly, says there are no problems with the eyes, [They’re not sticky or anything], she says that the skin is lovely. She explains about the umbilical cord [It is dry now, but may become a little moist as this is the process by which it separates. This will take about a week]. She says that while she is aware that mothers don’t like looking at the cord, the mother should check that the surrounding skin does not
become red and to notify the midwife if it does. She indicates the area with her finger. Midwife O asks if the mother has things for the baby’s feed at home and what sort of steriliser has she got. The mother says that the mother in law (the lady who is waiting for her) has got all that in, so Midwife O will have to ask her (said jokingly). Midwife O does not check the baby’s napkin area and leaves the mother to re-dress the baby.

Finally Midwife O gives advice about contacting the emergency services over night, that there is always someone at the hospital and to call if the community midwife doesn’t arrive tomorrow [That would mean there’s been a communication problem].

The midwife says [You can go home but you’ll have to wait for me to write up the notes; that will be about 5 minutes].

The midwife’s body language is open and very relaxed and there is good eye contact with the mother. Some of the information is probably meant kindly but the focus is on telling rather than discovery and building relationship. A woman’s self-esteem is very fragile during childbearing (Halksworth 1994) and in general, information given to women, which focuses on the midwife’s knowledge and lack of the woman’s, potentially disempowers the woman rather than raises her self-esteem. The rationale for some information given to women prior to transfer home, was difficult to interpret in that it neither facilitated relationship, catharsis or confidence.

It is suggested that the extract illustrates the interface between new discourse and pre-existing practice. The current discourse which promotes woman-centredness, (choice, control, empowerment) and non-medicalisation is challenging traditional structures of the maternity services (DoH 1993b). Midwives are under pressure to merit equal status with obstetricians and diminish personal power within relationships with women. The above may exemplify potential problems when it is assumed that new political edicts can be simply implemented into practice. Durkheim identified the concept of ‘anomie’ in which traditional norms and values are being undermined with no new standards to guide
behaviour or situations in which accepted norms and values conflict with reality (cited in Giddens 1989: 127). In the research setting, midwifery practice appeared to resemble this. It is suggested that while midwife O espoused a commitment to empower women and may regard her information-giving as contributing to this end, traditional, constraining structures remained unchanged. There is dissonance between these aims and the pre-existing context of constrained resources, medical hegemony and deeply ingrained practitioner-centred practise. To utilise Bourdieu’s (1990) concept of habitus, the imposed values have no objective means of transmission or legitimation and are at odds with the culture’s established possibilities. The discourse appears empty with no practical foundations on which to build practice. It is also suggested that lack of language and theoretical aims which give practise meaning, contribute to the confused agency.

9.12 Preference and partiality
An unexpected finding was the openness with which all practitioners asked, admitted that they had patient preferences, although they asserted that this did not detrimentally affect care-giving. The three pilot study interviews with neonatal intensive care nurses, revealed factors which appeared to influence relationship and these were echoed in the two research settings. Contact with the other during admission or in an acute episode is one factor. The other concerns communication about the health care episode. Practitioners reported perceptions of enhanced relationship and greater satisfaction and motivation to communicate if the other demonstrates a grasp and understanding of the situation. On page thirty of this chapter, midwife D refers to women who appear not be interested in their care. In the following extract, amongst other factors, midwife H reveals the impact on relationship of perceptions of women knowing too much and too little.

(613-690) VW: ..... Are there any people who you find easier to interact with than others?

Midwife H. Er (...........) nice people (laugh).

VW. What do you call a nice person?
Midwife H: You do get some very, very aggressive people, erm in their nature, erm, who are ver, you know, I don’t want this, I don’t want that, I want this, I want the other, you say, well that’s fine, but let’s just talk why you don’t want them and why you don’t want this thing and erm and I can tell you the pros and cons of why you want them and that sort of thing, it’s all sort of ‘uuhuuuhuhuu’ very antagonistic, erm, tt, I find (...) tt, God, very unprepared or ignorant women very difficult, because they’re taking on this responsibility of having a child, bringing up a child, you know, you really should have done something about this, you really should have armed yourself with a little bit more knowledge, you know, not necessarily going parentcraft classes but at least read something, you know just having an idea of what’s happening to you. I feel that’s very frustrating, because I feel these women are being very erm, tt, what’s the word, I feel they’re are being irresponsible, in a way erm.....

VW: The converse of that, the women who know a lot, how does that affect your interaction?

Midwife H: That can, that can be very difficult, especially when they, they know a lot and they think they know as much as you, that’s difficult, because you have to accept that they’ve got this knowledge, but then erm, to try and actually discuss other issues around it, that they haven’t thought of, because they haven’t connected it and because they’ve only got limited knowledge. Erm, they can get quite affronted or, quite, you know, again quite aggressive about it, because they’re realising they don’t know as much about it as they thought they did. Erm, they can be quite difficult, but it can be quite nice when people have taken the time and energy to look into, to what’s happening to them and erm, you know, what their future holds, you know, during the pregnancy and afterwards, it is quite refreshing that.

VW: Are you conscious that you avoid people without the knowledge?
Midwife H: No, you have to see everyone but erm ... I don't think I avoid them. God that would be awful ....

Midwife D had similar views

(164-77) Midwife D: Erm, (......) I like, I especially like looking after women who ask lots of questions, who really seem to be interested in what's going on? I sometimes, it's not, I don't find it very easy to look after the women who just lie there and really don't seem very interested in anything that's happening. You know, I try, I really, like I try to explain things, I would never dream for example of putting someone on a monitor, or a trace and walking away without explaining what it all means, but I find it quite difficult when, if I'm explaining, it's very clear to me that they're not listening. I find that quite difficult in kind of underlying things, makes me feel, I don't know quite why am I bothering to explain this if you're not even listening, but erm again, you don't get many of those really, most women are very interested in their pregnancy and what's happening.

Instead of exploring why there is lack of social interaction, the woman's apparent disinterest appears to be taken at face value to become a source of disincentive for the midwife. Kirkham (1989) found in her study that midwives' information-giving to women in labour was increased when they perceived that women had a higher level of understanding. The above suggests that the desire to maintain status may motivate midwife H to offer more information. Alternatively, it may indicate a reluctance to engage with others to merge world-views when these do not match personal ones.

In Kantian theory, the notion of impartiality and fairness are central and definitive of morality (Blum 1980). It is unfair to accord benefit or burden through personal preferences and interests. Certainly attachments to particular persons can lead to violate impartiality and therefore fair treatment of others. Even so, there is a limit to the demand of impartiality and scope outside of that limit for benefiting those whom we choose to benefit (going
beyond duty). One may give something of ones’ self, rather than depriving others of what is morally their due through the institutional relationship.

While he acknowledges that personal feelings are subject to partiality, Blum (1980) argues that altruistic feelings are grounded in the concern for the other’s distress rather than personal features. These two elements are independent of one another. In keeping with Buber’s (1958) disregard for the Other’s identity, we need not have affection for someone with whom we sympathise, there may be no liking of them. It may be true that personal affiliations give rise to altruistic feelings, but only if our obligations to others arise are neglected, are they morally deficient. This also goes for acting out of a sense of duty and partiality itself does not define moral action. A just person is one who can be counted on to overlook personal interest and preference and while sympathetic and concerned responses may be capricious and transitory, the inadequacy lies with the person not the emotion per se. It is suggested that midwife H acted in a judgmental way, and allowed personal values to override her objectivity. This example, also demonstrates that while altruistic emotions as referred to in chapter three, may enhance care and concern through heightened saliency of distress, there is a danger of the reverse occurring through prejudice. The next extract suggests that familiarity nurtures relationship.

(630-720) Nurse F: ..... No you don’t get fond of everybody. I mean being a human being, you get fond of certain people, but, yeah, I was very fond of patient C she was, yeah, she was lovely. But she’d been in before as well so we’d know her from before, her and her daughter, they were really nice.

VW: What type of patients do you feel it more difficult to feel fond or (....) who you feel closer to?

Nurse F: I’mmm (....) I don’t know really (....) I’m trying to think (.....) I don’t know whether it’s the type of patient, it’s the personality, you know, the same as you’d be at home, you get on with different personalities better than others, I mean, you remember patient D whose, you know, I
was quite fond of her actually, in a funny sort of way, although (...) (laughing lightly) I don’t think many people were, but black was black with her and if there was something wrong, she’d tell you you know, you had to be very firm with her and just, you know, carry on. Which didn’t, it didn’t bother me at all the way that she spoke to me sometimes, I’d just sort of laugh it off or walk away and come back later and you know, that was fine. But there might be, you know, might be other patients on the unit who I perhaps haven’t got to know very well and I, you know, I wouldn’t be able to say that I was very fond of them as yet, you just, it’s partly the situation you’re in, partly if you’re there at the right moment or if you’re not. It depends on who you get fond of really, I think all of us were fond of patient C because she’d been there so long that we’d all had moments with her.

VW: That is more to do with familiarity that is // rather than them as a person

Nurse F: // Yeah, yeah, yeah

VW: Do you ever find that you’re having to fight, you know, a dislike for someone or (...) a difficulty in getting close to someone or (...) where perhaps you just have to realise well, I don’t, I can’t sort of warm to this person.// I mean, do you ever feel like that and feel you have to push through a barrier// like that

Nurse F: // Mmm // Mmm. You do with some people yeah, they, yeah. There was a lady in recently who I, I don’t know what it was about her but I just, I didn’t, I didn’t like her as a person really but I would never have (...) make that.. you know, I would never have shown her that obviously, I would never have cared for her any differently to anybody else (...) just as in real life, there’s always going to be people who perhaps who don’t get on quite so well as you would with others, so you perhaps don’t give as
much of yourself to them as you would to somebody else, you know, you
give, you give enough to care for someone properly and adequately and
perhaps not quite so much as you would to someone else, you don’t give
them that extra sort of human touch. (...) but I think luckily, all the nurses
are different people and we all take to different people so that’s
something. I think we have to accept as nurses that we’re not going to
love everybody, every patient on the ward and they’re not going to love
all the nurses. There’s always going to be somebody, that you’ll click with
and someone else will click with someone else and that’s you know, that’s
the way that life works really isn’t it? I think if you don’t accept that,
that’s when you run into difficulties really. If you, You know, try and make
yourself the one for every one.

Familiarity permits predictability, formulation of rules for engagement with the Other,
improved potential for successful outcome and reversal of Bauman’s (1993) mismeeting
mentioned earlier. Instead of a false predictability derived through a reductionist approach,
in which patients and women become an anonymous case in a bed, time and contact
provide a more real and individual predictability. Data emphasise that time, which is
essential for this process, is often not available and more time or skills to compress the time
taken to build relationship is required. It is suggested that in addition to the individual’s
role in establishing relationship, the corporate, collective, multi-disciplinary responsibility
and ethos of the service is of vital importance to establish a trustworthy foundation for all
health care relationships.

9.13 Difficult relationships
While one elderly female patient caused mild frustration for the palliative care nurses, all
relationships were respectful and generally amicable. While never observed, nurses were
able to identify potentially problematic situations which required sensitive and tactful
handling, as Nurse C describes.

(592-604) Nurse C: ..... erm (.....) erm One lady we had that was a ex-
nurse who was, she was very frightened basically and very demanding, she
wanted everything just so erm .. didn’t find it that easy to talk about what was happening to her and the nurses, we were getting very, very frustrated trying to manage her and erm what eventually happened was, I plucked up the courage to be honest enough to say “we’re finding this really difficult, why, why are you ... this way?” (... and it actually really helped, she, I mean, she had no idea, that we were finding her care so difficult erm (...) and I think that was, that was really useful.

Nurse B demonstrates insights into how relatives may be aggressive in response to bereavement.

(605-28)Nurse B: ..... the daughter in particular was quite aggressive towards the staff. There were obviously reasons behind that and you had to be understanding of the situation that the daughter was in, to appreciate, you know, why she was reacting like that and it wasn’t personal dig at any one member of staff, it was just something that we had to learn to cope with and. So it, it changed me in that I needed to, to think about how everybody whose losing that person feels differently and it’s important that, you know, not everyone’s going to get upset and distressed, some people are going to be verbal and can may be quite aggressive and you know, it’s all about them, nothing matters but, it’s them, you know, she’s aggressive because she’s feeling out of control, she’s losing her mother.

The de-brief meetings, described in chapter five, in particular appeared to provide a forum for staff to analyse, evaluate and progressively develop nursing practice. Nurses were able to express frustration, depersonalise tension between themselves and patients, strengthen team identity, problem-solve, obtain support and revitalise caring values.

Within my ten days of observation in the maternity setting, I encountered six conflict situations. Women were abusive towards midwives, parents waited resentfully by the bedside or partners complained at the midwives’ station for being kept waiting to go home.
Often it concerned situations over which doctors had control, although midwives received the brunt of the anger and frustration. It was also evident that midwives had internalised political and organisational values. As opposed to seeking to identify what the disharmony symbolised and how it could be avoided, two midwives' were primarily concerned with possible complaints to the hospital.

Midwives appeared traumatised by the encounters and were keen to share their frustration with me. In the following extract, midwife B expresses her annoyance with a young woman hospitalised antenatally, who she feels bullied her and tried to tell her how to do her job. Despite identifying that the woman did not want to be in the hospital, she admits that she could not resist retaliating.

(245-79) VW: So how do you deal with that sort of situation, if they're openly frustrated?

Midwife B: (...) well, it's very difficult really (...) one woman, one day I found her very difficult, I'd looked after them for several days, you think that the women you care for, you can make friends with, I say friends, I put that in inverted commas, you know (laugh) you have a good rapport with them and er you establish a relationship (...) er and then they can take it too far and err, sort of try to (...) get you on their side and, and get you against the doctors, you know, the pressure they put on you is amazing. One day, this particular lady, just put too much pressure on me and she became very, very erm, rude, erm (...) just obnoxious really and just out of order with the things that she was saying. It was just very, very (...) I can't even, I can't even conjure up the words today.. but she was very cocky and I didn't deal with her very well. (loud) Well, I was very assertive and I put her in her place and she was better after that erm I can't really remember what I said but I think she was surprised to hear someone speak to her like that. I just told her to wind her neck in, as we call it in Norfolk
Midwife B: *You know, just to stop, giving it her everything (...) it*

VW: *How did you feel after that, after you’d responded in that way?*

Midwife B: *(...) At the time, she’d upset me so much that I had to give it that and I felt, I felt a little bit unsure of myself because erm, and I spoke to the sister at the time who was on duty with me and she said ‘Good! that’s what she needs, she’s a young immature lass and she’s been winding everybody up and she can’t get away with it and perhaps you being her age group, may have helped’. It might have done, she might have needed some older person, but it seemed to work so I was fairly reassured that it settled after that.*

The midwife’s reaction and managerial support illustrate the existence of traditional expectations of the patient’s inferior, non-participatory role, although it is acknowledged that the patient participation in this case was unconventional. Both this and the extract involving nurse C on page 9-46/47 involve situations in which practitioners felt they had to confront the patient and attempt to limit their personal autonomy. As discussed in chapter seven, moral agency involves the nature of motives as well as acts and practitioners therefore need to examine if the challenge to a patient’s behaviour is self or Other-centred. It is suggested that nurse B’s interaction with the patient was motivated mainly out of concern for the quality of nurse-patient relationship and care. The narrative suggests a tentative approach with concern for the patient’s integrity. Midwife B’s approach suggests more personal values such as respect for professional status were more at stake.

These scenarios represent complex practice situations which Schon (1983) asserts cannot be solved by formal theory alone and advocates reflection-on-practice to identify practical knowledge. In both of the cases mentioned, both tacit and practical knowledge are required in deciding on the action necessary, that is, whether to ignore the distressing behaviour or to confront it and how to minimise potential negative effects of the action, such as patient alienation. These two contrasting responses to difficult situations usefully exemplify the influence of practitioner values on clinical decision-making and agency. That
contemporary literature on reflection pays little regard to values will be the focus for
discussion in later chapters.

Within the maternity setting there were different approaches to dealing with these conflict
situations. The above was the only one in which there was direct retaliation against the
woman. In other situations midwives remained openly calm and respectful and attempted
to reason with parents. Privately, they shed tears, were frustrated and angry and
occasionally, in communication, exaggerated the truth to achieve respite. With the
exception of midwife B, there was a good deal of evidence of Hochschild’s (1983)
emotional labour, as they worked through their own feelings, in order to maintain
professional role. Hochschild maintains that there is an awareness when our feelings do not
fit the context and deep emotional experiences are associated with the will to evoke,
suppress or to allow an emotion. Midwife B was professionally disillusioned and was
shortly to leave midwifery, and perhaps lacked such will to struggle and suppress personal
feelings.

There were no apparent structures such as the palliative care unit’s debrief meetings and
clinical leadership to support midwives through these distressing episodes or to channel
energy into constructive solutions. Savage (1995) found in her study of two ward settings,
that where support was perceived, nurses were more able to sustain their practice.
Arguably, peer or managerial support validates personal values and goals within the work
culture and therefore maintains motivation to work towards practice ideals.

In contrast to Hochschild’s (1983) emotional labour in which commercial rewards take
priority over personal values, midwife D in the next extract works through an abusive
relationship in order to preserve both personal and professional values. Midwife D
discusses a situation encountered during one of my observational days. There had been
friction between the midwife and woman all during the day and as I left the ward area, I
noticed the midwife in conversation with her at the bedside.

(408-512) Midwife D: Yeah, that was a very frosty conversation. I had to
go and tell her that her scan had been delayed, so I took a big deep
breath, you know, I got all tense, because I knew she was going to swear at me and she got really unreasonable and kept telling me that she was the f’ing most important patient on the ward? and that her pregnancy was f’ing more precious than any other pregnancy.... and that she should take priority and erm, I found it very difficult and I said ‘Well, the scan’s been delayed, can I do a trace in the meantime?’ and she wouldn’t. I think she told me to f’ off then as well actually. So I said to her, ‘so your pregnancy is the most precious in the world, but you won’t let me trace your baby to see if it’s OK?’ And she just said ‘I know that it’s OK, I can feel it moving’. And when I finally got the scan organised, I introduced her to the woman that was going to be doing it? and she just looked at the senior sister and said ‘about f’ing time too’. I mean it was just (laugh) very, very difficult.

VW: I know what struck me was that you kept working at that relationship.

Midwife D: Yeah, I kept going back//

VW: // Why was that?

Midwife D: Because I don’t give up very easily, and I thought, this isn’t going to beat me, she’s not going to get the better of me. I’m not going to let her see that she’s upsetting me, although she did, first thing in the morning, when she first told me to f’ off. I finished the drug round, went into a little room and cried because I was just so taken aback, I really wasn’t expecting it at all. She doesn’t know that she made me cry, she never saw me upset again. And erm, Yeah, I kept going back and by the end of the shift, she actually came up to the desk and talked to me civilly and you know was quite polite and had a laugh...erm and she was all right. And then postnatally, I erm, deliberately went to see her, and just said ‘Congratulations’ and you know, I admired the baby. You know, so I made sure, I didn’t want her thinking ‘errrr, I’m not speaking to you’
'cause that's not professional, that's childish, so I deliberately went to see her to say 'well done for the baby and normal delivery and everything' and erm she smiled at me and said 'thank you' and ermm..

VW: So it wasn't just about trying to show her that she'd not upset you, there was something else there?

Midwife D: It was partly for me as well //

VW: // It was partly for you?

Midwife D: //Partly because I didn't want her thinking she'd upset me, partly professional and partly because I thought, I didn't, didn't understand. I take everything to heart, I take everything very personally and erm people don't very often speak to me like that or people don't often speak to anyone like that do they? and I, I was just so surprised, that I wanted to get to the bottom of it and I actually asked her, on the day she was being rude, when she was still antenatal, if I had done something to upset her and if she had a personal problem with me and if she would like another midwife to look after her and she looked quite surprised at that and said 'It's not you, it's just this f*ing hospital, I just don't f*ing want to be here'.

VW: So from a professional perspective (...) what were trying to achieve?

Midwife D: I think I just wanted to show her that we midwives are not easily rattled and that you can call us what you like, but we'll just keep coming back, we still care for you. The fact that she was refusing to let me care for her, that's her business, that's up to her. But I kept going back; 'Can I do a trace now': 'No, f' off'; erm 'Can I do your observations?': 'No'. But I was there for her and I kept going back.
This extract evidences a fusion of the personal and professional commitment to care in response to the woman's hostility. As discussed in the previous chapter, activity may be governed by social forces such as role norms (Goffman 1959, Jourard 1971, Hochschild 1983), the regulating structures of the habitus (Bourdieu 1990) or authentically lived through internalised values (Bauman 1993). While professional responsibility may have, in part, motivated agency, there is evidence of deeper personal meanings embedded in practice and self-determined moral agency based on caring values. Caring is often associated with 'going beyond duty', 'giving that bit extra', 'going the extra mile' and these terms describe midwife D's agency when she visited the mother postnatally.

The above narrative provides an exemplar of the mutual growth and benefit which derive from caring relationship referred to by a number of authors (for example Buber 1958, Mayeroff 1971, Bauman 1993). The benefits to the mother of a caring relationship are easily identifiable; the midwife was accepting, concerned and committed to understanding the woman's experience; in the midwife's own words, she remained 'there for' the woman. The woman's humanity was therefore respected and valued. But what of the midwife? Mead's (1934) theory holds that self-perception and sense of self-worth are derived from our perceptions of how others see us, and implies therefore that each interaction involves risk. Bauman's (1993) notion of mismeeting represents the sense of threat when interacting with strangers. Yet, in caring and being altruistically there for the Other, the protection and security of non-involvement are voluntarily forfeited. In the face of aggression and risk of humiliation, there are notable contrasts between midwife D above and midwife B (page 47) who allowed herself to be deeply affronted and undermined. Midwife D was able to depersonalise the confrontation. This may be more comfortably undertaken in the knowledge that there was no cause to doubt her own moral agency and the readiness to respond to the needs of the Other. The potential for growth existed because the values which comprised the midwife's self remained intact and undefiled. Caring not only preserved the Other, but protected the midwife's own integrity.

Dealing with displeased service-users undoubtedly tests practitioners' caring virtues, but conflict seems displaced within a 'caring' environment. The frequency of disharmonious
As previously noted, the Changing Childbirth Report (DoH 1993b) directed a move away from the medical to a psycho-social model of childbirth, and included aims to empower and work in partnership with women. In keeping with this, the maternity research setting as described in chapter five, had very little in the way of a clinical, medical ethos. That the ward’s aims were in keeping with contemporary goals were confirmed with midwife H.

(549-566) VW: ...... it (the ward) has got a relaxed feel, like at the back of the station today, the radio is on, it’s quite homely.

Midwife H: Yes

VW: Is there any deliberate intention to make it more homely or is it just how it is?

Midwife H: A lot of it is how it is and the team that you’ve got on here. I think also it’s more, er .. it’s always more relaxing, you know, then they’re more likely to approach us, we’re more approachable if they see us being relaxed and erm, the atmosphere being calm and nice, than if was all very austere and very clinical and very erm, you know, erm, old fashioned nursing sort of. I think it would be more difficult for them to approach us and ask you silly questions, as they think they are and, I think it’s more conducive to communication and relieving anxiety.

Interactions between health care professionals and patients potentially benefit from favourable preconceived ideas which patients may hold. Wills (1982) suggests that patients’ perception of the helper, whether lay or professionally trained, as admirable, mature and competent and having a positive approach to people, facilitates relationship. This suggests that there are serious problems underlying the tensions observed.
Frustrations arguably arise as a result of raised expectations of the health care services introduced by the Patient’s Charter (DoH 1991) and Changing Childbirth Report (DoH 1993b). The rhetorical level of service these encompass, exemplify Hochschild’s notion of ‘discrepancy between promise and fact’ (1983:93). Even so, it appears likely that expectations are associated more with access to services and treatment rather than the relationships with health care personnel. While pressure of work must take responsibility for some care-deficit, research has shown that rather than abuse, over-worked practitioners induce consumer sympathies that they are doing their best under the circumstances (Staniszewska and Ahmed 1998). While hasty interactions undoubtedly undermine the caring environment, lack of time appears to be only a partial explanation.

While acknowledging, the perspective that ‘things were different in my day’, I began to wonder if the combination of the informal environment and factors such as chat between staff, lack of responsivity and privacy as identified in the text, were to blame for the friction between parents and midwives (and possibly medical staff). Midwives were perhaps failing to fulfil parents’ expectations of caring, service-orientated professionals.

The focus on woman-centredness and partnership-in-care has contributed to a transformation of the midwives’ work space to a more homelike, less clinical environment for women / parents. It symbolises a change in power relations from the staff to the ‘consumers’ and dispossesses staff of unchallenged control over the care context (Hochschild 1983:174). Despite this, the midwives found strategies, possibly sanctioned by the concept of demedicalisation, to maintain control over their work environment. For example, women were forced to take an active role to seek attention at the midwives’ station rather than call the midwife to the bedside. Within a busy environment this could add to women’s concerns about being a nuisance and increase rather than reduce anxiety. Arguably, as alluded to earlier, there is also insufficient support provided to women / parents due to the potential over-emphasis on childbirth as a physiological event.

In addition, it is speculated that while the chat, radio noise and decor may remove the formality and clinical ethos, the accompanying lapse in attentiveness and willingness to be of service, may lead women and their families to misinterpret intentions and perceive these
as serving the interests of the midwives rather than themselves as 'consumers'. This combination of factors may produce cognitive dissonance in which anticipation of stereotypical nurse/midwife role behaviours are disillusioned.

Schorr and Rodin (1982) argue that negative reactions result, if service users' expectations of the institution, practitioners and themselves as patients are confused. This occurs if patients do not understand how to behave, creating unpredictability and lack of control over the situation.

The ethos of the care-environment represents only one factor which structures delicate health care relationships. According to Lawler (1991) the crossing of social boundaries involved in body care has been made manageable and acceptable through religion and ritual. In the research context, traditional props and rituals, such as drapes, screens and verbal and non-verbal expression of interest in the Other, which function to define social and sexual boundaries and symbolise caring appear disrupted. These social structures which were necessarily devised when institutionalisation of caring first began may well have become taken-for-granted with the underlying values being lost to subsequent generations (Berger and Luckmann 1966). Given a situation in which professionals are undifferentiated from lay people, have no time and/or inclination to convey interest, concern or caring, it is naive to expect passivity and unchallenged access to the body of others. The reduction in professional etiquette and the accompanying decline in public confidence in professionals (Schon 1983) may be one explanation for the growing resistance to intimate examinations and intervention within the childbirth context (for example, Arms 1994) and the tension in ward areas.

The existence of tensions between midwives and women raises questions both for midwifery practice, the maternity services and midwifery education and suggests that there is an unprecedented need for further study into midwifery caring relationships.

9.14 Summary

The previous five chapters have presented and discussed interpretations of data regarding the nature of caring based on the conceptual framework discussed in chapter three.
As reported, practitioners in both settings experienced difficulty in discussing their caring agency, which suggests that caring per se is not a major influential discourse. It was proposed that this may in part be due to the personal, pre-conscious and intimate nature of caring practice. Individualised care and choice and autonomy derived from political agendas such as the Patient’s Charter (DoH 1991) and Changing Childbirth (DoH 1993b) were alluded to in both settings, but espoused and actioned with greater commitment and purpose in the palliative care setting. There was also greater sensitivity to and concern with patients’ experience and responsivity and relationship building were constantly manifest, in contrast to the maternity care setting.

Similarly, opposing attitudes towards the utilisation of theory to provide a framework for practice were extremely notable. Midwifery participants appeared to perceive theory as of little value while in the nursing context, there were structures, in the form of clinical leadership and debrief meetings which perpetuated values encompassed within a theoretical model of practice. This appeared to positively contribute to practice as observations reflected customary compared to visionary approaches to care-giving in the maternity and palliative care setting respectively. The clear differences lead to the hypothesis that theory positively influences caring practice. This relationship was unexpected since my initial conceptualisation of caring assumed the primacy of the affect. The finding suggests a closer relationship between cognition and internalisation of caring values and motivation of caring agency than original pre-understandings allowed.

A valid challenge to the association between theory and caring practice which is asserted here, would be that midwives were under greater pressure of work and therefore more likely to routinise practice and it is acknowledged that relationship building is difficult when contact is brief. However, data evidence behaviours which cannot be totally accounted for by the busy environment and rapid ‘turnover’. For example, the insensitivity, lack of receptivity and acknowledgement of the Other, time taken in information giving rather than listening, and chat amongst colleagues rather than with women, indicate suppressed caring values rather than insufficient time.
It is not believed that the midwives are uncaring, but that the habitus contains more constraints rather than possibilities to centralise caring values. The second chapter identified the tendency within institutions for practice to become routinised and habitualised and therefore less meaningful. These processes spare effort and arguably require motivation and energy to resist in order to work in a more critically reflective and caring manner. The role of social processes in transmission, legitimation and perpetuation within a culture were identified in chapter six, where it was also maintained that values and meaning are formulated by both discourse (theory) and practice. It is hypothesised that the theoretical and social structures which were evident within the palliative care setting and absent in the maternity care ward, positively influence caring agency.

The remainder of this thesis therefore explores educational and epistemological literature in order to identify the role of theory in promoting caring values and future potential for research into the prospect for a caring curriculum.

This study is undertaken at a time when there is major interest and debate regarding the nature and function of knowledge for professional practice (and indeed professional practice). This is associated with contemporary discourse, alluded to in chapter two, which challenges the value of theory formulated within the parameters of the scientific, positivist tradition (Schon 1983) and the increased emphasis accorded to personal, tacit and intuitive knowledge derived from reflection-on-practice (Benner 1984). It is intended that this current examination of the theory and practice for caring will contribute to the debate.
Chapter Ten

Implications of the research findings for caring practice and education.

In keeping with the ethnographic tradition, the research aims were to provide a description of caring within a nursing and midwifery culture. This entailed an investigation of how caring is manifest in practice and nurses’ and midwives’ individual understandings of what it is to care. These aims were based on the rationale that caring appears to receive low priority educationally and care-deficits in practice are consistently reported in the literature. While rejecting the view that caring is unique to nursing, it has been argued that because nurses and midwives achieve closest proximity to patients, they have the greatest responsibility for providing caring relationship, at a time when many patients are at their most vulnerable. It has also been maintained that nurses and midwives need to take ownership of their specific sphere of practice, to enable themselves to develop and protect the caring element. In order to contribute to this vision, the research included intentions to extrapolate findings to the educational context with the intention to gain insights into how caring might be included in both pre-registration and continuing education programmes. During consideration of this, the importance of clinically-based experiential learning processes also implicates management at ward level to facilitate the learning and socialisation processes, which are to be proposed and recommended.

In this chapter, the discussion of the research data falls into three main areas. Based on the theoretical analysis of caring, in chapter three and the interpretations of the data, the first section identifies how conceptualisations of caring in the nursing literature create a source of confusion and paradox, when placed alongside the possibilities and constraints within the traditional nursing habitus. It is maintained that frustrated caring agency may explain the reported shortcomings in caring practice and subsequent difficulty in achieving caring as a central value. It is suggested that this can be remedied to some extent, by educational focus on the theoretical analysis of professional caring, which can then be used to frame reflection. However, there remains the problem of the theory to practice gap and how caring values can become internalised in order to motivate and guide practice. The second area of discussion therefore, examines the learning experience, the dichotomy between formal and informal theory and argues that a combination of both is required to guide
practice. Based on research findings, it is maintained that the internalisation of caring values can be facilitated if caring values become objectified within the work culture, as was the case in the palliative care setting. The crucial role of socialisation processes, in embedding caring values in the work culture comprises the third area of discussion. This necessarily takes the analysis full circle, since without cultural solidarity, there appears little hope of placing caring at the centre of practice.

The chapter concludes by drawing out the educational implications of the discussions presented in the chapter and prepares the ground for the final chapter, which identifies recommendations and future work.

10.1 Conceptualising, contextualising and centralising caring in professional practice

That the vulnerability of hospitalised and ill persons places an automatic moral obligation on the NHS to provide a caring service was discussed in chapter two. Extracts of discussions evidence the anxiety and dependence caused by hospitalisation. For example, a patient in the palliative care unit wonders what there is to live for; a wife expresses guilt in being unable to cope any longer at home with her husband’s illness and fears for the loss of his dignity (chapter 5: 12); a mother experiences fright due to her bleeding caesarean section wound (chapter 9: 18) and other women express appreciation of being enabled to maintain personal control during childbirth, indicating their original fear, that this would not be the case (chapter 5: 13, chapter 9: 17). It has been argued that since nurses and midwives achieve the greatest amount of contact with patients, there is a moral necessity for caring to be central to their sphere of practice. Yet, data obtained in both research settings, evidence that external, dominant influences exert pressure on nurses and midwives which causes caring to become subordinated.

In chapter three, supported by contemporary literature, caring was conceptualised as being inherently moral and as being a commitment to maintain caring consciousness in relation to others. Caring comprises emotion, cognition and agency and makes salient the plight of the Other. Caring evokes altruistic emotions, such as concern, which motivate helping agency. Caring is Other-centred, individual and contextual. None-the-less, data demonstrate the elusiveness of the caring phenomenon and the clear discrepancy between how caring is
portrayed in the literature and the stark realities of professional practice. This relativist aspect of professional caring appears to be under-estimated and neglected in the nursing literature.

It is argued that the above points combine and comprise the main feature, which defeats the achievement of caring as a primary enterprise. It is suggested that the effects of this are complacency, confusion, role ambiguity, frustration, self-effacement and loss of caring identity. Intentions and perceptions of what it is to be a caring person are overwhelmed and undermined when the realities of practice are encountered. Melia (1987) identifies this in her examination of the socialisation of nurses and more recent studies also suggest that educational programmes fail to eliminate the ‘reality shock’ phenomenon (for example Kapborg and Fischbein 1998). These confusions and paradoxes will now be discussed in more detail.

10.2 Caring: known but unknown

The elusive nature of caring was noted at the beginning of chapter three and research data support notions that caring may be considered both personally inherent or synonymous with practice. In consequence, a deeper understanding of caring may not be sought. For example, in chapter 7 (page 23), midwife H says about caring; “... you just do it, because that’s what you do as a midwife.” In such a case, caring is taken-for-granted and may constitute practice described as non-reflective and presumptive (Jarvis 1995), which will be referred to again later in the chapter. We may also feel that caring is something personally known and in the same extract, midwife H says “... it’s (caring) just in your nature ... it’s just in there, you just do it.” The belief that caring is inherently female may also be implicit.

In Belenky et al’s (1986) research into women’s ways of knowing, they identify the possibilities, amongst others, that women either mistrust their own knowing and rely upon external authority or the reverse; that is, there is total dependence upon personal knowing. In midwife H’s case, in which she also implicates other midwives, the combination of inner knowing and distrust in theoretical and rational analyses, suggests a greater reliance on the
former and a rejection of external sources of knowledge. This is pertinent given later
discussion which identifies the role of formal theory as necessary to avoid routine practice.

Even so, professional caring involves agency which is difficult to describe and articulate and
as such, includes ways of knowing not valued by the scientific community (Belenky et al
1986, Hart 1991). This also means that agency is open to misinterpretation and
misjudgement by others. Throughout this thesis, caring has been portrayed as socially,
individually and contextually metamorphic and pre-determined strategies have been
considered incompatible. The uniqueness of each caring encounter necessitates practical
and tacit knowledge in making judgements. One example might be the judgements about
what might be helpful or best maintain a patient’s personal dignity. With receptive and
responsive practice, nurses learn that the agency anticipated to proffer benefit is not
necessarily the case for a particular patient. As a simple example, in the extract in chapter
nine (pages 25-26), a frail female patient wants her tea in a cup and saucer rather than
beaker and the nurse’s expressed surprise and doubt indicate the lack of individual
predictability. Other observations, not detailed, involved situations in which patients
choose autonomy rather than what the nurses anticipate would be best, such as sitting out
in a chair, rather than staying in bed. Within the palliative care setting, rarely were patients
led to co-operate with any intervention; negotiation usually preceded agency. In the
following extract patient A refuses nursing intervention, yet, if this is unknown to an
observer it could easily be misinterpreted.

(191-99) Nurse F: ... we’d very much like to (...) put a pillow on either side
of her, because she does tend to list over to one side erm and sometimes
she won’t let you and then you’re in a, you know it’s like between the devil
and the deep blue sea, do you actually put it in there and stop her from
listing over and possibly falling out of bed or do you let her maintain
control and take the risk? So it’s quite difficult.

In observing nurse-patient interactions and without particular information, it would be easy
to jump to conclusions and make incorrect judgements about the caring nature of the
agency. This un-determined nature of caring, highlights why it is important to
conceptualise caring as a process or principle rather than by the identification of sub-concepts, as exemplified in chapter three.

Similar misunderstandings may occur if personal ways of caring are judged in isolation. Personal differences were outlined in chapter nine (pages 10-12) and approaches such as being relaxed might be regarded as indifferent and rather than humorous, conversation might appear disrespectful. It also needs noting, that unless the patient is known, these might also be the patient’s perceptions of nurse / midwife behaviours. According to the above points, caring is both assumed and contextually variable, which makes definition, description and distinction complex.

10.3 Paradoxes of professional caring.
Research data make clear the inherent paradoxes when the theoretical explications of caring, which may inform practitioners’ self-expectations and caring intentions, are examined within the professional caring context. This incongruence may explain why caring shortcomings, disillusionment and low morale occur.

10.3.1 ‘Inflicting’ care
While nurses are encouraged to achieve closeness and attachment within their relationships with patients, professional caring often involves causing distress or encouraging patients to do things which requires burdensome effort of them. For example, while expressing her fondness for a female patient, nurse F remarks “.... you had to be very firm with her and just, you know, carry on” (chapter 9:45). The apparently contradictory concepts of fondness and firmness arise through caring intention. These helpful intentions are based on the expectation that the patient wants to get better and / or wishes to avoid further health hazards and pain. The issues of patient choice and autonomy were discussed in chapter seven (pages 10-18), where it was identified that, the tension between autonomy and beneficence presents a difficult ethical dilemma. Out of context, the above situation might suggest that nurse F was undermining the patient’s autonomy. Nurse F’s affection for the patient makes this unlikely, but the scenario exemplifies the practical and tacit knowledge necessary to recognise when patient behaviours indicate that care is genuinely unacceptable.
10.3.2 Collective caring

A further paradox entails the characterisation of caring as reflecting I-Thou relationships (Buber 1958), which conjures up visions of the dyad absorbed in relationship and oblivious to all else. While the principle of caring relationship, outlined above, has universal meaning, professional caring requires that this is balanced with specific contextual factors. Professional practice involves a duty or obligation element, which necessitates the application of ethical theory, such as utilitarian principles of justice and equality for the collective patient population and professional accountability for personal clinical competence.

Interviews with nurses and midwives, detailed in chapter five, identify the frustration of attempting to nurture caring relationship within the necessity to ration care, with the aims that attention is equally and fairly distributed and the necessary instrumental activity is undertaken. In chapter five, data identify the priority given to the drug round above relationship, in the palliative care setting. Arguably, the intention to give all patients their analgesia and the legal necessity for two nurses to be involved in the administration of controlled drugs, provide legitimate justification.

Data from the research settings also indicate that, caring as a collective nursing activity, takes on different forms which have implications for caring for patients. These forms include; the advocated ideal to distribute patient care over twenty-four hours, the perception of a collective skill repertoire and nurse-patient personality matching.

Extracts in chapter five identify that a collective approach to care is being undertaken in an attempt to transform task-orientated care to greater patient-centredness. For example, nurse C and midwife D optimistically promote this strategy in the hope that it will avoid feeling the need to rush to get the work done and the experience of guilt when, consequently, they feel that care-giving is less than optimum (chapter 5:26).

Brown et al (1992) suggests that, the ‘inter-changeability’ of nurses indicates that nurse-patient relationships are at odds with the focused and specific interactions described in the
literature. In the following quote, they suggest that collective caring is incompatible with caring relationship.

Nurses could be substituted for one another without any problem; what one nurse could do for a group of patients was similar to what any other nurse could do. Such a rationale illustrates how rudimentary the notion of nurse-patient relationship is and how at odds it is with the whole concept of a caring relationship (Brown et al 1992:39).

This critique derives from Brown’s et al’s comparison with lay-caring relationships (1992). The position in this thesis is reiterated; caring relationship is qualitative rather than quantitative and is a state of being towards and for the Other, in acknowledgement but regardless of identity. Whatever the contemporary, theoretical ideal, caring institutions, as the legacy of Christian values, symbolises society’s collective concern for the ill and vulnerable. This gives professional caring a very different perspective from one-to-one caring relationships. Noddings (1984:180) captures the essence of this argument, as she describes teacher-student caring relationships,

*I do not need to establish a deep, lasting, time-consuming personal relationship with every student. What I must do is to be totally and nonselectively present to the student - to each student - as he addresses me. The time interval may be brief but the encounter is total.*

The following extract also makes clear, that while nurses may idealise specific, focused relationships, the realities of practice are often prohibitive, if neglect of other patients is to be avoided. The pressure which patients place on nurses and which occasionally need to be resisted are exemplified in the following extract.

(263-71) Nurse C: (...) certainly yesterday the two nurses were very frustrated in that, they felt that (...) they'd spent an awful lot of time with patient A and we had, another patient that was dying and they knew full well that he wanted attention and she (patient A) was (...) almost sort of
jealous possibly of the attention someone else was having. That was their perception which then caused them more stress (laugh)

Arguably, due to the longer stay of patients and a greater staff-to-patient ratio, the palliative care nurses adopted a more strategic and collective approach than in the maternity setting. Where patients made heavy demands on nurses, debrief meetings involved problem-solving and the measure of patient case-load care was balanced with respect to ‘lighter’ and ‘heavier’ needs (either physically, emotionally or both) across the two teams of nurses, rather than one team caring for all the ‘heavy’ patients. Maintaining nurse integrity is the central feature of the theoretical model of care utilised in the palliative care setting (O’Berle and Davies 1990) and the above strategy is of clear benefit to both the staff and patients. As argued, caring is not just emotion and cognition, but necessarily agency, which is often physically and emotionally demanding. Arguably, caring values become more difficult to sustain, as demands become greater and energy to maintain caring intentions decline.

Whether in lay or professional contexts, pragmatism does not exclude caring.

However, additional interpretations of collective caring encountered during field work, involved insights into personal and individual team members attributes. In the next abstract, nurse A identifies what she perceives as her personal limitations and her colleague’s strengths.

(467-82) Nurse A: I think, one of the things I sort of have to tell myself is that not everyone, no matter what job would be good at everything and that’s one of the areas I hate dealing with this real deep emotional stuff, I don’t feel I’m very good at it and I don’t feel I ask the right questions and have the right answers and some people I feel are a lot better and so I’m quite happy for them and I’ll do the bits I feel comfortable in doing, I don’t expect myself and I don’t want to be able to do absolutely everything, do you know what I mean? I think you need, it needs to be recognised that everyone’s (.) erm (.) good at some things better than others (..). I’m quite happy with that (laugh).
Nurse A’s perceptions of herself may reflect, not limitations, but simply a different personal way of caring. This reveals the potential problem where relationship skills are viewed instrumentally and with pre-determined structure, causing nurses to undermine their own caring abilities. The extract also raises the issue that while a collective approach can blend the skills of the nurses, some aspects of care are central and professionally mandatory rather than optional. Morality is personal (Bauman 1993) and while collective practice may enhance the scope of care provision, dependence upon others to fulfil our personal responsibility to the Other negates caring.

In chapter three, it was noted that Buber’s I-Thou relationship and Christian Agape involve caring for the Other without partiality. In chapter six (pages 7-8), nurse B expresses her determination to compensate for occasional discriminatory tendencies in the unit. Nurse F (chapter 9: 46) identifies that preference and partiality is a fact of everyday life. As she says “There’s always going to be somebody, that you’ll click with and someone else will click with someone else....”. The moral questions of what happens if nurse B is not on duty or what if no-one ‘clicks’ with patient X are obvious ones. While the literature idealises closeness within nurse-patient relationships, this suggests caring as analogous with the dictionary definition of caring as affection. This achieves inadequate depth of meaning when compared with caring as accepting the moral responsibility for the Other in meeting them as ‘face’ (Levinas in Bauman 1993).

Nurse F and midwife H (chapter 9:41-43 and 44-46), who also admits patient preference, maintain that the provision of care is not detrimentally affected and Blum (1980) argues that personal preference need not automatically exclude moral agency. The above analysis is undertaken, in order to emphasise the complexity of placing caring at the centre of professional practice and the importance of developing an understanding of caring in the professional context. While caring agency may be emotionally mediated, conceptualisations of caring, as solely feelings of closeness or attachment are misleading. This is expanded upon next.
10.3.3 Caring as an emotion

Data derived from the interview question aimed at revealing what caring means in nursing and midwifery (chapter 7.1-2 and 6) suggest that articulated meanings are associated mainly with the day-to-day activities of meeting patients’ needs. This contrasts with nursing literature which emphasises emotional or existential meanings (for example, Smith 1992, Boykin and Schoenhofer 1993, Brykcznska 1997). This latter conceptualisation is evident in interview data, in which midwife F associates nursing patients with sympathy, that is, “...caring as in aaaaaaah” (chapter 7.8). Nurse F states, “...its (caring) about sympathy and empathy (...) more than anything” (chapter 7.2). Indeed, as identified, emotion stimulates the desire and motivation to respond, in order to relieve the Other’s distress. Yet, the spontaneity of personal caring may be contained, for example, by pressures to keep abreast of work demands. The earlier example of prioritising the drug round exemplifies the potential tension between immediate caring responsiveness and professional duty to all patients. Within the maternity care setting, the closure of a ward has resulted in a rapid patient admission and discharge rate, noted in chapter five. This creates a situation in which there may be little time to care and this results in conflict between caring, conceptualised as responsive agency versus the clinical reality of being available to care - but only sometimes.

Emotions and action are inseparable features of caring. Caring might be described as enacted emotion, which embodies deep, personal values. These values are crucial to our sense of self-worth since they motivate us to do what we hold to be good and worthwhile (Oakley 1992). Research data exemplify the association between emotion and achieving personal practice ideals. For example, nurse A admonishes herself - “Oh God that looks horrible”, when she felt her body-language was inappropriate while communicating with an upset patient (Chapter 8: 6). In the following extract midwife T illustrates the impact of whether or not personal caring goals are fulfilled.

(184-211) VW: How do you rationalise that in your own mind, that you can’t reach your ideals sometimes?
Midwife T: Well it isn’t feasible I suppose. Sometimes you can accept it and you go off and think, well I did my best I would have liked to spend more time with Mrs X, but Mrs Y needed this, I just did the best I could under the circumstances and sometimes you go off and you think. Oh dear, I’ll do what I can ‘erm, then gone on to somebody else; and sometimes you feel that you haven’t shuffled it quite as well as you should and sometimes you feel, well you’ve probably done as well as you could under the circumstances and (brightly) sometimes you go off and you think and I went off last evening and it’s a really nice ward in 7 at the moment, they’re all getting on really well, they’re all interacting and I feel that I’ve facilitated that to a certain extent; and I went off and I thought that was a really nice shift, you know, and people were all saying ‘oh thanks T’ and they were all addressing me by, by name and saying ‘Oh, T, do you mind if I just ask you something’ (...) and it felt good, I felt that I was supporting them all and they were all happy to share my care, you know that nobody was feeling out done by anybody else, that they were all feeling that they got what they needed from me; it came over that everybody was happy and that they were getting the care that they felt they needed. So that felt good, you don’t always feel like that, you definitely don’t always feel like that.

Being there for others and the ability to help contributed to midwife T’s sense of well-being and usefulness. In contrast, the maternity unit also provides examples, presented in chapter five, of frustration caused by the inability to meet their self-expectations in providing care (page 25). Midwife F explains that she sometimes goes off duty and feels “as though I haven’t achieved anything I wanted to achieve”, midwife O resigns herself to the view that “you can’t meet all the needs of all the people all of the time”.

Resignation in being unable to meet personal ideals, arguably, creates a tendency towards non-reflective, pragmatic or customary practice, rather than motivation towards caring practice development. If caring is frustrated through self-determined causes, it is either
rectifiable or rationalisable. If self-determination and control are lacking, caring may lose its meaning. As an intermediary and member of the multi-disciplinary team, activity can be perceived as being a personal contribution to helping the patient. Arguably, this is the case in the palliative care setting, where nurse-doctor liaison appears mutually agreeable. In contrast, as the descriptions of conflict situations in the maternity care setting suggest (chapter 9: 48), parent aggression towards midwives arose through lack of midwife-doctor teamwork. It is suggested that if nurse-doctor relationships are antagonistic, medical prescriptions may be perceived as task-like and represent acts of subservience to the doctor, rather than helping acts for the benefit of the patient. This is implied in the extract in which midwife D expresses her perceptions of the importance doctors place on caring relationship (chapter 7: 27), "... it doesn't carry any weight with the doctors .. to the medical staff that's not important, they would want to know, why hasn't her blood pressure been done?".

Given the ambiguous nature of professional caring, it is understandable that other aspects of practice, such as the instrumental component make other activities seem less important. Where doctors are perceived as authorities and relied upon to determine knowledge (Belenky et al 1986), nurses’ and midwives’ inner knowing may be given little value. Since caring for others may be a major source of self-worth for some, a disregard or undervaluing of this agency undermines and disempowers.

While not espoused, midwives may adopt a scientific, medical model rather than developing their own vision of practice. Similarly, policy or contemporary discourse imposed by management, without negotiation, such as bed-closures, curtailed hospital stays, named nurse / midwife requirement (DoH 1991), may constrain and divorce the personal sense of agency, control and self-efficacy. Indeed, O'Berle and Davies (1993) argue that nurses whose personal caring values are frustrated by the organisational pre-occupation with instrumentality, become disillusioned and dissatisfied. The lack of ownership of practice in the maternity setting may explain the personal impression that midwives were beginning to lose their will to care, the non-reflective, routinised work patterns and the qualitative differences between the two research settings, identified in earlier chapters. In the maternity setting, interactions with women were superficial, giving the sense that midwives’ separated relationship and task and gave priority to the latter. Compared to the palliative
care setting, there was little interest in receptivity, responsivity and sensitivity as an overall practice ethos. Some midwives appeared to have little insight into the impact they had on the women. Women's reports of being ignored or spoken to abruptly (chapter 9:20-21), the midwives' taken-for-grantedness of women's major life events, such as the dawning of the caesarean section day or experience of an emergency situation (chapter 9:16 and 18), provide examples. Possibly, due to low morale, midwives sought to maintain self-worth through personal friendships with colleagues at the midwives' station. This role of interest is returned to again later in the chapter when the process of internalisation of values is addressed.

The paradox between caring, as intuitively known or as characterised in the literature and professional practice, arise due to the nature and purpose of health care provision. This involves the shared purpose of nurses, doctors and managers to meet the population’s health care needs and to relieve suffering. In order to place care at the centre of nurses' and midwives' specific sphere of practice, organisational aims need to be incorporated while preserving the relational element of caring practice. Nurses and midwives may occupy an intermediary position, but this need not mean it is a subservient one. As Brown et al (1992 :75) note, the requirement to obey physicians loyally was changed to “sustain a co-operative relationship with the co-workers”, in 1973. It is argued that equilateral respect and relationship with doctors and managers is crucial in achieving caring practice. Nurses and midwives need to embrace and articulate clearly the moral necessity for caring relationship in practice and establish caring values within the work culture. The need to accept responsibility for the development and perpetuation of a caring culture within the wider health care arena will be referred to again towards the end of the chapter.

So far, it has been argued that caring achieves a somewhat ambiguous status in health care practice, which may result in lack of role identity, inability to harness and protect caring. In consequence, caring relationship may be marginalised resulting in disappointed personal agency and deficits, due to lack of personal energies and organisational supportive structures. It has been argued that increased understanding of caring within the health care context would enable practitioners to formulate, evaluate and steer practice more clearly. Nurse and midwife clinical leaders need to be in a position to advocate the moral obligation
to maintain caring as a central practice value, in the wider political arena. The remainder of this chapter speculates how this might be achieved.

10.4 Education for caring

While it may appear superfluous to question whether caring has value (Carter 1989), data suggest that it is necessary to re-sensitise practitioners to the patient's experience of illness and/or hospitalisation. The nurses in the palliative care setting appeared committed to achieve the 'connecting' element of their adopted theoretical model (O'Berle and Davies 1990), which involves getting 'in touch' with the patient's experience. Arguably, if applied to the maternity setting, this could assist midwives to shift focus, in order to become receptive, responsive and sensitive to women's experiences. The potential for such activity to be seen as intrusive has been referred to in an earlier chapter (Salvage 1990). Alternative strategies may also be utilised. For example, in midwifery, post delivery 'debriefings' of mothers are currently receiving emphasis (Hammett 1997) and not only give women the opportunity to discuss and gain information about their birth experience, but for midwives to gain women's phenomenological insights. Kirkham (1997:199) suggests that the traditional midwifery knowledge 'muted', due to over-reliance on medical, scientific knowledge can be restored by listening to women's stories. This may help to avert the mismatch between the childbirth experience midwives appear to perceive and the reality. This may also be achieved through reflection which will be discussed later.

It is also recommended that the caring phenomenon needs to be both conceptualised and contextualised within educational curricula. In preparation and continuing education programmes, an understanding of caring as a one-to-one relationship needs to be constructed and differentiated from professional obligation, an entity comprising purely feelings or pre-determined strategy and placed within the professional context of day-to-day practice. While there can be no definitive caring theory, theoretical exploration and caring principles can be used to frame reflective activities, which potentially help to link theory to practice. It is, however, acknowledged that deeper theoretical understanding alone is insufficient to establish and maintain a work culture in which caring is a central value. There can be little assurance that the theory will become practice values and commitment to caring relationship as described in this thesis. Yet, the differences in practice and
articulations about practice between the research settings, support the assertion that individuals are able to transform the given ‘raw material’ (Kemmis 1985:148) of existing biography and social situation into a product of their own making (Kemmis 1985, Freire 1993). This reflects the discussion in chapter eight, where authentic practice or praxis, which is guided by personal existential values was distinguished from superficial, role activity. Learning which is necessarily involved in shaping practice is discussed next. But as will be identified later, in addition to cognitive and psychomotor ability, praxis and a creative formulation of caring practice, involves internalisation of values which gives activity meaning and significance.

Jarvis (1995) identifies four main types of learning theory; behaviourist, cognitive, humanist and social. The latter two constitute the experiential approach to learning. Experiential learning reflects the epistemological and ontological advances discussed in chapter two and is based on the view of the socially located learner actively and reflectively engaged in the learning process. Given the personal engagement necessary for caring, the theory’s ontological and epistemological foundations fit well with the study’s conceptual framework of caring.

Initially, there will be an exploration of Kolb’s (1984) experiential learning cycle. While both Kolb’s (1984) and Jarvis’ (1995) model include experience and reflection as the source of learning, Jarvis’ consideration of the learner’s ‘biography’ increases the relevance of the socialisation aspects of the research findings. The post-modern challenge to formal theory and emphasis on personal knowledge leads to discussion of Schons’ (1983) theory of reflection and Benner’s (1984) emphasis on practical knowledge. This discussion concludes with the assertion that personal knowledge and formal theory, in relation to caring, offer the optimum educational strategy, to shape creative rather than static practice. This notion is derived from the observed difference across the two research settings, which suggest that theory can successfully guide care. Closely associated with this, is the proposal that the affective aspects of attention and interest are necessary, in order that, theory is made meaningful and relevant to practice.
10.5 Kolb’s model of learning - experience and reflection as the source of learning.

Kolb (1984) contextualises his theory in the perspective of humans as a learning species, who need to adapt and shape their physical and social worlds. While he acknowledges the rewards of technological advancement, he advocates the need to recognise afresh the primacy of individual experience. He recommends that:

.... this learning process must be reimbued with the texture and feeling of human experiences shared and interpreted through dialogue with one another. In the overeager embrace of the rational, scientific, and the technological, our concept of the learning process itself was distorted first by rationalism and later by behaviorism. We lost touch with our experiences as the source of personal learning and development and, in the process, lost that experiential centeredness necessary to counterbalance the loss of “scientific” centeredness that has been progressively slipping away since Copernicus (page 2).

Kolb considers learning to be adaptive and transformative, rather than static and defines it as the process whereby knowledge is created through transformation of both subjective and objective experience. It is argued later that this transformation is the source of value creation and internalisation.

Kolb (1984) draws on the work of Kurt Lewin, John Dewey and Jean Piaget. Dewey’s pragmatist perspective places emphasis on the need for educational strategies to translate abstract academic ideas into concrete realities of practice. The importance of the learner’s personal involvement and subjective experience in the learning process is derived from Lewin’s phenomenological perspective of Gestalt psychology. Piaget contribution involves the impact of experience on cognitive development and intelligence. Kolb’s theory therefore, adopts a holistic and integrative perspective on learning that combines experience, perception, cognition and behaviour. Knowledge is the result of the transaction between social and personal knowledge. The former, is the civilised objective accumulation of previous human cultural experience, whereas the latter is the accumulation of the individual person’s subjective life experiences. Learning is conceived as a process rather
than behavioural outcome. It is based on the interplay between expectation and experience, such as unforeseen circumstances, miscommunications and miscalculations, which create a rent in continuity and certainty and results in learning. Thoughts are formed and reformed and modified by experience, therefore, knowledge is derived from and tested in practice.

These processes can be determined from examples in the research data. Nurse B (chapter 9 page 63) identifies how the wish to understand the ‘aggressive’ behaviour of the daughter of a dying patient created a learning situation: as nurse B says, "it wasn’t a personal dig at any one member of the staff, it was just something we had to learn to cope with. So it changed me.....". A further example involves nurse E’s perspective; "... if they’re not making eye contact with us, I still think it’s important..." (chapter 9: 13). Her commitment implies that experience has caused her to identify what she does in such an eventuality. These two examples suggest both a learned attitude and available repertoire of behaviour in such cases.

10.6 The social self, social constructed knowledge and learning

While there is some similarity between Kolb’s (1984) and Jarvis’ (1995) experiential learning models, there are some distinct and important differences. In particular, Jarvis (1995) emphasises the social formation of the self, social embeddedness of knowledge and the fundamental role of the learning process.

Kolb (1984) identifies that learning involves transactions between the person and the environment, but he takes a phenomenological perspective, which focuses on the psychological (Cooper 1996) rather than sociological. Building on the work of George Herbert Mead, Jarvis (1995) argues that mind and self are learned phenomena which are formed as a result of knowledge, skills, attitudes, feelings and values gained through experience. It is from this ‘biography’ that individuals are able to impose meaning on their own situations and experiences. Biography is defined as the ‘subjective assessment of what is known, what is of interest, or what is needed’ (Jarvis 1992:97). The crucial role of interest will be discussed later.
The following extracts of data exemplify the potential additions of both preparatory and continuing education programmes to a practitioner’s biography.

(213-239) Midwife D: You see I was told off by a sister once, because a woman had been there (in the delivery room) for half an hour and I hadn’t VE’d her (performed a vaginal examination) to find out what was going on? and she wanted to know what I’d been doing for that half an hour. And what I’d been doing was, I had been doing the trace and explaining everything, but just really giving her the chance to calm down. You know, they come in frightened, crying or whatever, and I think it’s the last thing they need is to come in and have an internal straight away, it’s not necessary, you know, the baby’s heart beat was absolutely fine, so we’d just been chatting and I think I’d given her a drink, or something just to calm her down, before doing anything else.

VW: Has that changed your practice then, the fact that someone had wondered why you hadn’t done a VE?

Midwife D: No, not at all, because this particular sister does that to everybody, she just likes her board, you know the board on delivery unit where it says what’s going on in every room, she likes it to be bang up to date and because I’d not done mine straight away (...) she does it to everyone, but no, I wouldn’t dream of, it’s not the way I was taught, I was always taught to just calm everything down, because I wouldn’t want to be cared for like that, I wouldn’t want to come in and have a VE immediately.

Midwife D who has been qualified (via the three year programme) for two years, exemplifies the potential for durable learning while being initiated into the profession. The characteristic of localised attention to task of the novice practitioner, which Benner (1984) problematises, in this case, calming everything down, is possibly instrumental in the adoption of practice values. It may be, that instead of seeing this as a phase to be transcended as quickly as possible, careful attention to particulars could be encouraged and
deeply ingrained. In the above extract, the work context is clearly task and midwife-orientated and one wonders how long it will be, if confronted with constant pressure to do the ‘VE’, before midwife D conforms.

While my following question in the next extract is a general one, nurse F exemplifies the lasting influence of professional continuing education.

(542-566) VW: Are there any instances that have perhaps happened in the past that have influenced your care-giving in some way?

Nurse F: I don’t know, the most, the most important thing I think, I remember coming back from my oncology course and somebody asked me what the most important thing was that I’d learned and she laughed at me when I said it, actually, but it always (...) I don’t know, it just seems to be very im, uh, it seems to be something that you can easily forget as a nurse or as any sort of medical person and erm, (laughing gently) you’ll probably laugh as well because it seems so simple but it’s just to remember that the patient in the bed is a real person you know, and they’ve got all the feelings and thoughts and you know all the things that you’ve got inside you ..... and just to remember that all the time, and not to treat them as just, you know, a disease in a bed, but to treat them as a real person who might be, you might be in that position one day. I don’t know, I think that’s probably the (...) most important thing, if you’re going to care for someone, to remember really.

Nurse F has specialised in oncology for six years and knew on qualification that this was the speciality for her. Kolb (1984) differentiates between Piaget’s concepts of integration and substitution. The former principle results in more permanent learning, since new learning builds on pre-existing, stable beliefs and theories. In nurse F’s case, learning possibly fit pre-existing values and consolidated them. Substitutional learning may be superficially adopted since the values or ideas are incongruent with pre-existing biography. Interestingly, both nurse F and midwife D, related the other’s experience to how they would feel, if it was
them. In contrast to objectifying the patient’s experience, this reflects May’s (1969) view, described in chapter three that love makes possible the sense of shared human experience.

10.7 The learning experience

Jarvis’ (1995) source of learning is created when there is ‘disjuncture’ between biography and experience which creates problematic situations and where existing knowledge fails to explain perceptions. There is a quest for meaning and understanding, which results in transformation and learning. The nature of experience exposed to and an individual’s stock of knowledge, create the source of learning and are therefore crucial in identifying how caring can be addressed educationally.

On examining the data, there are examples of situations, particularly in the maternity ward, where it was personally anticipated that disjuncture would occur but it did not. For example, midwife L (chapter 9:13) failed to respond to the woman’s cues of distress while performing a postnatal examination. Midwives appeared insensitive to women cues of discomfort, vulnerability or need, a mother’s fright due to a bleeding wound was not perceived or allayed, women waited and were ignored, while midwives chatted at the midwives’ station (chapter 9:20). Other examples can be seen within the section on receptivity and responsivity (chapter 9:15-18). One explanation may be that caring is not associated with practice and therefore interest and attention are placed elsewhere.

Authors draw attention to the complex nature of human learning (Jarvis 1995) and identify that while experience may be the foundation of learning, it may not necessarily lead to it (Boud et al 1993). Learning depends upon the variable nature of experience and level of consciousness (Jarvis 1995) and individuals need to have active engagement in experience, which ‘has to be arrested, examined, analysed, considered and negated to shift it to knowledge’ (Criticos in Boud et al 1993:9). Kolb (1984) discusses a quote from Hegel’s works in the following extract.

In Hegel’s phrase, “Any experience that does not violate expectation is not worthy of the name experience”. And yet, somehow, the rents that these violations cause in the fabric of my experience are magically repaired.
and I face the next day a bit changed but still the same person (Kolb 1984:28).

Importantly, Jarvis (1995) recognises the influence of active attention on learning and suggests nine different responses to an experience, divided into three categories; non-learning, non-reflective learning and reflective learning. The following references to research data presented in earlier chapters exemplify the former two levels of attention in practice and their influence on agency. While intending to empower women, midwife O was unaware of the potential disempowering impact she had (chapter 9:36-40). This appears to fall into Jarvis' (1995) non-learning and non-reflective categories, as there was no evidence that the situation was perceived as problematic, there was no apparent disjuncture and therefore, no remedial action. In contrast, evidence of Schon's (1983) reflection in and on practice (to be discussed later) was apparent in the extract of my interview with nurse A (chapter 8:6). She illustrates a concern about her body language while talking with a distressed patient. This suggests that she had internalised and reflectively lived out her theoretical framework resulting in self-monitoring and modification of agency.

Jarvis (1994) suggests that pragmatic knowledge, which is the knowledge the person believes will achieve the desired outcomes, underlies much of professional practice. Also, knowledge may be presumptive and result in practice which is inattentive and standardised. As identified in chapter two, this presents a particular challenge in institutionalised caring practice. The habit of relying on pre-determined strategy and role behaviour may be deeply ingrained and presents a contrast to caring which requires letting go of routine and predictability in order to free caring consciousness and responsivity. The following extract illustrates that strategies are needed to heighten reflectivity in the context of everyday practice;

(546-9) Nurse A: I suppose (bec)ause when you do things you don't necessarily always analyse them do you? it's only when later perhaps you think about them and why you did it like that, it brings it out...
While routine, presumptive and caring practice are incompatible, the standard of pragmatic practice depends upon the nature of the desired outcomes, which may maintain the status quo or be constantly seeking the ideal. The recognition that experience may not create disjuncture raises the question of how to motivate learning where practice is customary or presumptive, as in the maternity research setting and achieve a more evolutionary level, as in the palliative care.

Jarvis (1995) proposes that new experience is processed in accordance with previous knowledge, whether this is conscious or unconscious, and it is either accepted or rejected as the result of the process. In the former case, individuals may internalise objectified culture and thereafter externalise it through social interaction. In turn, this makes actions and values culturally available for transmission, legitimation and perpetuation.

In the cases of nurse A and midwife O above (page 21), it needs to be acknowledged that communication theory is currently much less abstract than empowerment. Also, role-models were available to nurse A in the unit. Undoubtedly, implementation of abstract concepts such as choice and patient autonomy, as discussed in chapter seven, and indeed caring, present difficult challenges, particularly where there are no practice examples to emulate or counter experiences to create disjuncture. In view of the rapid changes in health care ideologies and philosophies, more frequent introduction of new practice values can be anticipated and educators need to support practitioners to explore the practicalities and implications of their implementation. It is suggested that midwife O's case is a prime example of the theory-to-practice gap and reveals managers' expectation that new practice values can be simply imposed on practice.

It is the theory-to-practice gap, which creates the major challenge to infusing caring values into practice. While it was suggested earlier that theoretical exploration of caring within the professional context is a beginning, and the adoption of a theoretical in the palliative care setting appeared to impact on practice, caring needs to become part of practitioners' biography, including values and agency. This is addressed next.
10.8 The theory-practice gap

Authors define the theory-practice gap as a failure of theory taught in education programmes to influence practice (for example, McCaughtry 1992, Rolfe 1996. Lathlean and Vaughan 1994). It has been an issue for both managers and academics for sixty years (McCaughtry 1992) and remains a topic in current literature. The recognition of practical knowledge, however, appears to have provided a new perspective. For example, Dale (1994) suggests that rather than theory to practice gap, there is a theory to theory gap. That is, the gap between the theory educators teach and the theory clinicians gain and use in practice, from experiential learning.

Authors have argued that Schon (1983, 1987) has eradicated the theory-practice dualism with his notion of knowing-in-action (Kemmis 1985, Usher et al 1997, Davies 1998). For Usher et al (1997) the theory-practice gap can be bypassed if practice is conceived as action informed by theory. For Kemmis (1985:145); Schon is ‘doing theory’. Reflection has been the source of raised optimism as the following quote testifies;

"I believe that the greatest strength of reflective practice is its ability to provide an opening from theory into practical implementation of what we know to be good nursing practice (Davis 1998: 206)."

Schon (1983) found support for his argument that thought and action are a false dichotomy, in Gilbert Ryle’s (1949) work as follows;

"'Intelligent' cannot be defined in terms of 'intellectual' or 'knowing how' in terms of 'knowing that'; 'thinking what I am doing' does not connote 'both thinking what I am doing and doing it'. When I do something intelligently, i.e. thinking what I am doing, I am doing one thing and not two (Ryle 1949:32)."

In Schon’s (1983) view, therefore, theory is something which is practised or enacted, not merely a result of disembodied contemplation. His theory of learning experience mirrors that of Kolb (1984) and Jarvis (1995), in that disjuncture stimulates practitioners to reflect.
upon what they are doing. In particular, Schon’s (1983) theory places emphasis on the nature of knowledge that professionals utilise in practice. Rather than what is learned, Schon (1983) focuses on what he terms ‘reflection-on-action’, as a means to uncover the ‘knowing in action’.

Reflection involves reliving experiences and emotions, in order to examine and evaluate what happened and what learning was achieved (Boud et al 1985b). The literature abounds with a wide range of ways to frame reflection, for example, in addition to knowledge, reflection can focus upon feelings, values, attitudes and action aspects of experience (Boud et al 1985b). It can be based on phenomenology and aimed at finding meaning and raising awareness (Johns 1998:8) or applied to uncover hidden personal assumptions (for example, Argyris and Schon 1974, Mezirow 1991). Others suggest models with which to frame reflection, such as Carper’s ways of knowing (Johns 1995), Habermas’ three perspectives of social reality; that is, the technical, practical and emancipatory (Kemmis 1985, Mezirow 1991, Cranton 1996, Cruickshank 1996). The conceptualisation of caring in chapter three could also provide a framework for reflection. In efforts to enhance caring, these approaches might be utilised to aid the analysis and conceptualisation of caring. Practitioners might identify individual ways in which caring and concern are expressed, the knowing encompassed in both receptivity, responsivity and how personal caring is balanced with professional obligation. Arguably, reflection could be utilised to eradicate routinisation and promote individualised care, to gain insights into the impact of personal agency and consciousness of ‘being-towards’ others. The utilisation of reflection to develop caring practice will be developed later.

As identified in chapter two, the acknowledgement of the limitations of science to solve the problems of humanity, created an interest in the place of tacit and practical knowledge and this is central to the work of both Schon (1983) and Benner (1984). Schon (1983) challenges the technical-rationality model of professional practice, on the basis that solutions to practice problems may be ineffective, if situations are made to fit into categories of a theoretical framework. Additionally, practitioners may be desensitised to information which does not fit the theory. An example of this from the research data, involves my critique of theoretical ideal of providing choice and promoting patient
autonomy on the basis that it potentially undermines professional responsibility and caring for the Other (chapter 7: 10-14). Within midwifery, what is perceived as a normal physiological event, may be associated with death or permanent disability for some women or their partners. The lack of insights into the experience of women in this latter case, exemplifies the argument that rigid application of theory may result in practice which is built on fixed-ends and instrumentality.

Schon (1983) also argues that the focus on technical-rationality emphasises theory and subordinates attitudinal and practical knowledge components of practice. He suggests that formal theory is insufficient to support professional practice, as it fails to satisfy 'the rigour of relevance'. By this he means that theories have limited capacity to solve the complex problems within professional practice. The discussion at the beginning of this chapter highlighted a variety of ways in which professional caring fails to match its portrayal in the literature. Schon (1983) identifies the process of 'reflection-in-action' from observations that professionals have to modify theory in order to make it relevant to the situation in hand. His knowing-in-action, involves a tacit understanding of the specifics and involves practical knowledge based on a learned repertoire of actions derived through previous experience. Knowing-in-action involves recognition, judgement and skilled performance with possible solutions being developed and tested in on-the-spot experiment (Schon 1987). Schon (1987) argues, that in contrast to application of static theory, dynamic thinking and doing are united and constitute the artistry of practice. Usher et al (1997) assert that the strength of tacit and practical knowledge lies in the fact that it is context-specific and particularised, narratively connected and part of the individual's experiential world. This tacit knowing will be discussed later in the chapter. The rejection of fixed-ended and unresponsive practice, explicit within Schon's theory, is particularly important for the development of caring practice. Because, as conceptualised in chapter three, caring is individual and contextual, there is no typical presentation and therefore application of static theory is antithetical.

Benner (1984) is probably the best known nursing theorist promoting the recognition of nurses' knowing-in-practice. Her well known model of 'novice to expert' is based on the model of skill acquisition formulated by Dreyfus and Dreyfus. Her central purpose is to
extract and make explicit nursing knowledge derived from practice. Experience is associated with the development of knowledge over time, which differentiates phases of development from novice, advanced beginner, competent, proficient to expert. Benner utilises Polanyi's (1958) work based on Gestalt psychology, in which the perceptual grasp of situations changes over time. Initially, practitioners focus on the instrumental task in hand but, with experience are able to accommodate a more comprehensive insight, until 'connoisseurship' is achieved. Benner (1984) analyses practitioners' paradigm cases, which combine reflection on clinical episodes, in which tacit knowledge influenced care-giving or altered the practitioner's way of understanding and perceiving clinical situations.

In America, by utilising qualified practitioners’ written accounts of tacit knowing in practice, attempts to facilitate student nurses’ intuitive thinking are underway (Beck 1998). Nyiri (1988) suggests that tacit knowledge cannot be precisely defined and can only be transmitted by examples which embody it. Written accounts may provide such a means. Beck (1998) reports that Benner’s model is based on the notion that pattern recognition facilitates intuition. Interestingly, Beck notes that students themselves have made an association between intuition and 'cutting corners'. This educational effort highlights another difficulty, since arguably, such focus on intuition places pressure on nurses to acquire expert status. This may result in, rather than 'knowing more than they can say' (Polanyi 1958), exaggerated accounts of knowing more than they know! Certainly the assessment of expert levels of caring would be inappropriate, in the extreme.

However, Benner’s model is problematic also in the context of caring as conceptualised in this thesis. As the title of Dreyfus’ and Dreyfus’ model suggests, it focuses on skills acquisition and this is of undoubted importance in extending clinical skills. Never-the-less, the exemplars of developing practice expertise value ‘assumptions, expectations and sets’ (page 6) which suggest unconscious information processing. In addition to Gestalt theory applied by Polanyi (1958) in which ‘the whole is equal to more than the sum of the parts’, the Gestalt law of ‘pragnanz’ involves four aspects of perception (Jarvis 1995:62-3); similarity, proximity, continuity and closure. All these are potentially incompatible with intentions to provide individualised care, where the essence is particularity rather than similarity and tenacious attention is required, in order to resist premature closure and make
assumptions about what the person needs. In the effort to increase clinical, technical skills, the underlying caring values may receive unequal attention. As Benner's work itself implies, the values underpinning practice may involve the instrumental and academic rather than relational and ethical. Attempts to extract the personal knowledge from practice in relation to caring would need to proceed extremely cautiously, in order to avoid commonalities being utilised in pre-determined strategy. Caring is not about how to do things but about personal development of a certain way of 'being' towards Others.

Acceptance of the 'art' of caring practice creates potential difficulty in accommodating the huge variation in individual caring agency. This requires the possibility of flexibility with in care provision and organisational appreciation that caring cannot be standardised. Heginbotham (1996:135) argues that in implementing organisational structures, such as patient-centred care, there exists the need to acknowledge the tension between management directives and the non-specifiable 'craft' aspect of nursing practice. In balancing the organisational perspective, there is also need to maintain professional ways of being, in terms of, for example, language and affectionate behaviour. Since, as argued, there can be no contract to be caring, codes of professional conduct will also remain necessary.

Informal theory may have the appeal that formal theory lacks. For many practitioners while formal theory seems 'remote, irrelevant and useless' on one hand, it appears 'powerful and threatening' on the other (Usher et al 1997,123). Midwives' reactions, reported in chapter seven, identify the negative image they have in the maternity research setting. Yet, it is argued that reliance upon informal theory alone, results in varied standards of service and lack of professional cohesion and purpose. If taken to its furthest conclusion, reliance on informal theory would result in a return to the time when nurses and midwives knew how, but not why, which led to efforts to produce the 'knowledgeable doer' via Project 2000 programmes (UKCC 1987). It is maintained therefore that, rather than total reliance upon informal knowledge, this is blended with formal theory.
10.9 Theory to guide practice

Benner’s (1984:294) definition of experience based on the work of Heidegger and Godamer reveals an emphasis on informal theory to guide practice;

Transactions count as experience (Benner’s emphasis) only when the person actively refines preconceived notions and expectations. This “negative” view of experience has positive outcomes. Experience is gained when theoretical knowledge is refined, challenged, or disconfirmed by actual clinical evidence that enhances or runs counter to theoretical understanding.

Benner is suggesting a one-way rather than reciprocal relationship between formal theory and knowledge gained through experience and implicitly, the superiority of the latter. This perspective reflects Belenky et al’s (1986) category of subjectivist knowing, in which inner knowing is primary and external knowledge rejected. The advantages of integrating knowledge learned from others and that known intuitively find advocacy in the following quote from Virginia Henderson (1987);

When nurses’ sensitivity to human need (their intuition) is joined with the ability to find and use expert opinion, with the ability to find reported research and apply it to their practice, and when they themselves use the scientific method of investigation, there is no limit to the influence they might have on health care world-wide (in Ogier 1989: xi).

This supports the argument in this thesis that an apparent blending of theory and personal knowing contributed to the qualitative differences in practice across the research settings.

While Schon (1983) identifies the potential problems of technical-rationality in constraining practice, he does not reject it and advocates an over arching theory to guide practice. As he claims;

An overarching theory does not give a rule that can be applied to predict or control a particular event, but it supplies language from which to
construct particular descriptions and themes from which to develop particular interpretations (Schon 1983:273).

Other authors maintain the importance of formal theory (for example, Brookfield 1992, Usher et al 1997, Watson 1998). They argue that theory provides the foundation for professional practice (Usher et al 1997), offers an ideal vision of practice (Brookfield 1992) and can be utilised to guide and evaluate without standardising practice. Brookfield (1992) suggests that, ideally, formal theory should be grounded in the practitioner’s experience, be accessible in terms of language and sensitive to complex and unique situations.

A persuasive argument for a combination of theory and personal practical knowledge can be derived from the rapid change in practice provoked by Government policy, such as The Patient’s Charter (DoH 1991) and the Changing Childbirth Report (DoH 1993b) recently alluded to. This means that practice is continuously evolving and professionals are called upon to perform tasks for which they have not been educated. Accordingly, practical knowledge which worked successfully yesterday may not necessarily realise the ends and values today or tomorrow (Usher et al 1997). Schon (1983) rightly identifies the misfit between theory and practice, but arguably, just as formal theory becomes outdated, practical knowledge also has to evolve in order to find ways to incorporate new values. Previous discussion relating to midwife O and the facilitation of empowerment of women, exemplifies this (chapter 9:36-40). Without a theoretical understanding of empowerment, its limits and ethical nuances, it is difficult to implement in practice. In the case of midwife O, she may have associated the principle of giving information with empowerment, but was unable to theoretically evaluate the results of her strategy.

Schon’s perspective regarding the value of formal theory to guide practice, with the proviso that it may misfit the reality, appears particularly relevant in the case of caring education. It has been suggested that a ‘dialogue’ between formal and personal knowledge provide the best approach. Even so, the central difficulty has yet to be addressed. That is, how knowing, whether personal or formal is transformed into caring agency.
10.10 Transforming caring ‘theory’ into values and agency

Lauder (1994) argues that authors have over-estimated the extent to which Schon’s (1983) epistemology of practice has overcome the theory-practice gap. There are concerns that his theory addresses the ends, but not the means of practice (Lauder 1994, Richardson 1995). Lauder (1994) notes that reflective processes do not explain how the nurse decides on the best course of care for the particular patient, or how thinking becomes translated into action. Lauder (1994) draws on the Aristotelian notion of deliberation, practical wisdom and syllogism. The former involves that nurses are concerned with producing good for humankind and for each particular individual and that not only ends but also means are considered. Practical syllogism concerns Aristotle’s notion of practical wisdom in which intellectual activity alone achieves nothing and that action in the pursuit of good is imperative (Aristotle 1980). Within chapter three, caring in the professional health care context, was conceptualised as necessarily involving action. The related concept of praxis was referred to earlier in this chapter and in chapter eight. In failing to address what transforms thinking into acting, Lauder maintains that Schon fails to unite theory and practice.

This returns the discussion to a further element of the concept of experience, the existential one. Since caring cannot be enforced and therefore depends upon a personal commitment to be caring, this is a pivotal concern.

One’s belief in the capacity and reliability of human caring, and the individual’s ability to transcend social structures in order to shape the work culture will be influential as to whether caring is left to chance or actively facilitated.

That people have a propensity to work for improvement rather than maintain an unsatisfactory status quo, is implicit in the distinction between human ‘existence’ in contrast to ‘being’ (Jarvis 1992). Respectively, these are portrayed in the following quote;

...... the body is not only a passive recipient of experiences; it soon seeks to initiate them in creative and reflexive action. The human essence is creative.... (Jarvis 1992: 36)
Polanyi (1958) implies a belief in the intrinsic human value system and pre-existing meanings, which guide apprehensive knowledge. This is easily concurred with when contemplating Polanyi’s example of the pre-articulate fellowship among people, which enables tacit recognition of another’s suffering and the physically experienced, sympathetic response. Since such immediate sense experience is indescribable to others, and with Wittgenstein’s argument that language is socially constructed in the mind, such shared sympathies must be inherently human, rather than socially learned.

However, although seeing another in distress provokes uncomfortable sense experience, receptivity and responsivity to such distress cues cannot be assumed. Research data reveal that midwives suppressed responses to women in their care and despite increased receptivity and responsivity in the palliative care setting, institutionalisation and patient preference were facts of life in both settings (chapter 9: 41- 46). Polanyi (1958) himself acknowledges that feelings in response to another’s suffering can be suppressed. As identified in chapter three, Kant’s view that emotions are unreliable and partial (Blum 1980, Oakley 1992) is the basis for his argument that moral agency should be based on reason and duty. Bauman (1992:3) sums up one view of human nature;

... humanization is essentially a learning process split into the acquisition of knowledge and the taming, or repressing, of animal (and almost invariably antisocial) predispositions. The distinction between knowledge to be put in place of the natural predispositions, and the predispositions it is to replace, is often conceptualized as the oppositions between ‘reason’ and ‘passions’, or between ‘social norms’ and ‘instincts’ or ‘drives’.

It has been identified that individual biography, that is, what is known, of value and needed, determines whether experience acts as a source of learning and ‘being’ or non-reflective ‘existence’. Brookfield (1992) identifies that meanings and understandings of practical work shape the consciousness of practitioners about the nature and significance of their work. Similarly, Schon (1983) emphasises the relationship between practitioner values, disjuncture and practice development.
...each individual develops his own way of framing his role. Whether he chooses his role frame from the profession's repertoire, or fashions it for himself, his professional knowledge takes on the character of a system. The problem he sets, the strategies he employs, the facts he treats as relevant, and his interpersonal theories of action are bound up with his way of framing his role (Schon 1983:210).

Practice values therefore, partially determine whether or not disjuncture, which initiates learning, occurs. If caring values are internalised, patient distress and vulnerability will be salient and provoke agency. However, alternative practice goals, such as getting the work done, efficiency or technique, will highlight different elements. Noddings (1992) differentiates between intellectual and interpersonal attention. While the former refers to attention to theoretical perspectives, the latter involves attention to the person. Extracts of data discussed earlier, in which nurse A focuses on her body language and midwife O on information giving, exemplify attention on the theoretical rather than inter-personal. In contrast, other data suggest that the palliative care model encourages focus on the experience of the patient and family. As identified in chapter 7 (pages 27-8) nurses adopted strategies to maintain the patients’ identities and social networks.

Given then that values are central to the learning process, a caring curriculum or learning strategy needs to address how values are internalised, in order to facilitate disjuncture. This requires a further look at the nature of experience.

In analysing the concept of experience, Kolb (1984) differentiates between subjective and objective elements. As an objective phenomenon, experience refers to temporality, such as twenty years experience, or as experiential processes such as, undertaking, observing, encountering (Boud et al 1993). In its subjective form, experience is a sensation or internal state, such as happiness and joy. Kolb (1984) argues that these two perspectives are inseparable, as experience causes a permanent change in both the subjective and objective human elements. This association was discussed earlier when it was argued that persistently frustrated caring intentions may dampen motivation and result in routinised and non-reflective practice.
This duality is exemplified in Dewey’s metaphorical description which also conveys how the meaning given to our objective experience can enrich our subjective senses experience and agency.

*Experience does not go on simply inside a person. It does go on there, for it influences the formation of attitudes of desire and purpose. But this is not the whole of the story. Every genuine experience has an active side which changes in some degree the objective conditions under which experiences are had. The differences between savagery, to take an example on a large scale, is found in the degree in which previous experiences have changed the objective under which subsequent experiences take place. The existence of roads, of means of rapid movement and transportation, tools, implements, furniture, electric light and power, are illustrations. Destroy the external conditions of present civilized experience, and for a time our experience would relapse into that of barbaric peoples....* (Dewey 1938:39).

The subjective, sense experience associated with apprehension (Kolb 1984), appreciation (Polanyi 1958) and interest (Habermas 1972) in mediating perception, cognition, motivation and learning, appears central.

Educators identify that the three domains of learning, that is, the affect, cognitive and psychomotor are usually treated separately and either cognition (Kolb 1984) or the latter two tend to be emphasised (Boud et al 1993). Some argue that emotions and feelings are neglected in our society and educational institutions (Boud et al 1993, Gardner 1993) and are the most difficult to address educationally (Krathwohl et al 1964). The apparent contribution of the theoretical model in the palliative care setting to enhance caring practice has motivated a closer look at the inter-relationship between the three domains and it is concluded that cognition and the affect are inseparable.

Kolb’s (1984) theory of experiential learning is based on these two distinct modes of grasping experience, apprehension and comprehension. Split-brain (laterality) experiments
pioneered by Pepper and Feigl, appear to have provided a scientific solution to the 
philosophical problem posed by Cartesian dualism (Kolb 1984), in which the mind 
subordinates physical sense experience (Lycan 1996). While still inconclusive, there is 
strong suggestion that judgement is not only cognitively based, but may be mediated by 
either affective or cognitive processes or a combination of the two. Consequently, Kolb 
argues, in opposition to Cartesian dualism, that knowledge is formed from the dialectic 
relationship between apprehension and comprehension, in which the two are coequal.

Apprehension concerns subjective knowledge of the here-and-now reality as experienced 
by the senses (Kolb 1984). It is taken-for-granted and is difficult to describe. Any attempt 
to reflect upon the knowledge gained automatically changes the immediate experience. 
Schon’s (1987:25) description of attempts to articulate knowledge-in-action portray the 
identical difficulty.

\textit{Whatever language we employ, however, our descriptions of knowing-in-action are always constructions. They are always attempts to put into explicit, symbolic form a kind of intelligence that begins by being tacit and spontaneous. Our descriptions are conjectures that need to be tested against observation of their originals - which, in at least one respect, they are bound to distort. For knowing-in-action is dynamic, and “facts”, “procedures”, “rules”, and “theories” are static.}

The tacitness in Kolb’s concept of apprehensive knowledge and Schon’s knowing-in-action, gives further explanation to practitioners difficulty in articulating meaning of caring discussed in chapter six.

Like Schon’s constructions above, comprehension involves conceptual interpretation and 
description of experience (Kolb 1984). It constitutes the organisation of experience and 
current state of knowledge which can be communicated, analysed and reflected upon, 
integrated, communicated to others and objectified. Kolb notes that positivists espouse the 
comprehension pole of knowledge and notes Piaget’s Cartesian, rationalist orientation in 
which sensation is secondary to thought.
For him only sensations and perceptions are the starting point of knowing, it is the organisation and transformation of these sensations through action, most particularly internalised actions or thoughts that create knowledge (Kolb 1984: 101).

Polanyi (1958) adopts the extreme opposing view and challenges the supremacy afforded analytical powers. He states;

... into every act of knowing there enters a passionate contribution of the person knowing what is being known, and that this co-efficient is no mere imperfection but a vital component of his knowledge (Polanyi 1958: x).

In support of his argument, Polanyi (1958) draws attention to the affective element which motivates the intellectual powers to eradicate confusion in complex situations and the pleasure when this is achieved. Emotion clearly plays a part in the models of learning, detailed earlier and the interrelationship of the cognitive and affect can be detected. For example, the learning models of Schon (1983), Kolb (1984) and Jarvis (1995) involve surprise and feelings of disjuncture when current knowledge fails to explain encountered experience. Benner’s (1984) paradigm cases of nurses’ learning in clinical practice, illustrate the emotional elements of ‘expert practice’ based on qualitative perceptions and differentiations. A quick perusal through ‘Novice to Expert’ (Benner 1984) identifies feelings of; uneasiness, gut feelings, panic, challenge, concern, uncertainty, frustration, elation after successful intervention, fulfilment, pride, satisfaction, amazement and inspiration, to name but a few. Nurse A could recall the emotion of ‘getting the body language wrong’ which, presumably would be adjusted in subsequent interactions.

The qualities which Kolb accords apprehension are crucial to identifying a means to promulgate caring values and links with education of desire and interest (Habermas 1972, Usher and Edwards 1994, Jarvis 1997). While drawing on Polanyi’s (1958) work, Kolb identifies that apprehension is intimately associated with appreciation. Appreciation is largely the process of attending to and being interested in one’s experience and, in turn, deepens the apprehensive experience. Chapter three identified that caring is crucial in
guiding perception of the patient’s experience (Griffin 1980). Consequently, caring could be interpreted as an apprehensive process. Kolb (1984) uses the phrase ‘preferences precede inferences’ to highlight that, we notice those things that interest us and interest is the most elementary act of valuing. Similarly, Habermas (1972) notes that interest precedes knowledge and interest involves pleasure associated with an object or action. Maurice Merleau-Ponty maintains that environmental features manifest differing degrees of salience depending upon practical, symbolic and emotional values and the individual ‘chooses’ the stimuli to which he will be sensitive and responsive (Hammond 1991:5). Perception, cognition and action are therefore intertwined. However, in the context of caring agency, interest can also create difficulties.

Bauman’s (1993) concept of ‘mismeeting’ and depersonalisation of strangers was referred to in chapter nine, where the lack of focused attention on mothers in the maternity setting was identified. While learning involves disjuncture and dissonance between personal knowing, values and experience, interest and attention require the opposite, that is an affiliation or bonding with the ‘subject matter’. Data suggest that in contrast to disjuncture as the source of learning, the development of interest in others appears to be stimulated by familiarity and similarity. This view is based on the expressed preferences of nurses during pilot interviews in the neonatal intensive care unit and field work in the two research settings. Interest appears to be enhanced in cases of perceived, personal similarity and levels of the patient’s interest and understanding of the health episode. For example, nurse F notes that “it’s the same as you’d be at home, you get on with different personalities better than others” (chapter 9:45). Midwife H says that she prefers “nice people” and finds “very unprepared or ignorant women very difficult” (chapter 9:42). The innate, empathetic response of infants to the distress of others suggests that there exists an intrinsic association between familiarity, caring and altruism (Gardner 1993). The above finding may evidence difficulty in communicating with those, who do not share our personal horizons. The latter example may demonstrate how discourse may distort caring agency.

Following The World Health Organisation’s (1985) strategy, “Health For All”, governmental policy began to strongly emphasise individual responsibility for personal lifestyle and health (DoH 1992). This may result in more of a contractual basis for health care, with expectations of the service-users and judgements about deservedness. The more
recent publication "Our Healthier Nation" (1998a) appears to acknowledge that the health-damaging social and environmental factors are in the government's gift to rectify. Yet, as has been argued earlier, caring is impartial and further work is required to explore and address the potential inequality that these practitioner preferences create.

Educationally, interest as a means to stimulate learning, represents the utilisation of affective objectives as a means to cognitive goals (Krathwohl et al 1964:57) but it does not explain the reverse. That is, how a theoretical model can mediate the affective processes of attention, appreciation and interest. The relationship between Kolb's apprehension and comprehension, Habermas' interest and knowledge, Merleau-Ponty's perception and thought reflect Deweys' reciprocal relationship between subjective and objective experience referred to earlier. All concern the argument that the facts (or conceptions) are not equally perceived but are discriminately selected above other objects and therefore are only given meaning and existence through their connection with sense experience. While subjective sense experience determines what we will attend to, reciprocally, comprehensive knowledge can provide satisfying sense-experience and consequently influence what is attended to. Kant's phrase perhaps explains it more succinctly, "Thoughts without content are empty, intuitions without concepts are blind" (Kolb 1984:106). If put another way, apprehensions are the only means for comprehensions to become validated and existent. Gardner (1993) argues that an individual's feelings remain rudimentary and disorganised without symbolic structures within a culture, by which they might be discriminated. Based on this, it is conceivable that cognitions become internalised values which subsequently motivate agency.

Just as Kolb's apprehensive, subjective experience increases salience, professional socialisation formulates an "appreciative system". This encompasses the set of values, preference, and norms on which practice goals are identified and addressed, how situations are assessed and what constitutes good practice (Schon 1987:33). In terms of practice, meaning and significance shape and perpetuate the social and cultural context (Schon 1987). Arguably, the theoretical model of care within the palliative care setting represents such an appreciative focus. The model helps to frame practice and therefore increases the salience of selected aspects of practice and gives focus for team communication and
development. If facts are not available culturally, they cannot become part of the professional ‘appreciative system’ (Schon 1983) to become valued, attended to or acted upon. In this sense, it appears that attention to ‘facts’ is equivalent to the internalisation of values. With reference to socialisation processes discussed in chapter six, values central to the habitus (Bourdieu 1990), become embedded and achieve saliency. To return to the concept of disjuncture as the source of learning; whatever comprise the dominant cultural values are likely to become salient, part of personal biography and the potential cause of disjuncture, learning and practice development.

10.11 Initial caring socialisation
Roach (1984) suggests that every individual is capable of caring and Blum (1980) maintains that rather than being consciously chosen, values are formed through upbringing and peers. It is therefore argued that recruitment and selection processes need not attempt to specifically distinguish caring from non-caring applicants. As identified, individuals care in a variety of ways and judgements might be arbitrary and unreliable, leading to rejection of suitable candidates. The view is held that individuals entering the caring professions have a desire to help others. The purpose of education for caring, therefore, needs to maintain and nurture these caring values, within the practice culture.

During professional preparation students have moral visions of their practice and those they will serve (Argyris and Schon 1974). Davies’ (1993) study of role modelling identified that students have pre-existing notions of good and bad practice. She undertook a qualitative study (grounded theory) to determine if observation of role models provided students with insights into knowledge embedded in practice. Six students, selected on the basis of their ability to articulate experiences from an analytic perspective, identified positive and negative practitioner attributes. Positive characteristics included a pleasant manner, relaxed, calm, confident, non-judgmental, caring and patient-compassionate, touched patients a lot, gave them hugs and took time to talk to them. Lack of respect for dignity and privacy, non-caring, emphasis on routines, rather than the person and slap-dash behaviour, comprised negative attributes.
There are other examples of mismatch between student ambitions and practice. For example, Kapborg and Fischbein (1998) analysed data from nurses' day-to-day diaries which noted both positive and negative practice experiences following a three year nursing programme. They concluded that nurses were unprepared for the lack of time to care for patients and communicating with patients and relatives. This finding mirrors Melia's (1987) study of student professional socialisation. If educational preparation fails to help students face the realities of qualified practice (Kapborg and Fischbein 1998) caring values may soon be lost (Roach 1984).

Davies (1993) identifies that clinical role modelling serves to nurture professional ideals and values on the one hand or perpetuate routinisation and task centredness on the other. Incongruence between students' pre-entry expectations of practice and the reality would be eradicated if caring values, balanced with organisational constraints were embedded in practice. It appears clear that if the personally valued behaviours are not available they will either lose their salience and practitioners will either conform to legitimated values and activities or leave.

The processes of achieving the salience of caring values both collectively and personally within the culture is discussed next.

10.12 Learning caring by working alongside

Above and earlier in chapter six, the necessity for objective means by which knowledge and values are made culturally available (Berger and Luckmann 1966) was emphasised. Chapter six also addressed the dichotomy of language versus practice as the source of meaning. This was resolved by adopting Mead's view that language and the meaning of social phenomena are learned in tandem (Burkitt 1991). The necessity for both theory and practice in making meaning are implicit in the previous discussion of the learning processes of midwife O and nurse A. That is, that theoretical ideals are best facilitated if articulated attitudes and behaviours are culturally manifest and therefore, can be modelled or collectively established.
It has been identified that caring involves pre-knowledge (Blum 1980, Noddings 1987, Bauman 1993, Jarvis 1997), tacit and practical knowledge (Polanyi 1958, Bourdieu 1990). This makes linguistic objectification of caring values sensed, rather than known. Caring may be beyond precise articulation, but caring values motivate and are enacted in agency which is both consciously or sub-consciously available as we work alongside or interact with others. Therefore, caring values need to pervade practice in order to learned experientially.

An example of the power of role models was provided by one of the palliative care nurses seen subsequent to the study. She noted that the nurses were 'so interested' in the patient's experience, it permeated the work and impacted on her personal practice. This also raises the issue of behavioural conformity and implications for health care provision if practice ideologies work against rather than for patients, such as efficiency concerns. None-the-less, the power of the work environment to transmit values, attitudes and practical knowledge, non-verbally, is evident.

As identified earlier, due to the unique nature of each caring relationship, it is the meaning embedded in the 'being towards the other', rather than the actions themselves, which convey caring values. For example, practitioners tacitly balance patient autonomy and dependency (Hall 1979) and provide supportive and affirming agency, while avoiding intrusive and patronising relationships. Caring involves sensing how, from numerous possible reactions, a patient is experiencing particular health care circumstances, what is helpful or may cause further distress. Nurses learn to convey interest and a willingness to help and support in personally symbolical ways, such as the observed leave-delaying tactics, proximity, facial expression, touch and eye contact. Midwife T provides insight into the need to respond in different ways to different people as she notes, "Most people do want the midwife to be fairly chatty and familiar, but some people actually don't, they just don't seem to want that closeness...". Caring involves perceiving and responding to unanticipated patient responses, knowing when someone needs time alone for either joy or sadness or companionship to defeat the panic of perceived difference and isolation. As nurse D comments, "...you just have to realise that there is actually some value in you just
It is clear that practitioners adopt their personal ways of caring through observing others in the workplace. Earlier chapters detail authors who note how practitioners, through experience, become comfortable with caring activities, such as touch (Estabrooks and Morse 1992, Savage 1995). Estabrooks and Morse (1992) suggest that practitioners first watch the approach of others towards patients and following personal experimentation, adopt what feels comfortable to them. In chapter nine (page 11), midwife H can "vaguely remember" being aware of feeling comfortable with her interaction skills and nurse A appears to be in the process of learning particular ways of communicating empathy through body language (chapter 8: 6). Lave and Wenger (1991) refer to this as 'situated learning', in which neophytes learn from experienced practitioners by peripheral involvement with their practice. Learning is a social rather than individual phenomenon, which emphasises the importance of co-participation. The nuances of caring expressivity is beyond the reach of mere implementation of theory into practice. Somehow, the knowledge which comprises the tacit judgements which mediate subtle responses to subtle cues, is learned. The embedded values within each perception and response are the source of how caring values contribute to a caring habitus.

The important role of working alongside has implications for midwives who often work on a one-to-one with women, in contrast to the palliative care, where patients often need the assistance of two nurses. Anecdotally, due to staff shortages, student midwives are used to 'make up the numbers' and may experience minimal role modelling. This is not helped by the focus on skills, and once competent, students are expected to work alone rather than in partnership. According to Lave and Wenger (1991) excessive direct involvement rather than peripheral learner participation in the work, inhibits or eradicates potential learning. The midwifery work ethos comprises competencies to achieve, rather than a unification of staff through practice ownership and development. In order to achieve a shared vision of practice, Argyris' and Schon's (1974) argument that professionals are resistant to share personal insights, indicate that strategies to encourage focused dialogue appear essential. Certainly a shift in purpose is required if caring values are to become culturally embedded.
10.13 Nurturing and managing caring emotions
Within the conceptualisation of caring in chapter three, it was identified that commitment is required to maintain a caring consciousness in relation to others. It is therefore a personal endeavour, but as argued, can be enhanced, if caring values are available for transmission within the work culture. It is acknowledged that the research explored the manifestation of caring and what caring means to the research informants rather than their emotional and cognitive processes. Therefore, while data provide some insights, these are limited. It could be anticipated though, that educational strategies could help to increase the saliency of levels of attention afforded the Other and the factors which sustain or inhibit it.

Goleman (1995) maintains that empathy or receptivity to the distress of another is built upon self-awareness, which requires continuous monitoring of feelings. The more that we are open to personal feelings, the more receptive we are to the experiences of others. He reflects Polanyi’s (1958) view, referred to earlier, that the recognition of another’s suffering has deep genetic roots. Gardner (1993) advocates the notion of personal intelligence, which includes the ability to interpret personal feelings and distinguish the nature of experiences had by others. These are inter-related since, personal feelings have a degree of correlation with our perception of the feelings of others in different circumstances. Carper (1978) refers to Dewey’s differentiation between perception and recognition. Recognition may be satisfied when a label, which meets pre-conceived categories is attached to the patient. In contrast, perception involves seeing the particulars of the other’s experience and need.

In addressing the education of personal intelligence, Gardner (1993) suggests that discrimination of personal feelings which enhance being towards others may naturally emerge. Alternatively, the individual’s experience can be influenced through enriched practice and language. Based on this view, if, as argued, a caring culture is established, caring values would emerge through socialisation processes. Even so, authors identify that the discrimination of feelings involves cognitive processes (Gardner 1993, Goleman 1995). Goleman (1995) suggests that this takes the form of internal dialogue and that personal intention and purpose are central in directing attention. In chapter nine (pages 51-53), midwife D allows good insights into her inner dialogue, as she maintains the principle of
being there for the woman even when she feels her care is refused. This supports the earlier discussion regarding the need for a guiding framework. The following outlines a few of the internal processes which could be focused upon educationally.

Individuals could be encouraged to appraise the level of attention given to the Other and to discriminate experienced emotions into those which enhance or inhibit agency. It is possible to distinguish the sense of giving to or denying the Other by the residual state of knowing that the call to care has been either answered, inhibited or ignored. Whether or not caring has been fulfilled is a tacit assessment as described in an earlier extract involving midwife T (pages 10-11) and as indicated by nurse A;

(603-17)VW: ...do you recognise what impact you’re having on the patients, consciously?

Nurse A: ....No (laugh) ....I suppose you can come away from certain situations and go ‘Yes, I feel good with that’, but I don’t know how you’d measure it actually.

Midwife O also trusts her sense experience to evaluate her care-giving:

(632-34) I feel most of the time, wherever I work, I tend to feel happy with what I’m doing. If I’m happy with what I’m doing (...) I’ve given my best...

In applying Kolb’s notions of apprehension and comprehension, because caring is made consciously salient through reflection, the outward signals indicating the experience of the Other are deeply attended to, internalised and become a source of motivation. Goleman (1995) suggests that the key to intuiting is the ability to read non-verbal cues. Only through ‘emotional intelligence’, by which he means our knowledge and awareness of our own feelings, can insights into another’s experience, or empathy be possible.

Accordingly, one can nurture a consciousness of feelings of attachment to the plight of the Other, in which the self is secondary to the moral responsibility to the Other. Data suggest
that nurses strive to achieve attention to the patient’s experience. Nurse F portrays the ideal synchrony between caring agency and patient values;

... that's what it's all about basically (...) listening to them, you know the way they do things at home and the way they prefer things to be done and try to carry on doing that as near as you possibly can (chapter 7: 28).

With commitment to maintain oneself as caring and with continuous endeavour through success and failure caring may become our first tendency in relationship with Others. Reflection may enable attunement to personal feelings, in order to become more perceptive and sensitive to others. An awareness of personal feelings could be examined in tandem with responses, in order to explore the strength of our caring motivation. Factors which inhibit or enable caring could be surfaced in order to strengthen the awareness of responsibility for the Other. These may be personal features, such as tiredness, stress, shyness, self-preservation, dislike of involvement or strangeness. Also, characteristics of individuals referred to by Stockwell (1972) as unpopular patients and involve which prejudice and partiality result in either rejection or acceptance of responsibility for the Other. These involve factors such as nature of the illness and whether health deficit is perceived as self-inflicted, such as smoking and certain sexual behaviours. Again, the contemporary focus on personal responsibility for health and health-care rationing raises the profile of such considerations. Personal values and expectations of others form the basis of our judgements and subsequent being towards others. For example, midwife F reveals a mismatch between her expectations of mothers’ capabilities and their independence in caring for their babies in the following; "...some people will say 'well I've had an operation so I can't do it' and you think, well you're going to have to do it when you get home" (chapter 7: 25). As referred to earlier, patient participation or lack of it, influence interaction. These few examples fundamentally involve discriminating our receptivity, responsivity and responsibility towards others and overcoming protective defences when faced with difference.

In the palliative care setting, the theoretical framework arguably assists cognitive processes, in providing language in which caring values are tacitly present, and enable cultural
objectification, sensitisation and legitimation. As argued in an earlier section, the way in which theoretical models describe practice influences the practitioner's framing of practice and determines what is subjectively attended to and acted upon. The subjective experience therefore formulates the nature of the practice.

Even so, as Belenky et al (1986) identify, women may be dependent upon external authority for personal knowing. Nurses have a legacy of looking outside themselves for knowledge to guide practice. Despite overcoming the earlier 'handmaiden' days, emphasis on scientific knowledge in the shape of research and evidence-based practice are potential contemporary replacements. Belenky et al (1986) suggest that the latent knowledge that individuals already have about caring relationships through their personal experience, needs to be drawn out, nurtured and elaborated. Given the potential for self-doubt, it is important to validate nurses' personal knowledge which they bring to caring encounters, while at the same time, valuing the contribution of rationality, as argued earlier.

The commitment to expend energy on creating and maintaining a caring consciousness is personal and arguably, individuals are able to sustain personal caring practice. While articulation about caring can only be virtual, caring values may tacitly shared through discussions on practice with others. This can establish a unified energy which is essential if caring is to become central to practice.

While Freire's pedagogy is set at national and international levels, the message of creating culture is a pertinent one. Change requires collective effort and the courage of an innovator to share a vision with others. Polanyi (1958) reveals that the fate of personal hopes for human betterment rests in the bravery and conviction of the individual and the acceptance of the group.

Heuristic passion seeks no personal possession. It sets out not to conquer, but to enrich the world. Yet such a move is also an attack. It raises a claim and makes tremendous demand on other men; for it asks that its gift to humanity be accepted by all. In order to be satisfied, our intellectual passions must find response. This universal intent creates a tension: we

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suffer when a vision of reality to which we have committed ourselves is contumely ignored by others. For a general unbelief imperils our own convictions by evoking an echo in us. Our vision must conquer or die (Polanyi 1958: 150).

The realisation of caring practice cannot succeed as an individual’s crusade but only as caring values deeply embedded within the practice culture.

10.14 Achieving practice cohesion through clinical structures.
Team cohesion and clinical leadership were features which emerged during the research and appear to contribute to the differences in caring practice across the two units. Again, the study was not designed to explore team and leadership processes, therefore details are limited and these comprise areas for future research.

There were established structures within the palliative care setting, such as a strong team spirit, de brief meetings and clinical leadership which, collectively, appeared to contribute to the sharing and perpetuation of caring values. The research setting was fortunate in its nurse-to-patient ratios and nurse-doctor inter-disciplinary working more favourable than most; a lecturer practitioner, clinical specialist and motivated team leaders who inspired and maintained interest and attention to caring goals.

In the palliative care, the de-brief meetings were not contrived reflective sessions, but were reflective problem-solving, decision-making discussions made necessary through clinical situations. This approach may usefully avoid perceptions of reflection as predictable and repetitive (Cruickshank 1996) or that it involves only dramatic and emotionally charged aspects of care (Stoddart et al 1996). Examples of issues collectively addressed include, the conflict between patient autonomy and minimising risk of harm and needing to find ways to balance the needs of all the patients, as previously mentioned in chapter seven and five respectively. Nurses also expressed personal concern for the level of care provided, which confirms the salience of the unit values encompassed within their theoretical model, of choice, dignity, the patient’s experience, awareness of caring frustrations and the development of coping strategy. Their practice framework, therefore, provided the
necessary language to enter into social and intellectual interactions and a sense of ‘we-ness’ with others (Belenky et al 1986:26-7). The more established staff, including nursing assistants and senior nurses were committed to raise, discuss and problem-solve practice issues as a team.

In the maternity setting of practice, examples of situations, which would provide ample opportunity to explore, promote and establish caring within the culture via shared communication, have been previously alluded to. For example, midwife O needs to make further progress before achieving her espoused intention to empower women (chapter 9:36-40). Arguably, discussion against a caring framework would reveal deficits in conscious attention to the Other, the problem of how to give such a large amount of information, while maintaining caring relationship, would be surfaced and amenable to solution. Midwife D’s conflict situation provides a further example (chapter 9:51-53), of an opportunity to share values, while exploring practice situations. In this case, midwife D could articulate the feelings she had to overcome to remain available for the woman, and the values underlying why she did so. These are examples of how theory can be blended with intuitive, tacit and practical knowledge. In contrast to theory being given primary emphasis above personal knowing, practitioners’ personal understandings can be articulated and given value. Yet, arguably, only if they are collectively legitimated, and the work place is shaped to contain them will they maintain their salience above others.

The above observations in the maternity care setting support the assertion that professional practitioners’ propensity to view personal insights and learning in practice as ‘private, tacit, ephemeral’ and may be hesitant to communicate with peers (Argyris and Schon 1974:144). Authors suggest that this denies them the opportunity to test ideas, to identify personal assumptions (Argyris and Schon 1974, Kemmis 1985) and to share practice conundrums (Schon 1983). Also, importantly, Schon (1983: 333) suggests that reflecting on practice with others brings the practical knowledge and knowing-in-action into consciousness by articulation.

Habermas (1972) argues that while the meanings individuals give to persons, things and symbols are personal, they are not private. Meaning cannot be derived in isolation.
Language objectifies personal perspectives which enable meanings to be shared and culture created. Habermas (1972) notes that this not only relates to the meaning of objects in the cognitive sense, but includes the significance of affective states and emotional life and normative modes which involve for example, obligation, duties and rights and awareness of what ought to be.

Both Wittgenstein and Heidegger emphasise that language is crucial to perception. Since language enables thought and meaning, only by use of language can things be conceived (Mulhall 1990, Finch 1995). Wittgenstein asserts that meaning is socially derived and challenges solipsism (Finch 1995), which assumes that experience is private, unique and socially isolated. This view is based on the lack of language to describe direct and immediate experience and which, therefore, denies shared and common understanding (Ayer 1956). Asserting that language cannot be private, universal or meaning-free, Wittgenstein disagrees with the notion of self-identity and suggests ‘identitylessness’ in its place (Finch 1995). He uses the concept of ‘language games’ to suggest that the meanings of words are socially constructed and are associated with a socially learned ability to interpret and anticipate the actions of others. In consequence, the product of a person’s inner experience has ‘intersubjective validity’ (Linge 1976). This provides explanation of how the sharing of thoughts, values and insights into practice, such as occurred in the palliative care setting, provides meanings and as a result makes salient collectively determined features within the environment. If the midwives had intentions to transform practice into a more visionary one, the above situations could so easily be turned into reflective learning experiences. As opposed to the above experiences of midwives O and D comprising isolated, personal values and practice conundrums, these could be shared and could enrich practice. As identified in chapter six, Mead argues that where a sufficient number of people are sufficiently moved, social transformation is possible (Burkitt 1991). Therefore, if caring is to become central it requires skilled clinical leaders to forge group cohesion and commitment, in order that caring values are established in the work ethos. Caring values need to be what nurses and midwives think and talk about, enact, value and nurture.
The role of clinical leaders in enabling group cohesion and practice development appears pivotal. Those in the palliative care setting demonstrated skill in balancing caring values with practical and organisational constraints, such as resources and staffing levels and the collective needs of the patients. Team processes were committedly facilitated both organisationally, in terms of protecting time to discuss practice and motivationally. They role-modelled caring behaviours and values and as mentioned earlier, demonstrated the determination to overcome situations which challenged the idealised practice values. For example, chapter five presents data which demonstrates well structured mechanisms for maintaining the integrity of the team, solutions to issues such as distributing care fairly and personal coping strategies. Without the approval of nurses who were in a position to organise staffing and care, this would not be possible.

In the maternity care setting, team leadership appeared to be more concerned with managing staff shortages, resources and problem-solving organisational difficulties with women or parents. While important, this subordinates practice values, agency and development. The team leader was aware of the amount of chat at the midwives’ station and it is suspected that politics raised through staff shortages and ward closures, which created low morale, influenced the management strategy.

10.15 Living with multiple perspectives
Data presented in chapter six, show that despite outward solidarity, informants privately expressed divergent values to those of peers. For example, midwife O disagreed with practitioners who value patient appreciation (chapter 6:8-9). Nurse B appointed herself patient advocate in the face of perceived colleague partiality (chapter 6:7-8). While team discussion and reflection provides a forum in which to share interpretations of practice (Boud et al 1993:19), contrasting views will be surfaced and will challenge practitioners to appreciate the uniqueness and validity of individual perceptions.

The co-existence of multiple perspectives is characteristic of the post-modern society and individuals are exposed to frequently changing dominant scientific narratives (Jarvis 1997), and ‘diverse and non-congruent, overlapping and discontinuous’ discourses (Usher 1997:8). Usher et al (1997) advise educators to prepare individuals for ambiguity,
inconclusiveness, discontinuity, un-predictability and conflicting views. They suggest that
individuals need to achieve the difficult task of espousing a view with commitment, in order
for it to have chance of success and at the same time a readiness to abandon it (Usher et al
1997). Bauman (1992:xxi-xxii) advocates an authentic recognition of the relevance and
validity of the views of others and the willingness to dialogue.

_Tolerance reaches its full potential only when it offers more than the
acceptance of diversity and co-existence; when it calls for the emphatic
admission of the equivalence of knowledge-producing discourses; when it
calls for a dialogue, vigilantly protected against monologic temptations;
when it acknowledges not just the otherness of the other, but the
legitimacy of the other's interests and the other's right to have such
interests respected and, if possible, gratified (xxi-xxii)._  

As opposed to uninvolved dialogue, Habermas' (1972) hermeneutic understanding seeks to
resolve situations in which communication within daily social interactions creates
disappointment, disagreement and disjuncture. Since interactants remain individuated while
simultaneously identifying with one another, they become both interpreters and partners in
dialogue. They not only share understanding with the other, but move beyond personal
pre-understandings, in order to achieve a reciprocal transformation of understanding. In
the case of the palliative care, there was a strong sense that nurses were unified in their
commitment to the unit philosophy, which subordinated other differences.

Given the intermediary role, nurses and midwives need to have practice values understood
and appreciated by other disciplines. The extract, which portrayed midwife D's resignation
that doctors mainly value technical and physical aspects of care, exemplifies how personal
values, as noted earlier, can soon become subdued. Just as emotional labour may be utilised
to convey caring values, in order to maintain amicable interactions (Jourard 1971,
Hochschild 1983), similar efforts may be employed to convey other values expected by
others, such as efficiency and technical skill. In both situations, personal feelings are
contained. It is not suggested that permission is sought from parallel disciplines, but that
interdependence is acknowledged. In the case of the palliative care caring values such as

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empathy, respect for individual autonomy were shared between nursing and medical staff, which arguably enabled practice development. Internalisation of caring values, as central, would lead to practice being seen anew. Incompatibilities between customary practice and caring values would become apparent. These would be require contemplation, description and change, which automatically impinge upon the activities of associated disciplines. Even so, strategy is required to counter the constraining forces which continue to marginalise caring practice.

10.16 Deflecting detrimental discourse.

Critical reflection can be undertaken to expose the constraining effects of dominant ideologies which maintain the status quo and reveal how things might be transformed (for example, Habermas 1972, Freire 1993).

Discussions in chapter three, regarding the essence of caring, suggest that the elusiveness of caring makes it victim of both rhetorical and ideological use. In chapter two, it was argued that the desirability of caring and emotion depends upon what suits the political, social climate at the time. Also, how practitioners frame their role or see themselves in the institution and the organisational culture bounds the scope of practice (Schon 1983). As discussed, the intermediary role is exposed to both medical and managerial regulation.

Foucault (McHoul and Grace 1993) argues that at any given historical period, people are subjected to discourse, which serves to normalise a population’s ways thinking and acting. Despite the need to manage contextual pluralism, personal morality depends upon personal autonomy, and freedom from dogmatism and ideology (Polanyi 1958:216, Habermas 1972, Carper 1978, Bauman 1992)). The process of achieving personal emancipation and simultaneously facilitating it in others reflects Freire’s moral enterprise that liberation involves humanisation of those who were the oppressors (1993). Freire’s (1993) interpretation of the concept of ‘praxis’ comprises reflection and action, in which new consciousness of the constraining social, political and economic forces liberates people to recognise their ability to realise a changed culture.
The liberating and emancipatory educational paradigm, which focuses on power associated with repression, coercion and control is characteristic of the post-modern era (Usher et al 1997). Knowledge is portrayed as value and power-free and as a means of freedom and liberation for those attaining it. Foucault identifies that rather than victims of oppressive power, discourse provides the criteria by which individuals evaluate themselves and with increased sense of self-empowerment and personal responsibility, rules, norms and structures become covertly perpetuated by self-governance (Usher et al 1997). The source of power and control resides in what is perceived as value-free expert knowledge but in actuality is held by those who perpetuate the discourse. A contemporary example observed in both settings is the choice paradigm. Available NHS resources limit choice, which make it a rhetorical aim. Yet, practitioners have adopted it as representative of best practice. Also, Wells (1995) suggests that internalisation by nurses of resource constraints and demands may limit their clinical activity, rather than argue for more means. Within the study, the internalisation of restriction on resources appeared to be related to the perception of the purpose of the unit and average length of stay, as detailed in chapter five.

These above processes may be seen to fulfil one of the aims of contemporary education, which Jarvis (1997) identifies. That is, the fitting of people into social roles and functions. His second contrasting aim concerns enabling individuals to think for themselves and therefore to be self-directing. While an individual’s quest for knowledge may result in self-governance (Usher et al 1997) and hence subjection, it permits some degree of resistance and autonomy in the ability to identify alternative discourses (Usher et al 1997). It is suggested that with deeper understanding of the caring phenomenon and critical reflection, political discourse could be distinguished from ideal, caring practice. It is therefore necessary to detect ideologies, which are incompatible with caring.

Yet, reflection itself is ideological (Kemmis 1985). For example, practice may prioritise personal interests or as Foucault suggests, appealing, contemporary ‘imperatives’ may have hidden, negative outcomes. For example, despite calls for patient-centredness nursing discourse which advocates the protection of the self (Johns 1996) and the emotional cost of caring (Tschudin 1997, Smith and Agard 1997) prevail. This includes O’Berle and Davis’ (1990) model of care implemented in the palliative care setting which places ‘preserving
integrity' (of the nurse) as central. Johns (1996) suggests utilising reflective cues based on caring philosophy, and argues from an existential perspective that in order for nurses to aid patients own becoming, they themselves must be empowered to fulfil their potential. Johns (1996: 1136) argues;

If nurses are not themselves empowered, then they will struggle to work in empowering ways with their patients and families. Being empowered means creating the conditions where caring becomes possible. This includes processes of education and learning opportunity that shifts the focus from primarily a patient-centred focus towards a practitioner-centred focus.

The argument in this chapter so far, supports Johns’ notion that nurses and midwives need to be in a position to shape their practice, in order that it can comprise caring. However, a conceptualisation of caring, as advocated in this thesis, would call into question the self-centred recommendation within Johns’ final sentence.

While balancing utilitarian values necessary where resources need to be utilised wisely and fairly, a deeper more unified understanding of professional caring would empower nurses to evaluate and challenge imposed management decisions, where these are insensitive and dehumanising. Without an understanding of caring in professional practice it is impossible to differentiate between policy which inhibits or enhances caring practice. For example, interpretation of the data, suggest the possibility that the emphasis on childbirth as a physiological event and aims to counter the medical model of care (DoH 1993b) seemed to over-ride caring receptivity and response (chapter 9:16-18). Similarly the discussion of patient choice and autonomy addressed in chapter seven, identified how caring may become distorted. This was epitomised in nurse C’s comment; “We’re all capable of making a decision, why should the patients be any different?” (chapter 7:14).

Other health service policies which, while dehumanising patients, also dehumanise nurses and midwives who are powerless to resist governmental manoeuvrings. As reported in chapter five, women are transferred home whether ready or not; media report stories of patients left on trolleys in Accident and Emergency departments. In the process,
spontaneous caring receptivity and responses are possibly suppressed into extinction. Wells (1995) draws attention to the potential need for health care rationing, in response to the unlimited demand for finite resources, against the increased use of expensive medical technologies and growing numbers of elderly consumers. Until nurses become more politically active, politicians, managers and doctors may determine what care can be delivered within the available funds.

Nurses and midwives are being faced with the potential for increased responsibility. For example, The Government’s recent green paper ‘Our Healthier Nation’ (DoH 1998a) recognises the contribution of all the professional groups to contribute to the ‘new dependable’ NHS (DoH 1997). In this latter publication it states: “Local doctors and nurses, who best understand patient’s needs, will shape local services” (DoH 1997:5). The Joint English National Board (ENB) and Royal College of Midwives’ (RCM) statement on midwifery education for practice (ENB 1997a) envisage that the boundaries of midwifery practice will expand and increase involvement in national policy making. Other publications call for nurses and midwives to broaden their sphere of practice and make a greater contribution to health care (for example, NHS Executive 1993, DoH 1994a, 1994b, Joint Committee of Professional Nursing and Midwifery Associations 1997b, DoH 1998b). Increased contribution cannot be achieved without sufficient autonomy (Watson 1995) and a more influential voice in health care planning and policy.

Within the interview, pauses and ‘false starts’ were left in situ to illustrate the hesitancy and tentativeness of the responses. It may be characteristic of carers, who with a sensitivity not to overpower others, make it easy for others to express non-agreement or non-compliance. Belenky et al (1986) differentiate ‘separate’ from ‘connected’ relationships. Connected relationships assume equality and are based on care and trying to understand the other. Compared with this, separate relationships are asymmetrical and involve the “doubting game” (page 104). Belenky et al (1986) suggest, that women often find challenge and confrontation personally uncomfortable and negating, which may result in a failure to defend their position. It may be that nurses and midwives have to learn to distinguish the types of communication in which they are involved and adopt confident, articulate and reasoned approaches to inter-disciplinary relationships. Hopefully, with doctors and
managers as colleagues, both types of relationship will be functional. This commitment to create and perpetuate caring values in practice means straddling two worlds, one which is receptive and responsive to the Other, which requires an insistent commitment to structure a world in which caring really matters.

10.17 Summary and implications for education
This chapter has introduced a number of epistemological and professional issues which necessarily have implications for educational strategy at both initial preparation and continuing education level. In particular, the need for formal and informal theory to guide caring agency was addressed at length. At the beginning of the chapter, it was identified that caring may be considered innate and it is suggested that, in order to reduce the risk of presumptive practice and to encourage greater critical reflection regarding the caring capacity of agency, both pre- and post registration curricula need to address caring theory. However, it was also contended that perceptual problems arise because caring theory differs significantly from caring practice. This is due to the variable manifestation of caring itself and the nature of the health care context, which on occasion, prohibits caring agency as described in the nursing literature. For example, Buber’s (1958) I-Thou relationship may be disturbed, due to the obligation to meet collective needs. It was suggested that this ambiguity may confuse caring agency or result in frustrated caring culminating in the potential for lowered self-esteem and propensity to non-reflective, routinised practice. Educationally, it is therefore crucial to explore differences between caring in its universal and esoteric senses and caring against the contextual possibilities and constraints within the health care organisation. Additionally and in consequence, while management, medical and professional structures place emphasis on formal and empirical information as the basis for practice, personal and practical knowledge acquire particular importance. It is suggested that during initial preparation and continuing education, educators need to nurture practitioners’ attention to and confidence in their personal and practical knowledge which enables caring. Conversely, in order to support visionary caring practice, it was argued that personal knowing and practical knowledge need to be combined with a readiness to develop theoretical frameworks with which to underpin and critically analyse practice. Also, within the context of a combined individual, collective and multi-disciplinary approach to service provision, it is necessary to facilitate reference to external authority.
acceptance and evaluation of multiple perspectives. It can be seen that educators face the challenge of highlighting and placing value on practitioners' personal and tacit knowing, while simultaneously fitting them for practice, professional regulation and defined organisational contribution in which often only tangible evidence is legitimated.

Experiential models of learning were outlined and these assume that learning occurs as a result of disjuncture between a socially constructed individual biography and experience. It was shown that personal values and meanings frame practice and hence influence whether or not disjuncture is experienced. This provided the basis for the argument that theoretical models, which encompass a vision of caring practice can be the source of learning and practice development. None-the-less, concern was expressed that theoretical principles, values and attitudes are not necessarily transformed into agency. It was hypothesised that theory is affectively mediated and needs to be internalised in order to create salience and to motivate and influence practice. Consequently, the social validation and perpetuation of caring values is paramount if compatible and beneficial theory is to be discriminately selected and utilised. Educators clearly have a role to play in sensitising practitioners' attention and interest in caring values in order that these claim interest and attention above other features in the practice environment. Drawing on Benner's 'Novice to Expert' model (1984), it was identified that learners' attention may be instrumentally focused initially and it is important that educators highlight the moral, caring and relational aspects of practice. It was also identified that the capacity with which we are able to respond to others depends upon self awareness of personal feelings. The ways in which education programmes might focus on practitioners' feelings, attitudes and internal, moral dialogue were offered. Also, that reflection may be framed to increase self awareness, underlying assumptions, affective and ethical elements of practice was identified. Educational intention to sensitise practitioners' empathy and concern might be achieved in the classroom, but data evidence that qualified, clinically based staff can also effectively facilitate this. They therefore need preparation and opportunity to acquire the capability to raise the salience of caring issues and facilitation of student and peer reflection.

The importance of the socialisation process to support the internalisation of caring values was emphasised and indicates the necessity for positive role models who validate and
nurture the caring values of neophytes and qualified staff alike. It was identified that expressive activities externalise the values which are embedded in practice and relational skills may be adopted as a result of observation of caring practitioners. Initial educational programmes therefore, need to ensure that learners have sufficient opportunity to observe caring practice and to shed role identities which situate them as workers rather than learners. While inadequate role modelling and socialisation may subordinate pre-entry caring values, research data suggest that in contrast, initiation into practice can result in deeply ingrained caring values. In the case of post registration education, it was identified that learning is more effective where the new values and information are compatible with existing knowledge and attitudes. This emphasises the importance of an educational strategy which effectively consolidates and develops foundational caring values during initial preparation.

Commitment to the achievement and strengthening of caring practice, might positively motivate practice leaders to place caring in the wider political context. It was suggested that in the absence of efforts to develop political awareness and influence, caring will continue to be undermined within the health care context. In order to defend caring as a central practice value, post registration education might provide the opportunity for practitioners to familiarise themselves with government and professional policy, and provide the skills of analysis and critical evaluation. Such motivation, knowledge and skills represent empowerment, which might not only increase the possibility for caring agency, but also to explicitly restore caring as a valued dimension of practice and consequently, a source of practitioners' self-esteem and motivation.
Chapter Eleven
Conclusions, recommendations and future work

The main research findings and theoretical explications and hypotheses are summarised in this final chapter. Recommendations for educational strategy are given followed by discussion of the methodological strengths and weakness. The contribution the research offers and work which needs to be done in the future are identified.

11.1 A review of the research rationale, aims and summary of the research findings.

Based on a concern that caring practice is not sufficiently addressed educationally, this research has generated qualitative data through ethnographic non-participant observation and semi-structured interviews aimed at fulfilling the following aims:- to examine how caring is manifest in nursing and midwifery hospital practice, what caring means to practitioners and how professional education might address caring. These research aims were addressed from the perspective that the work habitus controls, through cultural possibilities and constraints (Bourdieu 1990), the extent to which the status quo is either perpetuated or practice progressively develops, in keeping with cultural values and visions. It was also noted that there is tendency for institutionalised activity to become routinised and non-reflective (Berger and Luckmann 1966). This is incompatible with caring, which was conceptualised as excluding any possibility of non-responsive, pre-determined activity. Additionally, the intermediary role which nurses and midwives occupy represents a further hurdle in achieving caring as a central practice value. In consequence practitioners may uncritically prioritise medical and administrative values to the detriment of providing patients with caring relationship. The socio-political features of the health care context present caring with unique challenges and it is believed that this thesis offers deeper understandings of the caring phenomenon within nursing and midwifery practice than have been previously available.

The findings derived through interpretation of the data are summarised as follows:-

Field work in the two research settings generated data which illuminated qualitative differences in care-giving based on the conceptualisation of caring in chapter three. It is hypothesised that the reflective caring agency in the palliative care unit derives from the
day-to-day exposure to practice and articulations of practice which provide source and inspiration for caring to be perpetuated as a central value. Care was Other-centred, receptive, responsive and attentive to the patient's person and experience. Nurses appeared empowered by the work culture and environment to examine and solve, rather than suppress difficulties, which interfered with the achievement of their practice ideals. This suggests that practice was not based on role behaviours, which merely represent or symbolise caring, but that caring values were internalised and directed interest and attention to factors which influence caring practice. As discussed in chapter eight, in contrast to role or work, the nurses' activity constitutes praxis, in which work is transformed into meaningful agency aimed at achieving good (Holmes 1992).

In comparison, caring values were clearly being eroded in the maternity care setting where agency was task orientated and on occasions, unresponsive. Pressure of work, due to chronic staff shortages, defeated midwives' energies and motivations to appraise and develop practice. Although time is crucial, it is also maintained that this alone cannot ensure the development of caring practice. Other structures which motivate and maintain attention, interest and commitment to caring values are as important. In the palliative care setting, organisational structures, such as clinical leadership and team cohesion achieved during practice meetings appeared instrumental in the development of a practice culture in which caring values achieved influence and flourished. Articulations of practice in the two settings were also divergent. The palliative care nurses strove to maintain caring principles and ideals encompassed within a theoretical framework, which provided focus and direction. No such collective, theoretical perspective was evident in the maternity setting.

Contrasts across the two research settings provide an excellent, unique view of how practitioners can shape their sphere of practice given the opportunity, autonomy and authority. Practice in the palliative care unit is caring, progressive and exists in harmony with medical colleagues. While the nurses' work was demanding, the habitus enabled good self-esteem, energy and time to develop group cohesion, a work culture which legitimated their internalised values and consequently endowed practice with personal meaning.
As regards education strategy, the central role of socialisation processes requires that there is organisational and educational collaboration. It was argued that information available on education programmes, may or may not, be transformed into practice. It is the existence of caring values, which are socially legitimated and perpetuated within the habitus, which determine practice, rather than theory alone.

It is suggested that a further contribution of the research concerns epistemological insights into development of caring practice. While there is growing discourse on personal and practical knowledge, this thesis offers a dialectic. Data suggest that theoretical frameworks provide a means to achieve a collective sense of professional practice, saliency of actively selected practice values and the means to give practice direction. It is argued therefore, that while the post modern challenge to rationality gives personal and social knowledge greater legitimacy, the application of formal theory to guide practice should not be rejected. Data also highlight the potential detrimental impact of officially imposed discourses and substantiate cautions that the implementation of these in practice needs to be better monitored and evaluated.

Based on the research findings and arguments presented in this thesis, the following recommendations combine organisational and educational strategies to place caring at the centre of nursing and midwifery practice.

11.2 Recommendations

Nurses and midwives need to develop cultural identity in which caring values and instrumental care are coequal and unified elements of practice. There needs to be close collaboration between educationalists in higher education institutions and clinicians, who have both management and educational responsibilities. This is pre-requisite if a work culture as envisioned in this thesis, is to be developed.

Jarvis' (1995) view that education both fits individuals into professional roles and enables them to re-shape the work culture is concurred with. Caring needs to be essential rather than chance content within the curriculum. Lecturers have a role in facilitating theoretical exploration of caring within the professional context in formal educational programmes.
Pre-registration or continuing education modules could comprise exploration of the nature of caring as a universal phenomena within the professional health care context. In addition, discussions regarding the role of sentiment, emotion, duty, ethics, instrumentality, epistemology, reflection, socialisation processes could clarify understanding of the caring phenomenon. Reflection on feelings, could facilitate increased salience of patients' experiences, personal receptivity, response and feelings, which inhibit caring agency. The theoretical framework, therefore, needs to be combined with the recognition of tacit and practical knowledge.

In order to associate theory, practice and practical, intuitive knowing, it is also recommended that institutional-based education for caring, at both preparation and continuing education levels, needs to include experiential methods of learning. As opposed to educational modules with a block of study days, there needs to be constant interplay between theory, practice and reflection, in order, to contextualise caring, raise the salience of issues in practice, identify conflicts and solutions and infuse values, optimism, enthusiasm and commitment. The intention of focusing on caring is for practitioners to rescue caring values from being lost amidst competing work pressures; to create the opportunity for cultural validation of caring values, increase the salience of caring moments, deficits and to formulate ideas for practice enhancement to be tested in practice (Schon 1983). Importantly lecturers need to appreciate that everyone has the capacity to care (Roach 1984), there is no definitive caring model and individuals have a wealth of personal intuitive knowledge on which to draw (Belenky et al 1986). Also, probing personal feelings, such as those invested in the ideal of caring, creates vulnerability and individuals may to become evasive (Gardner 1993). Not everyone feels comfortable discuss feelings and emotions (Goleman 1995) and it will therefore require lecturers who have a particular interest, sensitivity and ability.

Based on the caring potential and motivation of individuals applying to enter the caring professions, it was argued in chapter ten, that emphasis needs to be placed on educational and socialisation processes rather than recruitment and selection strategies. It is suggested that educational efforts will be in vain without structures in the clinical area which work in parallel. Since Project 2000, there have been extensive changes in educational processes in
efforts to increase the academic level of practitioners (Dolan 1993). Student learning and socialisation was clearly considered to be part of the ward sister's role (Fretwell 1982, Ogier 1982, Fretwell 1985, Ogier 1989) and the current emphasis on academia rather than practice may disenfranchise ward staff from educational collaboration. Since education is no longer the responsibility of the NHS but Higher Education, learning may be associated more with educational packages, purchased by managers, rather than being ward-based. Unless deliberately countered at ward level, these educational programmes, distanced from practice, may offer little benefit. As the example with midwife O demonstrates, and as Schon (1983) argues, theory and clinical practice experience misfit, and the impact on practice, without collective purpose, appears unlikely. Without encouragement of shared discussions and problem-solving based on clear practice values, there will be little improvement to practice as a result. Although the English National Board's Educational Standards require that lecturers "are involved in clinical practice for the equivalent of one day a week" (1997b:19), these hours may not be accounted for within higher education institution's calculations of nurse lecturers' hours (Goddard 1998).

In order for caring to become central, it is crucial that clinical managers / leaders support caring values, since education separated from the clinical areas cannot effectively influence the socialisation of practitioners. Caring needs to be supported in the clinical area with well-prepared clinical leaders who focus on a clear framework for practice development, as well as their administration remit. The demands of ward leadership combined with facilitating learners were amply researched in the 1980s and concluded that lack of support for the role wasted the caring talents of practitioners and denied the patients optimum care (Fretwell 1985). There are however, some important differences between the 1980s and 1990s. Runciman (1983) notes that ward sister's work was concerned mainly with skills training and supervision and had limited insight into changes nursing knowledge and practice. Practice development is now indispensable due to the expectations of governmental, educational and professional bodies. Since it is envisaged that the clinical leaders are instrumental in the initiation and facilitation of change due to practice development, the provision of adequate support for the clinical leader will be decisive.
It is therefore advocated that education and practice development become the remit of a clinical post, such as the lecturer practitioner or clinical practice supervisor roles. Practice development needs to be shared by the clinical leader and a clinical educator who has the responsibility to work alongside the clinicians. This is recommended because the utilisation of clinical situations which require problem-solving, decision-making, practical knowledge and celebration, is essential in perpetuating caring practice.

As mentioned earlier, the recruitment and preparation of clinical leaders is pivotal. Such practitioners are required to be committed to promoting caring values, have the ability to balance practice development with organisational pressures, to nurture team cohesion and facilitate reflection utilising a variety of frameworks. They need to be able to solve problems as well as create and find problems, thereby utilising clinical experience as a source of further learning (Gardner 1993). This position is primary, since without this support, a new vision of professional caring cannot be shaped.

Preparation for these posts needs to include theoretical exploration of caring, professional practice and the role of socialisation processes in transmission and perpetuation of values and practice development. The position of any leader or leaders is, necessarily, a shared journey with the group, and others need to feel part of the transition. But it is the values of the person with ward management responsibilities, which determine the work priorities and which shape the work ethos. The clinical leader needs to have sufficiently deep insights to identify when caring principles are at risk of distortion and to envision how practice can be progressive. As data suggest, this includes the preparation of nursing assistants, which requires that the role keeps abreast of contemporary nursing and midwifery practice.

As supported by the research data, the practice culture needs to allow sufficient time for nurses / midwives to reflect upon practice together, to both identify goals and make constant review of practice. Within the research palliative care setting, the daily debrief meeting was a forum for nurses to problem-solve difficulties, which posed a threat to the provision of optimum care and for the group to renew motivation and allegiance to caring values. In the maternity setting, the opportunity to collectively discuss practice is deemed inadequate.
In centralising caring, the tendency to focus solely on relationship might arise. It is important to recall the position made clear earlier in the thesis regarding the equal role of instrumental agency within caring relationship. Analysis of practice, therefore, needs to incorporate this element but at the same time introduces the necessity for clinical leaders and lecturer practitioners to be resolute in addressing all practice issues within the context of caring relationship.

Where resources or pressures of work make the above structures unachievable in all areas, staff could rotate for a time, through units where an active caring strategy is perpetuated. The aim would be to rejuvenate caring values and to work more reflectively on return to their usual practice area.

Clinical leaders need to be able to articulate, in the wider organisational arena, the primacy of the patient’s experience, in terms of feeling cared for and being fairly treated and influence the health care agenda. It has been argued that self-esteem, which is dependent upon agency being valued is essential for the development of caring practice. It will be remembered that interest and attention to features in the environment are motivated by positive sense experience and socially legitimated practice values. Clinical leaders need to be confident about the contribution of their sphere of practice and be able to negotiate and state change with organisational managers and medical staff. In the situation where new ideologies are introduced, these need to be critically evaluated in terms of their impact on caring practice. Any implementation of new organisational strategy needs to be the focus of discussion within practice, in order to combine theory and reality.

In addition to co-ordinating educational programmes and associated reflection, the educationalist’s role would be to prepare, support and learn with colleagues, clinical leaders / practice supervisors and lecturer practitioners, in order to develop educational practice. This would necessitate that they had a good grounding in clinical practice and would facilitate reflection in practice either solely or jointly to maintain personal insights into practice issues, add fresh perspectives to group discussion and to instil commitment, enthusiasm and confidence. Just as practitioners need to share experience, similarly lecturers involved in caring education need to experience similar processes, in order to
overcome the sense of isolation and develop a collective vision of practice. They could also widen the appeal of caring practice development by disseminating information, in collaboration with clinicians about strategies, whether successful or not, at conferences and through publication.

11.3 Discussion of research methodology and interpretations of the data

The above recommendations are based on interpretation of the data and it is therefore necessary to evaluate the validity of methods and interpretations and consider its relevance beyond the two research settings.

Readers are reminded that attention to the validity of the research was made clear in chapter four, where the rationale for the choice of research methods was explained. This identified the benefits of combining observation and interview to both enrich and corroborate the data, discussed the sequencing of the methods and considerations regarding conduct in the field and during the interview. The cognitive and empirical phases (Polit and Hungler 1995) were carefully detailed in order to facilitate reader scrutiny.

In relation to my role as researcher, I acknowledge my lack of previous experience in undertaking qualitative research. Even so, there appeared no resistance to my presence and I feel that I was able to develop a trusting relationship with nurses, midwives and patients. While the researcher cannot avoid influencing the field (Berg 1988), I feel that participants communicated openly with me, thus increasing the validity of the information obtained. For example, nurses candidly discussed practice difficulties, such as the work demands of certain patients. Midwives made no effort to conceal usual behaviours, such as chatting and the occasional uninhibited expression of negative attitudes towards women or partners. My acceptance in both settings gives me reasonable confidence that what I observed and the information I obtained are as representative of the two cultures as possible, without ‘going native’. As intended, the combination of observation and interview as data generation methods, also reduced the likelihood of misinformation. Practitioners would be unlikely to intentionally provide information which would conflict with what I had observed. Interview transcripts indicate the difficulty in articulation and it was identified that as caring involves tacit and practical knowledge, which presents
difficulty. Some practitioners were able to convey deeper meanings in relation to their practice and it is acknowledged that vocal expression comes easier to some than others. Also, arguably, the use of a theoretical model in the palliative care provides a ready made language. None-the-less, observational data clearly indicate that practice and articulations about practice were positively correlated.

Although caring was conceptualised as a caring consciousness in relation to the Other and Others, I lacked the confidence and ability to manage the complexity of the caring phenomenon with regard to practitioners' inner dialogue. There is greater emphasis therefore on the manifestation of caring.

The previous chapters have presented and discussed interpretations of data regarding the nature of caring based on the conceptual framework discussed in chapter three. Morse and Field (1996) identify the importance of addressing the issue of subjectivity and personal biases, which influence the interpretations and consequently, the findings. It was acknowledged that such cognitive activity is unavoidably subjective and personal experiences which were instrumental in motivating the research were explained in chapter three. Practice was analysed against the research framework and while it is difficult to establish observationally the values which motivate caring agency, it is maintained that this facilitated the research intention. Whether real, virtual or rhetorical, data represent a snapshot of the agency the caring professions refer to as ‘caring’. A personal diary throughout data generation and analysis enabled me to acknowledge and check personal bias. For example, I was aware that my midwifery background might result in a less sympathetic view of the findings in the maternity setting, although, of course, it might have resulted in the opposite inclinations. Again, the conceptual framework served to increase validity and reliability as it provided consistency in the interpretation of the data. As will be discussed shortly, this also enhances the external validity in terms of theoretical generalisation.

Throughout, ample sections of data have been provided in order that the reasoning underpinning my interpretations would be clear to the reader. On occasions, a variety of possible explanations of phenomena have been offered. For example in chapter six, the
difficulty in articulations were discussed. It has also been acknowledged that some data are
difficult, if not impossible to interpret, such as the discussion in chapter eight concerning the
underlying motives of agency. On other occasions, such as in chapter ten, lengthy
theoretical explication has been undertaken, in order to provide the information to support
hypotheses. I have therefore aimed to theoretically support my interpretations, but maintain
at the same time, that since the data analysis was abductive, data led, rather than responded
to, the theory.

Reassurance regarding my interpretations were provided by the research settings
themselves. In keeping with my agreement when negotiating to undertake the research in
the two settings, I returned to present my findings and interpretations. In the palliative care
setting, responses suggested that my interpretations mirrored their own perceptions of what
was occurring and being achieved in the unit. Despite some nervousness regarding giving
feedback in the maternity setting, this was positively and even enthusiastically received.
The manager said that my interpretations and theoretical hypotheses regarding the practice
situation, accurately reflected what she knew was occurring, but had been unable to
articulate. The meeting also gave her opportunity to tell me, that due to staff shortages and
pressure of work, her management strategy had been to revert to task-orientated working,
in order to meet demand. The research appeared to provide important support, given her
tireless and frustrated efforts to transform what has become a job to some midwives, into
professional practice. Discussion aimed at addressing some of the problems, resulted in
confirmation of my interpretations. For example, one way to reduce, although not
necessarily resolve, the conflict situations in the setting, was blocked by medical staff who
were reluctant to give midwives the necessary responsibility to transfer healthy women
home following instrumental delivery. Recruitment was also of particular concern. The
manager was aware that some students are not practising in the unit following qualification,
due to the pace of work, lack of job satisfaction and the effects of the chronic low staff
morale on work relationships. This encounter emphasises how the wider political context
constrains caring despite references to a quality service (DoH 1997). Caring practice
clearly lacks political legitimation and organisational quality measures which value time
spent on tasks to the detriment of relationship are incompatible. Efforts to centralise caring
necessitate not only education and socialisation coherence, but political activity and resistance.

Consideration of the wider resonance of my research and external validity can be considered in terms of either empirical or theoretical generalisation (Mason 1996). As regards empirical generalisation, the small sample numbers, non-probability sampling and the unique nature of the contexts make this impossible (Hakim 1987). While some place emphasis on the importance of replication as a means of verifying validity, qualitative research is difficult to replicate, not only because of the uniqueness of the particular situation studied but also because of its intuitive nature (Hakim, 1987).

Alternatively, the relevance of the findings to other settings may be theoretically explored. Lincoln and Guba (1985) suggest researchers need to give details of the participants and research setting, to enable readers to evaluate the applicability to their own or other contexts. In chapter five and throughout the chapters in which data were presented, it was intended that an impression of the research context could be elicited. It is also suggested, that despite the uniqueness of the two settings, both reflect the effects of the current political agenda, such as patient choice and autonomy. Other issues highlighted constantly in the media such as low staffing and low morale issues were evident in the maternity setting. In this respect due to relatively favourable staff to patient ratios and interdisciplinary relationships, the palliative care may be considered atypical. However, it is for just these reasons of difference, rather than homogeneity, that authors argue that qualitative research offers increased internal validity (Hakim 1997, Bryman 1988). It is certainly the case, that divergent features which emerged both within and across the research settings, facilitated the arguments presented in this thesis.

11.4 Future work
Initially, it is necessary to disseminate the findings and arguments detailed in this thesis in order to share insights and stimulate academic discussion. This will be undertaken by writing for publication either in book or paper form. While the initial interpretations of the data were presented at the 1998 Royal College Of Nursing’s annual international research
conference, it is intended to present papers based on the project at conferences next year. It is also necessary to continue the research both to test and extend the theory.

Implementation of the main recommendations ‘en masse’, would necessitate comprehensive change in terms of the development of clinical leadership, implementation of a framework for caring and reflection on practice. This would be a large project and would most likely involve action research within a unit wishing to develop a caring focus. If the interest existed in the research maternity setting, this would provide an ideal project. However, without increased staffing levels necessary to enable collective contemplation and discussion of practice, transformation appears unlikely. Within the general context, another option would be to organise and evaluate the short and long term impact of focused educational modules on practice as outlined above. Additionally, evaluative research could examine the impact of clinically based meetings with caring as the focus of discussion and reflection.

The clear difficulty with any of these proposed projects is how to measure the change and how long-lasting any change would be. Personal interaction with patients within this study support my personal view that patient satisfaction surveys measure the deficit or fulfilment of expectations against experience. Where practice is based on a consumer model of care, this need not necessarily represent caring practice. However, while this research set out to describe manifestations of caring and articulated meanings, the identification of differences across the two settings, suggest that some form of measurement can be undertaken. My personal fear, is that any framework for caring might become inappropriately pre-determined and lack the dynamism caring relationships involve.

The research was aimed at identifying manifestations and meanings, rather than the inner dialogue on which caring agency depends. Indeed, much of this may be pre-conscious. More work is needed in this area to identify the processes individual practitioners utilise to maintain caring consciousness towards the Other. This would include the nature and role of informal and formal cognitive frameworks.
11.5 Concluding remark

The caring essence of today's health care service appears now moribund and in urgent need of rescue. The overwhelming odds against the necessary change are balanced with an undeterred personal belief, that while individuals enter the nursing professions to care, education should prolong modernity's hopes and find ways to support this moral endeavour. This can only be partially achieved in the college or university classroom and in the generation of theory through academic activity. While educationalists are becoming increasingly distanced, there is need not only to be 'for' practitioners and students in clinical practice but also to be 'with' them in a joint commitment to put the caring back into health care. It is modestly hoped that this thesis can make a contribution.


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Appendices

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Appendix one
Recruitment for the pilot study in neonatal intensive care unit:
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Volunteers Wanted!

Could you spare some time to talk about your experiences of helping parents in the unit?

If so, I'd be grateful if you would consider being part of my research into the carer's experience.

For more details, please take an information sheet below, and if interested, drop in the completed form to:-
Viv Woodward
Midwifery Education Dept.
The XXXX
or contact Ext. 0000

Thanks!
Appendix one
Information Sheet

Dear Neonatal Practitioner,

I am undertaking PhD studies, supervised by the Department Of Educational Studies, at the University of Surrey in Guildford. I am at the initial stage of my research and believe that the Neonatal Intensive Care Unit is an ideal place to start. I would be very grateful if you would consider participating in my research.

My subject area involves the feelings, thoughts and other influences that practitioners experience while caring for people. My rationale for choosing this area stems from concerns that while cognitive skills such as problem-solving, critical thinking and research skills are emphasised within current educational programmes, the affective side of caring receives limited attention. This deficit exists at a time when there are many pressures on practitioners due to resource constraints and increasing professional demands, which leave little enough time for ‘extras’. Experienced practitioners have much insight to share about how they perceive and ‘connect’ with people in clinical situations. This knowledge could inform educational programmes aimed at nurturing ‘relationship’.

The research involves a qualitative design and participation would entail completing a brief questionnaire regarding biographical and professional details and a semi-structured interview, which would last between 30-45 minutes. To facilitate analysis of information, it would be helpful for this to be audiotaped and a copy of the transcript would be provided for you to ensure that my interpretation reflected what was said. With your permission, anonymous, representative sections of transcript may be included in my PhD thesis, but otherwise, any information shared would be kept strictly confidential.

If you are interested, please complete the slip below and I will contact you shortly.

Many Thanks.

To: Viv Woodward, ***********************

I would like to take part in your study/know more about your study

Name: ________________________________
Appendix two

Palliative care setting field work:
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Appendix two

An Exploration of Nurse-Patient Interactions and Relationships and Identification of the Expressive Component of Professional Care-Giving

I hope that you will consider participating in the above study which constitutes part of my PhD thesis, supervised by the Department of Educational Studies, at the University of Surrey in Guildford.

Study Rationale

The aim of my study is to describe the essence of caring interactions. My rationale for choosing this area stems from concerns that while cognitive skills such as problem-solving, critical thinking and research skills are emphasised within current educational programmes, the affective side of caring receives limited attention. This deficit exists at a time when there are many pressures on practitioners due to resource constraints and increasing professional demands, which leave little enough time for ‘extras’. While much of an experienced practitioners skill in ‘connecting’ with patients is intuitive and difficult to describe, knowledge gained as a result of the study could inform educational programmes aimed at nurturing ‘relationship’ and thereby contribute to the provision of quality care.

The Research Design

Initial phase: - 5th, 6th and 7th February 1997

I wish to observe in the area for two or three mornings prior to formal observation and data gathering in order to familiarise myself with the clinical area and carers and give staff opportunity to get to know me. I also hope to join the staff at the morning and lunch time hand overs.

Second phase: - 17th, 18th, 19th, 24th, 25th February 1997

After gaining the consent of nurses to participate in the study, I intend to spend five mornings observing nurse-patient interactions in one of the ward bays. Only patients identified by the participating nurses as suitable and those who give consent to participate, will be included in the study. After introducing myself to the patients, obtaining consent and clarifying my non-clinical role, I will take up a position within the bay where I am able to view participating patients, join the practitioner at the bedside during interactions and take up my previous position afterwards.
Appendix two

Field notes will be taken and I hope to undertake follow-up discussion with nurses which will be audio-taped if possible.

There is no intention to gather data from patients after each interaction and any exchanges will not be taped or aimed at evaluation of care. The purpose of discussion would be to clarify their subjective experiences before, during or immediately after the nurse-patient interaction.

Information obtained will be kept strictly anonymous and confidential. Audiotapes would be erased on completion of the study. Research Ethics Committee approval has been obtained.

I will be happy to discuss the study further and can be contacted as follows:-

Vivien Woodward, Senior Lecturer **********************
Appendix two

A STUDY TO EXPLORE AND IDENTIFY THE EXPRESSIVE COMPONENT OF PROFESSIONAL CARE-GIVING

PATIENT INFORMATION SHEET

Please consider taking part in my study.

I wish to observe how nurses care for their patients. I want to analyse how nurses develop caring relationships with patients and give them support. This information may be useful in understanding how nurses relate to patients, and in teaching students how to approach their patients.

The research involves the observation of patients and their carers on the ward. I will remain in the ward during the morning, making notes of the care and conversations observed. Subsequently, the nurse will be interviewed to review their interaction with the patient. During observation, notes will be taken and the interview may be tape recorded and later transcribed.

All data will be anonymous, will be kept confidentially, and not revealed to anyone else. You do not have to participate in this project, and declining to participate will not influence your care in any way. If, however, you agree to participate, you may withdraw at any stage, and you do not have to explain why. Withdrawal will not alter your clinical care.

Thank You

Vivien Woodward, Senior Lecturer ***************
Appendix two

A STUDY TO EXPLORE AND IDENTIFY THE EXPRESSIVE COMPONENT OF PROFESSIONAL CARE-GIVING

NURSE INFORMATION SHEET

Please consider taking part in my study.

I wish to observe how nurses care for their patients. I want to analyse how nurses develop relationships with patients, give them information and support. This information may be useful in understanding how nurses relate to patients, and in teaching students how to approach their patients.

The research involves the observation of patients and their carers on the ward. I will remain in the ward during the morning, making notes of the care and conversations observed. Subsequently, I wish to undertake interviews with the nurse to review the interaction with the patient. During observation, notes will be taken and the interview may be tape recorded (with permission) and later transcribed. Tapes will be erased on completion of the study.

All data will be anonymous, will be kept confidentially, and not revealed to anyone else. You do not have to participate in this project, and declining to participate will not alter your position in any way. If, however, you agree to participate, you may withdraw at any stage, and you do not have to explain why. Withdrawal will not effect your position in any way.

Thank You

Vivien Woodward, Senior Lecturer ***********************
Appendix three
Maternity care setting field work
Introductory information sheet ii
Information for mothers iii
Information for midwives iv
Appendix three

A Study to Explore Midwife Interactions with Mothers

I hope that you will consider participating in the above study which constitutes part of my PhD thesis, supervised by the Department of Educational Studies, at the University of Surrey in Guildford.

Study Rationale

The aim of my study is to describe the essence of caring interactions. My rationale for choosing this area stems from concerns that while cognitive skills such as problem-solving, critical thinking and research skills are emphasised within current educational programmes, the affective side of caring receives limited attention. This deficit exists at a time when there are many pressures on practitioners due to resource constraints and increasing professional demands, which leave little enough time for ‘extras’. While much of an experienced practitioners skill in ‘connecting’ with clients is intuitive and difficult to describe, knowledge gained as a result of the study could inform educational programmes aimed at nurturing ‘relationship’ and thereby contribute to the provision of quality care.

The Research Design

Initial phase:– Wednesday 21st, Friday 23rd, Monday 26th May 1997

After gaining the consent of midwives and women to participate in the study, I wish to observe within the area for two or three mornings prior to formal observation and data gathering. The aim is to familiarise myself with the clinical area and give midwives opportunity to get used to my presence. I also hope to join the staff at the morning hand over. In order for me to concentrate on the interactions, I will not be participating in care-giving.

Second phase:– June - July 1997

I intend to spend approximately ten mornings observing interactions between midwives and mothers on the ward. Only mothers identified by the midwives as suitable and those who give consent to participate, will be included in the study.
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After introducing myself to the mothers, obtaining consent and clarifying my non-clinical role, I will take up a position where I am able to observe general ward movement and join the midwife at the bedside during interactions and care-giving.

Field notes will be taken and I hope to undertake follow-up discussion with midwives which will be audio-taped if possible.

My interaction with mothers will be neither taped or concern evaluation of care. The purpose of discussion will be to clarify their subjective experiences of care received.

Information obtained will be kept strictly anonymous and confidential. Audiotapes would be erased on completion of the study.

Research Ethics Committee approval has been obtained.

I will be happy to discuss the study further and can be contacted as follows:-

Vivien Woodward, Senior Lecturer ***************
Appendix three

A STUDY TO EXPLORE INTERACTIONS BETWEEN MIDWIVES AND MOTHERS

INFORMATION SHEET FOR MOTHERS

Please consider taking part in my study.

I wish to observe how midwives care for mothers, how they develop caring relationships with mothers and give them support. This information may be useful in understanding how midwives relate to mothers, and in teaching students how to approach mothers.

The research involves the observation of mothers and midwives on the ward during your stay. I will remain in the ward during the morning, making notes of the care and conversations observed. Subsequently, I wish to interview the midwife to explore their approach to caring interactions with mothers.

All data will be anonymous, will be kept confidentially, and not revealed to anyone else. You do not have to participate in this project, and declining to participate will not influence your care in any way. If, however, you agree to participate, you may withdraw at any stage, and you do not have to explain why. Withdrawal will not alter your clinical care.

Thank You

Vivien Woodward, Senior Lecturer ******************
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The research involves the observation of mothers and midwives on the ward. I will remain in the ward during the morning, making notes of the care and conversations observed. Subsequently, I wish to interview the midwife to explore their approach to caring interactions. During this interview, notes will be taken and the interview may be tape recorded and later transcribed.

All data will be anonymous, will be kept confidentially, and not revealed to anyone else. You do not have to participate in this project, and declining to participate will not alter your position in any way. If, however, you agree to participate, you may withdraw at any stage, and you do not have to explain why. Withdrawal will not effect your position in any way.

Thank You

Vivien Woodward, Senior Lecturer ************
## Appendix four

**Nurse D transcripts and coding**

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Nurse D interview transcript  (asterisks indicate themes)

VW: The first thing then is, how long have you been nursing for, what sort of specialities have you been involved in?

D: Right ermm When I’ve been nursing for about erm seven years I suppose it is now (..) Erm I did a bit of, I worked with disability clients in the community before I did my training and I worked in some nursing homes err then I did my three year RGN training erm and then I did a year and a half on XX which is a surgical ward and (..) a year and a half on the oncology ward, on XY (..) So ermm and then I’ve been here for two years now

VW: Did I know you at all when you were a student nurse?

D: Yes I think yea

VW: Do I look familiar ?

D: yea you do

VW: Oh right, because I used to do that module, a few years ago, So you were on XY

D: yea

VW: and then //

D: // on XX and then XY

VW: OK and how did you come here?

D: Well, I was 15 months on XY on the oncology ward and errm I suppose out of all the oncology, I mean I enjoy oncology but I enjoy the palliative care side of it, so I did the 931 care of the dying course while I was on XY and and while the whole aim of the course (laughing) wasn’t so that everyone went into palliative care cause you know the idea was to teach you know palliative care skills to, for people to have those skills within the acute setting which you know which I agree with, but it is just seemed right for me to come here really. *2

VW. What are classed as palliative care skills specifically I wonder?

D: Errmm (..) well I suppose the kind of symptom control looking at that aspect of it errm and the communication skills and er the breaking bad news and that side of it errm. and just and I suppose looking at the issues of care of people that die which, which I didn’t really cover, you know, in my training really, you know at all really

VW: I just wondered I mean obviously we’ll be talking about caring and you know //
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D: // yea

VW: // it's just interesting to know if those things link. You know with what I see to be the underlying philosophy here/

D: // yea

VW: // cause I've seen a lot of people with shared approaches/

D: // mm-mm, mm-mm

VW: // you know compared with that, that's why I asked you// about it.

D: Yea, yea, yea //

VW: So how long have you been here?

D: Two years //

VW: // Oh right

D: this week (laugh)

VW: Congratulations (laugh) and you enjoy it?

D: Yes, yes I do

VW: Ermm, so my thesis is about trying to get a description of what caring is/

D: // right

VW: It’s very theoretical in the literature and there are different concepts of what caring is and the reason I’ve been observing and why I’m wanting to speak to people, is to try and start at grass roots level and //

D: // right

VW: identify what behaviours represent caring for someone ermm so not just dressings and things like that

D: // mm-mm, mm-mm

VW: but more the expressive side//

D: // mm-mm, mm-mm

VW: // sort of, you know, how do people talk about caring as well//
VW: So if you had to say to someone what your idea of caring is or what it involves what would you say?

D: Ermm well I think it’s very difficult, but I think, I think erm (..) there’s like some aspect is just the being with, the being with people and going, you know, going through or going along with them whatever it is they’re going through, their time of change or (..) or their experience ermm (....) and (..) some, something (..) sort of another aspect of it is kind of enabling people really to be (..) empow, you know, enabling them by empowering them to be able to deal with whatever it is they’re going through and and to be (..) be themselves through it, if you get my sense. erm you know helping them to, to bring out the strengths within them rather than (..) so that, so that erm their resources come from, from, you know they’ve got resources rather than anything that we’re doing for them. It’s actually enabling them to, to (..) grow through whatever change it is they’re (..) does that make sense?

VW: Yea, yea, it does, it sounds, ermm do you work to a specific model that you like or a particular writer about nursing at all?

D: Ermm, well I quite like the Davies and O’Berle model have you seen that one, // it’s in the office *3

VW: // No, I don’t think I know that one

D: Which is the erm, it’s a Canadian bit of research which is all about the supportive role of the nurse

VW: I think I’ve seen the diagram //

D: // yea, yea it’s the diagram which is erm and it’s got aspects like connecting and building that relationship ermm and I think there’s enabling on there erm . and central to it all is preserving your own integrity so that the professional has, has a sort of key responsibility to preserving themselves because of what, what they go through in being with those people. So to be able to be there for the next person you’ve got to be able to preserve yourself *20 (..) and erm the whole context in the diagram is, the whole thing is based on valuing so that.. you know in every relationship, every care relationship is based on the fact that you value them as a person. *3,d,e. *8:1

VW: How do you (..) and perhaps it’s difficult to describe it, but how do you actually realise that in your day to day work? While being with or helping people grow through the experience?

D: Ermm, I suppose, I suppose a lot of that is about that is kind of getting to know them as a person and trying to focus on that, on their, on their individuality rather than sort of getting them into this kind of patient. you know seeing them as a patient and expecting them to behave like patient and getting into those sort of roles erm (..) but trying to focus
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on them as a person and how they've dealt with other things in the past and what (.) you can get the strength you know what ever they have brought with them to this point in their life looking at what (.) trying to get them you know, to look at those things.*3,e,k,l, *8

VW: So is it at the initial admission when they come in or do you build up a relationship with them over time?

D: // erm

VW: How do you actually get to know them like that?

D: Yea, I suppose it’s, I suppose it’s initially on admission although sometimes, I mean a lot of those things you wouldn’t (.) really get on first meeting somebody you’d have to develop that relationship *19 erm so I suppose it comes over time really (.) when you’re getting to know them (louder) and it’s, you can’t always, you can’t always strike that relationship with everybody you know (.) you can work towards that but you can’t (.) erm you know different people connect with different people on different levels don’t they?. Which is why we work as a team rather than (.) working on our own because you know, inevitably, there’s going to be some people who connect better with some people. *3e,h, *8

VW: Do you find it quite easy to get people to talk about their experience and the things they’ve been through that have built these inner strengths?

D: Yea, yea. I, I think so and I think and often when people come here it’s often like a big time, you know, it’s either a crisis time or a big time of change, that people, that is the time when people then look back (.) and you know and they are often sort of reminiscing back to different times or erm (.) or, or even the experience that they’re going through while they’re here might trigger off memories of when they were in difficult times before or lost other people or you know other bereavements erm so they often talk about it anyway, but it might be (.) you know, it might that it just comes from them that they want to talk about it. *16,

VW: Do you ever sense when people don’t want to talk about those things at all?

D: yea, yea

VW: How might you//

D: // laugh

VW. // pick up from someone that, say, I suppose it depends what you say to them, but are we saying that you’re ready to explore deeper with people, would you say that is fair to //

D: // yea, yea, yea

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VW: // summarise in that way? And so perhaps you might try to explore with someone a little bit about their experience //

D: // yea

VW: // how might you pick up from someone that they’re not ready to do that or have you found that everybody usually is ready to //

D: // No, no I mean some people definitely (..) don’t want to and (..) I think, I mean I feel it’s kind of like non-verbal things they either look away or start shuffling and look a bit restless as if what you’re saying is making them feel a bit uncomfortable erm or you know perhaps they’re thinking about things they don’t want to think about so they you know feel a bit agitated erm and they might look a way and quite often people just change the subject they’ll just say, you know ‘when’s the next cup of tea coming round’ or ermmm ‘Look it’s raining’ or something you know (light laugh) just that’s a good sign that they really, you know it’s an indication that they really want to change the subject, which I think it’s important to respect that, it’s the, they should control over whether those issues are explored or not. *10 *3i), j) *20

VW: Are you ever in a situation that you don’t feel you know what to say to people?

D: Yea everyday, I’d say. *11 *20

VW: Oh (laugh) right. Have you come to any decision about how to deal with that yourself, because presumably it could cause quite a lot of well, distress//

D: // yea

VW: // or frustration or whatever, I mean how do you deal with that?

D: erm (..) Well I suppose (..) recognising that there just isn’t always anything to say. I mean there’s just a man just now (..) who was (..) who was kind of quite restless and ermmm (..) and looked quite, quite disturbed and there was something not quite right, but he wasn’t wanting to really say and it was difficult to know what to say to him really, so I, so I just sat down on the bed next to him and, and and didn’t say anything. Errm so, and, I suppose and that’s part of what I see as caring, is just being with people and that a lot of the time here there isn’t you know its either not appropriate or there just isn’t the things to say *3b, *20 errm but, but I think (...) you just have to, you have to realise that there actually some value in you just being here and it’s how, it’s how you’re being as much as (little laugh) as what you’re saying or what you’re doing. *3n *20

VW: How do you manage to increase the amount of time or your opportunity to be with people?

D. That’s, that’s’ difficult er (......) erm (....) well, I suppose, I suppose there are times that you’re, you’re with pe, people, patients anyway that you would erm (.) I’m, sometimes. it’s kind of about using those times (.) *21 to have quality time with them rather than just
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to go in and do things to them ermm but then, but then, also sometimes, I think it’s about setting aside time and obviously, when you’ve got a group of patients that you’re looking after you can’t do that with everybody, but some people it might seem that they, they need some time they could do with someone with them so to try and put aside some time to be there with them ermm which will probably// *8*12 *22

VW: // So you go along just to talk?

D: Yea, yea, I mean and it’s hard to keep that as a priority because there’s often a lot of other things to do, but, ermm (..) I mean, for any body that wouldn’t always be helpful, but I, I suppose it’s just a case of assessing who that might be helpful with *1, *13

VW: So do you fairly comfortable to go and be with people or might you feel uncomfortable with that sometimes?

D: Errm I suppose I might feel uncomfortable, but then I might question myself is that because they’re uncomfortable, ermm, which it could be (..) because they may, they might be making me feel uncomfortable because they be uncomfortable me being there *2, *20. But then, I suppose, I suppose there are things like, say if you wanted (..) if you felt that somebody needed, wanted, needed talk but was finding it difficult and it was may be you could try something like, you know, something like a simple foot massage or something if they’d like that. Then that’s often a good way of spending time with somebody cause you’re helping them relax which they probably need to do anyway *30 and erm the pressure is not really on for you, for you to be talking because the purpose is to relax but often in those situation that’s when, when they start to relax and start to trust you that, that things start spilling out from them. *14, *15

VW: It does seem easier to be with people when we’ve got specific things to do with them isn’t ?// really (affirming)

D: // yea that’s right yea, yea and something like that’s relaxing is good because it’s cause (..) you know (..) it’s diversional as well as (..) *14

VW: So you like the massage // ?

D: // Mm-mm, mm-mm yea

VW: // How often would you say in a week you do a massage?

D. (laugh) erm (..) well I suppose it, it kind of varies with the patients but probably (..) probably a couple of times, realistically, but then I think, but then it’s about, it’s also about empowering my team to do that, it’s not always about my team doing it, erm but it’s (..) doesn’t have to (inaudible) over me but (..) // *4, *7 *20

VW: // It’s just to give me an idea because the first morning I was here someone did a massage, but I know it’s a bit hit and miss when I am here and it’s trying to get the whole picture of your activities.

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D: yea, yea, continuously throughout previous sentence. // And on the weekends, I mean that last weekend every it was quiet so every patient had a massage (laugh). On Saturday we had a bank nurse who’s, who’s trained in massage and she was teaching some of the new staff how to do it err, which is good and there were a lot of patients that need, that you know, that benefited from the relaxation *3,*6,*23. So sometimes it’s time (inaudible)

VW: How do you manage to balance the time for the individual against the time of meeting everybody’s needs, this business of an individual needing something but also being aware of the people within your //

D: // yea

VW: team //

D: // yea

VW: How do you rationalise that?

D: Errm (...) well I suppose it’s, it’s about really prioritising, what, how you’re going to spend your time and I think if you’re trying to give individualised care and trying to give holistic care you know the amount of times you spend doing anything, in all those different things, parts of your job is almost endless really, you know you could, you could do one to one nursing and still feel like that you haven’t got enough time (laugh)*13, *17 really you know if you’re gonna (...) you know if you’re trying to address a lot of issues with people errm and if they’ve got lots of complex needs then (...) you know, it gets very time consuming but errm, so, I suppose you just have to prioritise really you, you know, who you’re going to spend your time with and, and may be if you’re here over a series of days to kind of try and, you know, prioritise within that time you know not just look at it from each day but look at it whose had what time over the week *8, *17 *20

VW: Do you feel the patients should know that there’s a need for this prioritisation? (...) You know does that make it easier if they know there’s someone else needing time and there’s not time for them at that moment or (...)?

D: (hesitantly) yea (...) I mean I suppose if it didn’t come up then I think most patients would realise that (...) you know that the nurse looking after them is looking after a few other patients and errmm *25 (...) I think for the amount of time they see us they, they realise that we’ve got, there’s other things going on,*25 I think if, if errm (...) well obviously if a patient was in demand of your time and you’d definitely, definitely for a, for a, some definite reason couldn’t spend that time with them and you had you be with someone else for whatever reason then you’d have to explain (...) that you know (...) while you understood their needs that that the fact was you had to spend some time with somebody else because that was a priority. *17a

VW: Do you find that happens that you have to say to people that I can be along in ten minutes but not at the moment or does // n’t that happen
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D: // Yea I suppose that does happen, yea that does happen, I think erm (...), yea, I think that’s OK, I think nurses should feel that that’s alright because, I mean, when you think about other professions they all make appointments don’t they to see people and sometimes some of the patients are actually wanting you to you know, they’re wanting to talk to you about some very, you know some complex issue about they’re frightened about their pain or they, they’re worried about going home and that could be quite a lengthy time you need to spend with them, so I think that’s fair enough to say well I haven’t got time now, but at two O’clock we’ll have a bit more time and I’ll come back to you then. And the same with relatives as well because often, often with relatives they come and just grab us when we’re passing and what we’ve found in the past here, is if that, if that keeps happening which it can do then actually take up a lot of your time in small little bits, it’s actually better to say to those relatives that erm I haven’t really got time to talk to you now but could I, could I make an appointment, I’ve done that before, made appointments to see relatives and set aside like half an hour and then and and often with those people if you’re actually doing that and they know that that’s their time and you’re going to give them an uninterrupted half an hour that’s better than the quick five minutes they keep grabbing you for (little laugh) so so I think you know, that’s fair enough to say that to them.

VW: The patients get a lot of choice here don’t they //

D: // yea

VW: // Do you want a wash, do you want a bath? //

D: // yea

VW: How do you feel about that, what is the purpose of that, do you feel comfortable with that? (multiple question)

D: Err, Yea, I think sometimes we go a bit over the top with it well, I think it’s important to give people choice cause often people that are in their, their sort of stage of their disease, if they are quite terminally ill and quite poorly they, they kind of, a lot of what they’re coming to terms with is losing the control over their life and facing lot’s of uncertainties and so if you can give them er how ever small it may be, you can give them some sort of choice, then that is empowering them in some way but I think but, sometimes that can be, that can end up being to the detriment really because I think we’ve got experience as nurses and we know, sometimes we know what’s better for them because of our training and our education and our experience, that’s actually fair enough, like things like with pressure area care you know, if a patient might be saying that the nurses say ‘would you like to be turned?’ and then the patient said ‘No’ and so the nurses think that’s alright because obviously, I mean, they’re quite poorly and if they don’t want to be turned then we shouldn’t be turning them but actually, you know, we know that pressure sores develop and that will then cause, you know, pain and, and you know, distress to the patient. So I think there’s, there’s times when we should be kind of using more, educating patients more rather than just giving them the ch,
well, (louder) I suppose you are still giving them the choice aren't you, but you need, it needs to be an informed choice really erm *8

VW: But if it was a wash say //

D: // yea

VW: Somebody didn’t fancy a wash one morning //

D: // yea

VW: (..) what would you think about that?

D: Erm (laughing) well I’ve always looked after the men while I’ve been here, so it happens quite a lot (joint laughter) They tend not to want a wash erm well (..) I suppose it’s very individual sometimes, sometimes there’s a need, you know that someone would feel better if they did something, if they had a wash they may feel better and that actually for their self-esteem they need *3e (..) they’re the sort of person that would always have washed and so it’s important they do (..) erm so, for their own self-esteem, so then I might try and encourage them a bit more, to do that *3p, but then we’ve had people, we’ve had erm other patients here that erm, I remember one man in particular who wouldn’t, you know, he was the type of man who, while he was at home, you knew he wouldn’t, he’s not the type of man who washed, erm and he was, he was very, scruffy and err he just thought we were all completely obsessed with washing *28 and it seemed (..) that, I mean that seemed to be right that it was his choice not to wash, so (..) you know, but I mean, every about every four days we insisted just for hygiene (laugh) purposes. *29 But I suppose, but he seemed happier not washing and that didn’t seem to bother his self-esteem that just seemed to be how he lived his life erm (..) which I think is fair enough but I suppose (..) errm, it’s like when people are depressed isn’t it, they just kind of withdraw, if it’s, if it’s because of depression I think sometimes it’s important to encourage people and to help them to do those things they don’t feel like doing.*3q

VW: What is it do you think you’re basing the anticipation of what someone needs, what sort of knowledge would you say it was, so you’re saying that it would probably make them feel good, make them feel better, can you identify where the knowledge comes from, what you’re actually using to make those decisions about what might be helpful for someone?

D: Erm (..) Yea, I suppose it’s in the context of knowing them as a person * 3e ermm and knowing what they, their life was like before, you know, if, if you know they were a very kind of, very (..) if they were a hairdresser or something and they were very bothered, they were always going on about their appearance and you knew that from their family or from them that they were an attractive person that always bothered about their appearance then in the context of knowing that about them you would assume that it is obviously of value to them .. to do that, so it would be worth encouraging and helping them to do that whereas that man, I was thinking of, you know, knowing him (..) what he valued was kind of peace and quiet and nobody fussing about him, he didn’t like women fussing about him, he lived
on his own, a very isolated life erm so what he would have valued would be the peace and quiet and (...) and the choice to live like he wanted to (..) so I suppose it’s knowing the patient.*3d,e, I, J, K, p

VW: Do you ever base those, I don’t really like the word assumptions, but if you’re trying to decide what would be helpful, do you ever base those decisions on how you yourself might feel, do you think, well if I was in this situation I’d want to do this, do you ever use that? Do you ever use that // knowledge?

D. // yes, I suppose, I suppose sometimes, I think there is a danger of that because then (...) because that’s projecting your values isn’t it on to a situation and it ermm (...) and I don’t think we should be doing that, I think we should be (...) trying to understand their values, to see where they’re coming from rather than (...) ermm assuming that their values are the same as ours (...) *3d,e 6b,

VW: Sometime people are difficult to get to know // aren’t they? (implying that this is not always possible)

D: //Yea, yea, some people aren’t so, it’s not so, it’s not so quite so cut and dry with some people ermm (...) so then I suppose you’d give the standard of care you thought was, was appropriate *3r (...) ermm until there’s any indication of it (laughingly) being otherwise, you know. *20

VW: From a physical point of view, say if you were lifting someone up the bed, how might you detect that perhaps they’re not comfortable or what ever you had done physically for them wasn’t appropriate//

D: // Wasn’t right?

VW: // Say, you hadn’t made them comfortable for instance, or can you think of times where perhaps you do look and someone and think // well

D: // They don’t look comfortable

VW: Can you think of how you might pick that up from people?

D: Do you mean conscious // patients?

VW: Yes, yes

D. ermm (...) 

VW: It might be anything, it might be while you’re doing a dressing, it might be lifting them up, it might be something to do with putting them in the bath, anything like that, I’m just trying to see if you recognise any cues.
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D: I suppose you'd just try to look for any kind of signs of tension or if they're looking (..) uneasy and a bit tense, errm I suppose things like, in their facial expression, if they were frowning *10b or, or shuffling *10b or trying to move themselves *10b errm and just looking just generally a bit restless *10b errrm (.....) and not, and not, and obviously not being able to relax *10b if they do feel a bit pre-occupied *10b may be (.....) which might be, it might not be that they're not comfortable it might be that they've just got something on their mind or errm (...) *10c

VW: Do you ever feel that patients will say 'Oh, that's a lot better and I feel comfortable' and something tells you //

D: //That they don't

VW: Yea, they're just saying that

D: Yea, Yea

VW: Are they, those sorts of things that you're describing?

D: Yea, yea, but then I suppose if you ask again and they still say that they're alright, then (laugh) you can't do more than that can you? (Joint laughter) *20. And, and maybe it's something else that that's not right rather than (...) you know it might not be the way you've adjusted their pillows it might just be that they're, that they're (..) bothered about something else *10c.

VW: How would you best maintain someone's dignity?

D: Ermm (......) well (....) I suppose (...) in respecting them (..) errrm (...) and all that that means really (...) errm (...) valuing them as a person (...) and (...) trying, and sort, ensuring that what matters to them is, is kind of (...) is taken on board by us, *3,d,e,i,l,p as that is what matters really (...) errm I think there are basic things like you know, making sure, giving people privacy *3r and errr (.....) and and space, to, if they want some time on their own or errmm *4 (..) you know and basic things like not exposing them *3r and keeping their dignity that way. Ermm (...) but then to everybody that that's not always their (...) you know, some of the men we have here they're not too bothered about (laugh) you know, that's not, that's not perhaps how, where they see their (laugh) dignity you know I think different people// *3p, k,

VW: //Well that's right// What is dignity

D: //What is dignity. // So it might be different things to different people (......) and, so I suppose it's trying to find out what that is and (..) respecting it (......) but I expect the basic things are kind of (.) of privacy that's a fundamental one really and everyone should have that, personal space. *3s

VW: You said at the beginning what's important for them (inaudible) //
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D: // yea

VW: Did you cover those things on the care of the dying course at all, things to do with dignity and giving choice?

D: I suppose it was kind of like assumed or it was (.....) yea, we talked about things like valuing you know, like examining what things might, what things we pers, as people value and ....erm and expressing those things and realising that different people in the group, value different things which ... you know as potential patients would be the same as any patient group because they tend to value (....) I can’t remember doing it on dignity. *31

VW: You mention the model that you value (small, laugh) //

D: yea //

VW: and maintaining your own integrity //

D: // yea

VW: So how do you do that, or what threatens you integrity I suppose you could start with?

D: Errm (.....) I suppose (.) being faced with the loss all the time, I think is the biggest threat to your *32 integrity, is, is, I mean just, just today, since I came on, errm A lady died this morning, first thing this morning errm who came in on Friday so I’d never met her (.) but this afternoon the porter, the porter just came round sort of like an hour after I’d just come on duty to say could you help me move the lady who’s in the viewing room,*33 so erm I went in to the viewing room, I’d never met her before and she’s all wrapped up, ready to go and we have to, we have to help put them in the coffin errmm (.) and (.) and he went to get the equipment we needed to move her, so I was left in this room with her, you know and I, and I just think, I mean that, you know, that’s quite bizarre in some ways isn’t it really? (laugh) Errmm, it’s mee, it’s facing death like that (.) well we meet it lots of different ways, sometimes you know them very, very well and you go through all of it with them, you know you, sometimes know them very well and you go through part of it and then you’re not here when they actually die (.) errm so you don’t really get to go through that all, being there for them then and then other times you just kind of like come in and literally see them just going in to the coffin, having never met them erm. not even knowing what her face looked like but just seeing her body and so (.) so, I think the different losses that you see and it might not necessarily be death but I mean, but usually death I think that’s what I mean really is the death, the loss is in the deaths errm (.) kind of affect you differently but I think even if they don’t even (.) errrm, it’s difficult (.) think (.) you know it’s fairly constant really and I think, even, even that has an, has an affect on you that’s important to acknowledge (.) nowledge the losses as they come *20 rather than errm (.).

mean, in the past I’ve kind of just like(little laugh) errm not acknowledged them as they’ve gone, as they’ve come and then sort of got sort of time I’m coming up for a holiday and and really got to have a (.) a peak of not really being able to cope with anymore more death and needing and really needing a holiday *32. I’ve never had a job (.) before this job,
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of where I’ve actually been so desperate for holidays erm you know I love my job, I’ve. I’ve, every time I get to a holiday I need, I can’t cope with anymore death and dying and I, I need two weeks without anybody dying (laugh and laughingly) you know before I come back// touch

VW: //Touch wood

D: Yea (high toned laugh) so erm (.) so, so that’s, it’s kind of a like stress that I’ve found, that I’m now trying to look at ways of acknowledging the deaths as they come (.) erm (.) and looking at ways, ways of *20 saying goodbye to patients, so that if you’re not here when they go then you have said goodbye, otherwise those, you know, otherwise those, you know, otherwise they just like come in and go out and (.) you’ve not (.) you’ve not clo (.) well you’ve not said goodbye really so you get lots of unresolved (.)

VW: So when you’re not here when they die you feel there’s something unresolved there?

D: Yea I think, I think you could err (....) erm (.) I think it’s important to recognise that that might be an unresolved (.) loss and you need to acknowledge it somehow even if, I mean obviously it’s not right that you’re here cause you need your time off, but erm, but erm (.) otherwise I think those unresolved losses just kind of pile up really and get into something bigger so. *20

VW: Does that impact on your day to day interactions with the patients, the fact that you’ve started to acknowledge, well, it’s important for you to say goodbye, does it impact on your day-to-day interaction in any way?

D: Yea, I suppose (.) erm, I mean I’ve only recently started thinking about it, I was talking to one of our counsellors and she was saying how she’d (.) you know *34 sometimes it’s just about (.) erm (.) you know, maybe you should just go par, if you knew, if you thought, you know you only have two days off and if you thought that someone was going to die, probably while, while you’re off these two days, then obviously it not, it doesn’t always feel right and this is something I felt uncomfortable, with wanting to say goodbye .. to people which you’ve been involved in their care but it doesn’t always seem right to say goodbye (.) to them, so, I mean sometimes it might be, but then even if it isn’t, you could just kind of like walk past the room and look at them and say goodbye, in your mind erm (.) as if you meant it, as if you’ve just said (.) because you needed to say it (.) so you’ve looked at them and said goodbye erm (.) so I suppose from that point of view. *20

VW: I was wondering if you had in mind that when you’re caring for people while they’re here that this might be the last day I spend with this person, I wondered if it pushes you to do more for people because it might be the last opportunity you’ve got to do anything for that person //

D: // yea, yea

VW: // Do you have any thoughts
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D: Well I suppose, I suppose that’s the case with all of our patients really, isn’t it (...) you know this could be, this could be their last (...) I don’t think, I don’t think you tend to think that at the time, I think you tend to think about it afterwards, you know

VW: What do you mean by afterwards?

D: Afterwards like errm (...) like even if you’ve been there for the day or if you haven’t been there and you come back and you find out that they’ve died and then you’ve know that that time that you spent with them that morning was the last (...) errm well and I’ve had other interaction with patients before they’ve died and uhm and uhm well one man I looked after in particular, you know, he just (..) the, the last thing he said was you know errm, something directed to me, you know an interaction between us and then he died and then, and I suppose (...) well I suppose it does kind of give more value, it does kind of, you feel wow that (...) well it’s a privilege isn’t it really to have been (...) have been the last person to do whatever to that patient. *35

VW: What about the people you don’t feel you relate so well with, or you don’t connect with. I’d agree with what you said earlier that we can’t connect well with everybody. Do you find that a source of stress at all or have you found a way to work through that.

D: Errm (...) I don’t really find that a source of stress no errm (...) no (...) I think if you’re clear in what your role is and what you’re here for then you can do that with everybody *20 *19 and then if you know that you, there will be some people it might go beyond that, it might, there might be more connecting than just what you’re here for *36 errm (...) but fundamentally there’s a certain (...) there’s a certain expectation that I have of what, of how, of what my role is *3r and what and how I’ll (...) care for people and so if I know I’ve cared for them in that way that, to me is caring for people, *3t then I could do that without connecting with them (...) errm (...) but with some people it would seem more (...) I suppose you’d, you’d felt that you cared for them differently because you’d connected with them (...) in a, in a special way *22

VW: That takes us back to he first question

(Joint laughter)

VW: Are there any other things that you can pick out, I mean what would be the minimum standard in your book, the people we acknowledge we don’t connect so well. So you’re saying your role is this (laughter as the nurse D switches interview room light on) can you identify what the minimum would be (...) or again I suppose, the alternative way is looking at what is the extra to the people you connect with better (...) I don’t know what way you would you find easier to // to actually describe it

D: // No , it is so difficult to describe, isn’t it, caring but (...) errm (...) well I suppose if you, if you, I suppose what I expect is that I will give people time and I’ll be patient with them and I’ll listen to what, what they’re saying *3t (...) that (...) errm (...) so, and, and, and, em, use those active listening skills with pat, with patients who you are, so that in every
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opportunity you're trying to pick up cues from them rather than (.....) errm (...) well without trying to jump to assumptions, you know, jump to conclusions *3t *22, *19
( .) errm (.....) yea (...) and, and if, if you, if you, I suppose, if you, if you, and I think you could do that, do that with everybody, you could listen to them and be patient with them and ermm.. and try and understand where they're coming from and what matters to them ( ..) errm (...) as much as they'll let you, you know, you know, you can do that without connecting with them (....)

VW: So what is the extra, do you think, with the people you do feel this (.) connection?

D: Yes, I suppose it's either if you kind of erm identify in some way with (.) you kind of have a shared value or you, something, something clicks and you think - 'yea I understand what you mean by that' or I've had a similar kind of (.) if it just rings bells with you or (.) or I suppose there are some people you just feel, just feel more compassionate about for whatever reason, I don't know what it is but (little laugh) err (...) it hits you a bit more with some people than others errm *22, *3h

VW: Do you think affection comes in to it, do you feel more affectionate towards some people, say the people you perhaps feel you connect more with or //

D: Yea, yea, I suppose if they, if they get to know you more as a person, as a carer as a person ermm (...) and a bit more familiar in that way erm ... yea I think affection comes in to it that is part of what caring is about isn't it and it's affirming people, well that's (....) well affection doesn't always come into it but (.) *3v,w

VW Perhaps we've got different ideas of affection, what would you define as affection, in practical terms, what would you say were affectionate behaviours in a professional role?

D Well I suppose affection means like warmth errm (.) well, well it's love in a sense, *3w I think there are different types of love but love in the caring, in the caring sense of the word errm and that might mean kind of like touch or (.) or it might not (.) it might be affectionate not to touch them do you (laughing) *3w,p,i know what I mean, there's not really (.) errm (.) well just in the way that people talk to each other, if they, in the familiarity of their, of their voice *3w and if and how they (.....) you know, if they call you by name or and (.) I suppose (.) it'd difficult to define these words we use (laugh)

VW: It's very different from relationship to relationship as well isn't it?

D: Yea, yea, some people are very affectionate you know sort of err (....) demonstrative *3w and would ermm (....) there was a patient, I can't think who she was now and she was always stroking my arm you know, if I held her hand, she just used to stroke me which (laugh) and you think, I don't know to some people, and like you say everyone's different aren't they?

VW: Did it make you feel closer to her not?

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D: No, I don't think it made, I think, I think perhaps actually, I felt a bit uncomfortable with it *3w *32a because I wouldn't (...) ermm (...) which is important because it makes, it makes you realise that may be sometimes when I sort of touch people, they might feel uncomfortable with that *3a (...) ermm (...) I felt a bit like a cat really, (laughing) she kept, may be she used to have a cat that she used to stroke and (laughing) she was missing her cat, I don't know, she was strange, the way she used to stroke me (laugh) But everyone else felt it was important, *37 (see *26) that she actually wanted to do it, so that was fine (...) I don't really think it was uncomfortable it was just strange.
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**Nurse D - Observation** (asterisks indicate themes)

Female bay, co-ordinating, one bank nurse and three NCAs

**Day 3**

(734) 08.20 Nurse D and MCC enter with drugs for C who is in bed, cot sides up. Nurse D polite, uses Christian name, both lean forwards, towards the top of the bed and look at patient’s face. Nurse D continues to look at patient’s face while she takes the tablets, *NVBS watches her reach for her glass of water. at the end MCC notices C moving arm towards table and moves this forwards for her (* picks up cue from small arm movement interprets meaning and acts to help)

(743) 08.28 drugs for D (quite a young woman, perhaps early 50s,) who is lying down on her bed after eating her breakfast in the chair. Nurse D crouches down by the bedside, face to face and eye *NVBs contact. Asks if she is all right, and how the tablets are working. *3a, *14, *10b

D says that these have helped. There is no water (orderly has been round), MCC goes out of bay to fetch a glass of water for D. Nurse D suggests to D that she gets dressed with help later. ?*3q, *6a, *21, *27, *29

Takes away aperient that D does not want (this appears to be common, there is no pressure for patient to take it although it taken to the bedside). leave the bay *3i, *3j,

08.30 ward orderly with water jugs and newspapers

(756) 08.35 Nurse D comes in to see B who is sitting on bed with legs over the side, having her breakfast from the table. Nurse D sits by her side, very close, but not quite touching shoulders, her shoulders are angled so that she is turning towards B, achieves face to face contact. *NVBs She conveys listening to B by reflecting what the pt is complaining of i.e. rubs own throat, to clarify pt’s symptoms (difficulty in swallowing) and circles hand on own upper chest, to discuss pt’s breathlessness. *NVBs, *18, *14, *3r.

She is the first nurse I have noticed nodding. *NVBs.

She does this about half way through the discussion and nods three quick nods twice in quick succession. She also shakes her head three times, once to convey understanding that B was saying something negative. *NVBs, *18

Nurse D tells pt that she will have a word with the Dr about her finding it difficult to eat things. *24.

Nurse D explains the pill and takes away the aperient *3i, *3j.

MCC remains at the end of the bed watching throughout, not really involved (two nurses needed for administration of CDs). They leave the room

(884) 09.50 can hear the NAAs discussing a patient’s skin in the bathroom (opposite the bay). they fetch nurse D who comes and goes into bathroom to have a look. Goes for tape and returns *24

Nac Looks for Nurse D wanting to apply cream to male patient’s groin area. nurse goes to have a look *24

(890) 09.57 almost sorted out in the bathroom

10.04 NAC walks back and for the along corridor, looks in

(898) Nurse D walks briskly along corridor *NVBs
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(973) 10.48 Nurse D comes in for A’s prescription sheet we have a pleasant chat about the staffing situation of the day. There is usually a nurse each end, unlike today when there is only her and a bank Marie Curie nurse.

Day 4
Male bay, 4 permanent staff, 2 bank nurses, one NCA
Co-ordinating

(1182) Nurse D is in bay with drugs, (probably with D) as she’s leaving. B says that he wants something. Nurse D stands by the side of the bed, looks into his face, she stands about 3 feet away (she looks as though she isn’t staying). *NVBs
I look to see what it is that gives me this impression but it is difficult, it may be proximity and posture. Is she further away/ body held more tensely?) She asks if the patients request has to be done immediately [Do you want me to do it now, or will it wait until after the drugs. *29,*17
She leaves

(1192) 08.35 Nurse B and D come in with drugs for B [do you want to sit up for your tablets?]. *10b
Says he’s all right and stays flatish. Nurse D says [we’ll get you sitting up for breakfast]. *29, *27, *3,b,d,i,j,k,l,p,v, *38
Nurse D puts the tablets in the palm of her hand for patient to help himself from them there, he uses the drink beaker by himself. She is standing over him with a slight stoop, smiling. *NVBs,*3v
Patient seems a bit confused at times. Nurse B asks [have you got any pain?] *6
he must cues that he has [a lot, a little or....?]. The patient reaches for another cup and asks if it’s from last night, Nurse D comes round to the side table and gets him some fresh water. *14
He mumbles that he wants to do something later (not sure what) Nurse D says [you’re the boss]. *3b,j,k,l

(1256) 08.43 Nurse D and B come into A (with medication). They sit him up although initially they encourage him to get up on his own. Nurse D says for him to put his hands on the bed to push himself up- ??*3b,g,x, *6c, *10
this is impossible he isn’t really with it, but it probably added to his dignity rather than assuming he was unable. He has another pill to take, which Nurse D puts on her palm and administers it from there. *38
D calls nurse D over and says he has a lot of pain. He is sitting in the chair and she sits on the bed opposite and looks at him in the face, her back is rounded and her hands on her lap, slightly apart. *NVBs
He has his hand up to his head he says [it’s never been this bad before]. She asks if it is in his chest (feels her own chest) or spine. *18
He say’s it’s a little bit in the chest, but that’s a bit better and it’s mainly his spine. [After the drug round, shall we put on the TENS?].*29, *17,
[Are you better in the chair or in the bed? You need to support your back]? *10b *14, *3,j,l, *29 (telling)
She leaves him.
(I’m missing ‘departure’ cues)

09.10 D moans as he reaches for his breakfast.
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(1495) Drs round about 11 O’clock:- SHO, Reg and Nurse D main discussion is about medication, but Nurse D has some input and it appears that the nursing view is part and parcel of it all. *24

C is able to go home tomorrow and Nurse specifies that early PM is best in order to sort the drugs out.*29a

D- patient is in chair and Nurse D sit on the bed at the top near to the patient, *NVBs the reg sits on the bottom of the bed and the SHO fetches a chair to sit around D. All focus on the patient and look at his face. Reg looks at him quite intently, with small head nods (this looks as though she is encouraging his participation). he is asked what medication has helped. He says [I have to be honest, I’m taking so many that I don’t know what is helping, nothing is helping at the moment]. They ask about the TENS, nurse D says that this has not really had much effect and has not been in for about a week. Reg notes that he looks as though he his holding his back tensely, what about trying a different position. He talks about the severity of the pain. Nurse D suggests that he try lying on a chair which reclines backwards. *14

D clearly states his goals. He wants to be home with his pain under control, did they think that this would be achieved. The Reg said that it would be achieved in stages. That initially he may be uncomfortable while moving and so on from there. She asked him about the radiotherapy- he said it hadn’t helped and they mentioned cancelling tomorrow. They go to A Nurse D and reg lean over and look him in the face.

*NVBs

Go on to B- Nursed D stands similarly to earlier, but this time, she looks as though she is staying for a bit. *NVBs

Whether she looks more intently, nearer proximity, posture looks similar, perhaps she looks more balanced.

Day 7

Female bay, 3 permanent nurses, one orientating, two NCAs, (nurse C co-ordinating)

(2647) 0821 Nurse C and D enter with drugs for D. Nurse D [We've got some pills and potions for you this morning]

Nurse D reads out patient number from the wrist band, Nurse C reads and checks this from the prescription sheet. She remains mainly focused upon the patient’s notes, while nurse D gives the pills. Nurse D automatically ensures that D has water to wash down tablets. *14

patient asks for a straw. Nurse C passes one immediately. Nurse D passes D water after each dose of medicine. *14

She asks D if she has any pain or headache. *6

she leans over the bed and looks at the patient’s face directly, shaking/nodding her head, reflecting understanding of what the patient says. *NVBs, *18

D complains of pain in her shoulders.

(2661) 0825 Nurse D and C comes in with drugs for A, same checking procedure. A is sitting in a chair. Nurse D stands nearest to A and Nurse C stands with table between herself and the patient. Nurse C crouches down and rests prescription sheet on the edge of the bed. Nurse D asks if A has any pain and clarifies the position and severity. *6

A identifies that she has 3 sites of pain, her left leg, stomach (constipation) and shoulders. Nurse C asks her if the shoulder pain is new. A says that it comes and goes. She complains that it affects her arms, making them weak [Its no use asking me to....] chuckles with nurse D. *39
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A is the focus of the two nurse who look at her. *NVBs

Nurse D puts the pills on the bedside table. *3bj,k,l,v.

A seems pleased saying [I can manage them like that]. Nurse D leaves, Nurse C asks A if she’s had a heat pad before and suggests that this might be helpful for her stomach, she explains that it’s like a hot water bottle.

(2682) Nurse D with pills for B (paraplegic). Asks if B has brought in sachets with her from home as they only have one left and it takes a while to obtain. *14

B hasn’t. {Shall we sit you up a bit straighter?]. *10b

B had looked low and lop sided while Nurse C and D were seeing to the others. She had been left though until now, although she hadn’t complained. Nurse D [I’ll get someone to help me] *20, *40
goes out and returns [Nurse C is coming to help] continues giving B her pills and assessing her pain and the effectiveness of medicines taken. *14, *3a, *21, *6

She clarifies the position of the pain as indicated in the notes by turning her own back to the patient, indicating on her own body and checking the position of the pain (loin). *18

[Do you want some Oromorph for that? That’s what you had last night, did it help, because it was quite a small dose?] *3b, *14, *21

B said that it had helped.

Nurse D [Shall I mix this with water?] referring to the sachet) B indicates yes and this is done. *14

B complains about the bed (as she had done to me) [It’s going up and down all night].

Nurse D [Which one are you on?] Has a quick look at it but doesn’t say anymore about it.

(2704) Nurse C arrives, stands on the opposite side to Nurse D and pumps up the bed (Patients are rarely told that this will happen) she checks with Nurse D that the height suits her, they hook their arms under the patient’s arms and bring B forward. Pillows are rearranged, *14

B grimaces and both Nurse C and D silently look at B’s face. *10b Nurse D asks if the pain is postural or If B needs some pain killers does her back feels supported. *3a, *14, *6

They bring B forwards again, rearrange pillows, lean her back. Nurse D asks if that is better, *14

B confirms that it is. Nurse D leaves ? to fetch pills, Nurse C leaves soon afterwards. They return with pills. *14

Nurse C leaves her last. B asks if she’ll be washed later, Nurse C says that it will probably be late morning by the time they get round.

(2744) 09.25 Nurse D comes to D, kneels at the bedside reading notes- *38

Asks her to sign personal property disclaimer. Checks bowels, pain (asks her again about headache. *14

D says that she’s not had headaches she had migraines years ago. Nurse D said that it was indicated in the notes, jokingly says that she’ll have to strike her head out on the pain diagram. *39

D complains of breathlessness saying that she gets breathless even talking to nurse D [That’s why my bed is so tidy, I daren’t move. Nurse D is cheerful, achieves good eye contact *NVBs

[Do you want your wash sooner or later?] *3b,l, *6c

D-[Anytime]
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(2756) Nurse D gives no indication of time and puts D’s folder away in the slot in the locker and goes over to A.

(2759) Nurse D with A (sitting in her chair) sits on end of the bed facing her. *NVBs
[ I’m just going to flick through your notes to see what’s to do today silence ] *41
[ Would you like a bath or a wash? ] *29, *6c
A [ I had a wash yesterday, I’d like a bath if possible ] *3j
Nurse D [ That’s fine, OK ] *3v
silence as she continues to go through the notes *41
[ I’ll pop back in a little while and help you with a bath OK? ] touches A on her knee.
*NVBs, *29
A - [ Will you? thank you ] Nurse D leaves the room
(In the end, NAB does this). *7

(2813) Nurse D comes in to D with a sheet of paper for her notes folder. D asks about chiropody service. Nurse D leans forward with hands on the table between herself and D.
*NVBs
She asks if D normally pays and that there is a private chiropodist who visits and charges £10. D says that she has an appointment booked through the community nurse and that this is at ‘B’ the nearby hospital. Nurse D says that she will ring to see if they can come over. *14

(3058) One of the nurses has started to help D with her wash. Nurse D comes to help and identifies that the other nurse needs to go for coffee. *7
Nurse D to A [ Are you alright A? ]. She comments that her bath won’t be long, but that there’s a bit of cue for the bath at the moment. *3d,l,v,*6,*16,*25
A says that it’s alright.

(3105) Nurse D comes to help NAB with D’s bed (who is grunting quite rapidly). While at the sink the consultant blows a kiss to her she looks at me, I wink. (I didn’t see this, although I knew he’d looked over to her, she commented on it later implying affectionately that it is a little unusual. perhaps she was worried about what I may be thinking!). *24

(3117) Nurse D tidies round, fully draws open main curtains, moves table to D and positions it to her liking (or at least that’s what I thought, but her husband and son return and rearrange the fan and table to be on her other side). *14
D asks for her glasses, nurse D passes these, asks if she has fresh glass, would D like a drink, anything else that she needs? *36
Checks her laundry-leans forward towards patient (See diagram in notebook). *NVBs

Day 10
Female bay, five, staff nurses, two NCAs, 8 patients, Nurse D co-ordinating
(3805) Since staffing levels were good, nurse D co-ordinating asked if anyone was owed time. Nurse E is owed 22 hours and it was said that she could go home in the afternoon. *7

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(3830) 08.50 Nurse J and NAC come to see Nurse D who is doing A’s gastrostomy feed, to see what needs doing. *7
They whisper because A is fast asleep.

(3834) 08.53 Buzzer going and someone is calling out. Nurse A comes from behind the curtains and goes into the corridor to see what’s going on. Nurse D walks quickly along the corridor in the direction of the call. *NVBs
She walks back soon after. Nurse A returns to behind the curtains.

(4040) Nurse D comes in with maintenance man looking at the air bed pumps. *7

Day 11
During debrief session:-
(4199) Nurse D said that she wondered that (female patient, bay 2) A was almost being specialised that it may be beneficial for a nurse to be based in the middle bay. She said that D had been talking to her and she felt distressed for A. Nurse D argues that as much stress was being caused to other patients by A not getting care and her buzzing or looking uncomfortable that if other patients had less nurse time because A took a lot of nurse time. They discussed how it would only work if the other two patients in the bay were reasonably self caring so that the nurse in their would only be tied up for ten minutes rather than an hour or so. this was thought by all to be a good idea and would be implemented tomorrow. The meeting closed. *20, *7
Appendix four  
Table comparing interview and observational data - nurse D

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<th>Nurse D</th>
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<tr>
<td>*1 nursing</td>
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<td>experience a, learning from past experience</td>
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<td>a) being with, sharing the patient’s experience, empathy</td>
<td>123, 292, 743, 2691, 2712,</td>
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<td>(There is some evidence of some conflict with this and some which supports if *3j is added)</td>
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<td>b) patient</td>
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<td>1194, 1258, 2698, 2744</td>
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<tr>
<td>d) valuing</td>
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<td>153,172, 200-204 542, 545, 579, 591-596, 611, 695,</td>
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<td>f) patients bringing strengths with them from previous experience</td>
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<td>h) connecting better with some than others (see *22)</td>
<td>203, 953-960,</td>
<td>?734 compared with 743 &amp; 756 also compare 1183, 1205</td>
<td></td>
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<tr>
<td>i) respect patient’s wishes</td>
<td>264, 591-596, 696, 754, 774, 1195,</td>
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<td>k) patient’s being themselves Vs role</td>
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<td>545, 591-596, 697, 709, 985,</td>
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<td>567,</td>
<td>7751</td>
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<td>r) standard of care, privacy, appropriateness, not exposing patients, giving people time, being patient with them, to listen to what they’re saying, picking up cues to avoid basing care on assumptions/conclusions Find out what matters to them.</td>
<td>621-624, 700, 704, 897, 903-907,</td>
<td>765,</td>
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<td>s) patient need personal space</td>
<td>719,</td>
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<td>t) belief that role is associated with a minimum standard of care that should be provided to all regardless of personal like/dislike</td>
<td>903-908, 932-939, 946,</td>
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<th>v) affirming people</th>
<th>972, 1195, 1198, 2673, 2764, 3064,</th>
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| w) affection - sometimes, sometimes not as warmth, love, familiarity in voice, using christian name, depends on personality/ nature of persons uncomfortable feelings | 970, 981, 985, 988-991, 998, | may account for variation in NVBs, 734, 743, 756 |

| x) Encouraging patients to do for self if able | 1258 | (may link with *3g patient growth and 14 nursing assessment of patient capability) If *3 categories are associated with *14 this may be equivalent to *21 ie combined instrumental and expressive caring) |

| 4 ? achieves practical implementation of espoused theories/personal ideology (? has difficulty in identifying how espoused theory- 'being with' can be realised in practice over and above routine patient contact/ has not through the practical | 365, 703 | note *3&*4, *8: am I just getting current discourse/ theory? |

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*5 Awareness of impact of self on the other

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<td>b. based on own imagination/experience of suffering/illness or not</td>
<td>a)751</td>
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<tr>
<td>c). based on knowledge of the patient / observing pt's capabilities</td>
<td>c)2744, 2763, 1257</td>
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<td>d) routine</td>
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<th>Leading the team /promoting caring / delegation / concern for team well-being</th>
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<td>2769, 3060, 3805, 3830, 4040, 4200,</td>
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*6 Tentative care rationale. It's almost as if these issues haven't been thought about in much depth before. Or may be that nurses rarely vocalise these issues notes

| 171-183, 191-204, 304-313, 414, 524, |
| 160 |

8.1 the focus on self preservation and relationships based on valuing everyone as a person beg the question:- when push comes to shove who gets priority. the self or the patient, need they be mutually exclusive?
### Appendix four

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<th>*10 Patient cues identified- avoidance b, discomfort c, alternative explanation for patient cues</th>
<th>a)252-262, 287, 325</th>
<th>b)657, 658, 659, 661, 663, 664, C)667, 688, b-743,1192, 1200, 1258, 1274, 2685, 2710, 10c) (theoretically correct, since cues may be identical for different emotions, see NVB literature)</th>
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<td>*11 unsure of how to respond to patient</td>
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<td>*12 Making time to be caring -using routine, setting time aside</td>
<td>317,</td>
<td>748, 756-73, 2744-55</td>
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<td>*13 a lot of things to do</td>
<td>322, 402,</td>
<td></td>
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<tr>
<td>*14 nursing strategies facilitating patient catharsis causing relaxation diversional therapy doing for nursing care suggestions to enhance comfort nursing touch</td>
<td>356, touch-984-986, 999-1003,1012-1013, 743, 764, 1204, 1248, 1274, 1516, 2654, 2684, 2698, 2699, 2709, 2712, 2714, 2715, 2746, 2821, 3121, (links with *3a sharing patient experience)</td>
<td></td>
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<td>*15 Patient’s trust</td>
<td>347,</td>
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<td>216-220, 455, 500,</td>
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<tr>
<td>*17 (was *9) prioritisation 17 a), asking patient’s / relatives to turn take b)There is some</td>
<td>402, 414, 440, a) 460, 475</td>
<td>1191, 1273, (note, this may be applicable in this context where the average stay is 10 days, but would not be on general</td>
<td></td>
</tr>
<tr>
<td>Appendix four evidence of non-</td>
<td>c) 321-5</td>
<td>see 1183&amp;1205</td>
<td>surgical ward with shorter stay. One can’t argue to keep people in hospital longer, caring needs to be perceivable by patients within shorter time span generally). Also, could a framework of time allocation, spreading care over several days actually work in practice?</td>
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<tr>
<td>response to a patient’s weal and woe</td>
<td>c) 321-5</td>
<td>see 1183&amp;1205</td>
<td>surgical ward with shorter stay. One can’t argue to keep people in hospital longer, caring needs to be perceivable by patients within shorter time span generally). Also, could a framework of time allocation, spreading care over several days actually work in practice?</td>
</tr>
<tr>
<td>(b) Does nursing routine / focus on ‘getting the work done’ get priority over patient’s needs or can this be justified as it addresses everyone’s needs rather than those vocalising their needs?</td>
<td>d)317-322</td>
<td></td>
<td>surgical ward with shorter stay. One can’t argue to keep people in hospital longer, caring needs to be perceivable by patients within shorter time span generally). Also, could a framework of time allocation, spreading care over several days actually work in practice?</td>
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<tr>
<td>setting time aside but difficult to keep as a priority</td>
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<td>surgical ward with shorter stay. One can’t argue to keep people in hospital longer, caring needs to be perceivable by patients within shorter time span generally). Also, could a framework of time allocation, spreading care over several days actually work in practice?</td>
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<tr>
<td>*18 paralinguistics associated with active listening</td>
<td>106</td>
<td>764, 770, 1270, 2659, 2694, 2695</td>
<td>surgical ward with shorter stay. One can’t argue to keep people in hospital longer, caring needs to be perceivable by patients within shorter time span generally). Also, could a framework of time allocation, spreading care over several days actually work in practice?</td>
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<tr>
<td>*19 building relationship/acknowledging that relationships differ from dyad to dyad note 1. what are the dynamics if the patient is of the ‘unpopular’ variety? Is there evidence that some carers take up the cause of these patients? If teamwork ensures equity then this is Ok but is there a formal mechanism to ensure equity? The debrief sessions could address this.</td>
<td>200, 899-900, 928, 2682, 2744, 2759, 1264-75</td>
<td></td>
<td>surgical ward with shorter stay. One can’t argue to keep people in hospital longer, caring needs to be perceivable by patients within shorter time span generally). Also, could a framework of time allocation, spreading care over several days actually work in practice?</td>
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<tr>
<td>*20 (was 3c) Coping mechanisms: rationale of self-</td>
<td>158, 160, 201, 270, 294, 296, 314, 331-3, 2688, 4200, note - perhaps this gives the nurses motivation to strive</td>
<td></td>
<td>surgical ward with shorter stay. One can’t argue to keep people in hospital longer, caring needs to be perceivable by patients within shorter time span generally). Also, could a framework of time allocation, spreading care over several days actually work in practice?</td>
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<tr>
<td>Note</td>
<td>Text</td>
<td>References</td>
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<tr>
<td>21</td>
<td>Combining instrumental and expressive elements (may occur if *14 in associated with *3 categories)</td>
<td>310, 747, 2691, 2698, 368, 415, 449, 509, 623, 806-814, 820-825, 847-853, 896-898, 945</td>
<td></td>
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<tr>
<td>22</td>
<td>Partiality (see *3h) Connecting with in a special way - Identify with one another in some way, 'something just clicks', understanding of the other, feel more compassionate, similar life experiences, uncertain of what it is, 'it hits you a bit more with some people than others'</td>
<td>314, 911-912, 953-960, 743, 756 Vs. 734 &amp; 1265-2375</td>
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<td>beneficial?</td>
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<tr>
<td>*24 nursing on equal footing with other professions/ multi-disciplinary working roles and relationships, nursing expertise Multi-disciplinary role and relationship</td>
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<td>428, 432, 3064,</td>
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<tr>
<td>*26 Evaluation of care a, not totally committed to care ideology but understands rationale and appears to comply. May evidence commitment to team working / compliance with cultural norms / lack of assertiveness /</td>
<td>a) 497, 1018,</td>
<td></td>
<td></td>
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<tr>
<td>*27 valuing nurses’ experience / practical knowledge</td>
<td>509, 518, 523, 751, 1195,</td>
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<tr>
<td>*28 Patient’s feedback to nurses</td>
<td>555, 2674</td>
<td>note. It may be that nurse D take control but simultaneously empowers (bargaining- you choose what, I’ll say when) Does nurse pick up patient cues that they are hesitant need encouragement as per *3q or is it instruction/control? Ie Fine line between</td>
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<td>558,</td>
<td>751, 1191, 1195, 1273, 1274, 2763</td>
<td>control and concern.</td>
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<td>*29 nurse power and control</td>
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<tr>
<td>a) used to achieve work load</td>
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<tr>
<td>b) used to enhance patient well-being ie encouraging patients to do for self</td>
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<td>a) feeling uncomfortable</td>
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<td>*33 ‘Viewing room’ Why this terminology?</td>
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Note: it may be that Nurse D take control but simultaneously empowers, Bargaining- you choose what, I'll say when. Is it cues picked up (3q) or instruction/control ie fine line between control and concern.
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Appendix five
Midwife T interview transcript i-xii
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MWT interview

VW The first thing then is about your nursing and midwifery history, why you went into nursing and midwifery etc.

MWT Right, er went into nursing initially because I couldn’t start my midwifery training until I was twenty or rather, yes, I would have been twenty-one either way. by the time I’d done my nursing and my midwifery or just my midwifery, so it seemed logical, ermm, so I went in to nursing a bit half heatedly thinking that what I’d always wanted was to be a midwife, but having got in to nursing, of course, there were bits of it I really enjoyed, so when I’d finished my training I then went on and did my oncology, before I then did midwifery, so I’d got that behind me as well, ermm then I did my midwifery, as soon as I’d finished really, they offered me, I was on district, we used to do midwifery in two halves then and I was on district and they offered me a community sisters post, which was a bit of a blow, considered I’d only just trained (laugh). Ermm, so Ermm, I picked myself up off off floor, I sort of thought that sounded kind of nice of they thought I could handle it and so I said I would do it, if they’d give me lots of support, which they did, error and then I was a midwife on community for quite a few years tt ermm then I did briefly come into hospital, really by that time, very soon afterwards, I actually, I got married and very soon after I came into community I actually got pregnant, so I actually wasn’t in hospital very long before I left again, so in fact of my erm (..) post-training has been in the district and I’m not sure whether that’s a negative or positive thing. It does mean that that I do have a very sort of holistic view of people, I do see sort of the whole family because that was the way that always dealt with my midwifery ermm, so that I’m used to ermm, exploring how the husbands and the children feel about it as well as the mother and how they interact and things, so I’m looking at all those aspects, I think that sort of side of things. Ermm (..) er (..) so while my midwifery might not be quite as up to date as I would like sometimes, I think, hopefully the caring side is (....) is err (..) there.

VW Can I just ask you about your oncology and what sort of experience that entailed?

MWT Well, I only did a six month course and that was down at the **** ***** err, so I suppose in a way, my experience was fairly limited, I mean it was a fairly intensive course in six months, at the time, it meant that I was on top of all that was going on in oncology and I was doing the first barrier nursing when it was a relatively new sort of thing and we were getting children through leukaeemias that had never survived before, so it was a really exciting time, erm, working on blood?? ward and er, I almost didn’t do my midwifery, I almost sort of got stuck there, particularly on the children’s ward but that was really depressing with sarcomas and things erm (....) yea, I was very genned up at that time, for where oncology was at that stage, but I’d be way out of date now.

VW What sort of/

MWT I was wondering really if there was a lot of focus on caring values or nursing models that you actually addressed within that course that you remember.

VW I have to say, that although I learned a lot in that six months course, I don’t drastically remember an awful lot about the holistic side of things, I think that came a lot
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more, when I got out into district, erm obviously, we did care about the patients and er... they did, you know, we did have time to talk to them I mean that was an essential obviously erm, I think, erm subsequently, when I came back, from having my daughter and I came back and I was working for seven years in the children’s hospice, that’s when erm .... true, hol, perhaps holistic care, even more than I’d had on the community, was the thing. I mean it would be nothing to work a sort of eight or nine hour shift because, you needed, or felt, you needed to be there, and then come home and be on the phone for hours to your sharer families, because, they needed you and you casually picked up the phone and unfortunately, somebody would say, ‘Yea, I’m absolutely fine’, you’d ring up another one and they’ say (mimic crying) ‘Oh, I’m so glad you phoned ooooooooh’, and I could be on the phone for minimum half an hour and often nearer an hour.

VW What role were you in when you were doing that?

MWT Well, I was a staff nurse but I was, we also, all had our own, sharer families that we were particularly responsible for, because, not only did we care for them while they were in the hospice, we cared fro them as a family, while they were not in the hospice. So that they had regularly contact, now that varied from erm, somebody, whose child was very sick and who would be rung twice a week, to somebody was not so immediately sick, but needed support, and you might only ring them once a month, so that would vary a lot, erm but you just fitted in what you could and sometimes you’d be aware that you hadn’t phoned somebody for a week and despite the fact that you were really shattered after a shift (underlying laugh), you would still go home and phone them because they needed it, they needed it more than you needed it as it were. So that was I think erm (... ) where there’s been problems, there’s been people who’ve had or been ern-i, losing children or erm (.. ) one lady who had been in recently who, who erm due to a problem in another hospital, the baby had been brain damaged and, and erm, she was going through all the traumas with this next pregnancy and dealing with this child as well, erm, yea, I was a able to be with her and to sort of go through some of the feelings that she was going through with her, so I think, that that’s quite II

VW So you were applying that earlier// experience

MWT // I think so, I think you always do, don’t you ? I think what you pick up as you go through erm you apply, hopefully (...) and you just hope that it’s all positive don’t you, but may be it isn’t sometimes.

VW You’ve started talking about my next question really, what is caring, what does it mean to you in your day-to-day practice?

MWT Yea, I was thinking about that, erm, it’s, it’s the holistic care isn’t it. the whole erm (...) it’s not just mum and baby, it’s their health that is obviously paramount but erm, erm, it’s their emotional sort of side, and how they are coping together erm (...) and where you don’t see it working ever very well, acting appropriately and supporting any problems that you pick up as you go along and (...) some people can have no problems really obstetrically or paediatrically and yet have lots of problems in other ways that you, you’re equally responsible for really . but you can sort of slip through if you’re not careful, erm and it’s
Appendix five

things like erm.. even if you’re busy, having time to plonk yourself down on the bed erm, and sort of chat through, you know, even when you actually think in the back of your mind I should be doing Mrs Jones’ IV or something, you know, you actually plonk yourself down and say now ‘Any problems?’ and look people in the eye erm (...) because suddenly they say (mimic cry)’Well actually, sometimes.

VW Do you sit down first or is it something about them that you think, I need to spend some a bit of time with them?

MWT Erm, I try to plonk myself down on the bed fairly automatically because I think it gives them less of a them and us situation, you know, If I’m standing there in my little nurses’ uniform with my stethoscope round my neck I am then the midwife, who, they hopefully respect and they know is doing their job, but erm (........) it’s the midwife, and is there to help them, but maybe they don’t think is there to chat to them, whereas, if you plonk yourself down on the bed, you’re almost making a statement, ‘Look, lets (..)’, you know, ‘Let’s have a chat’, may be. Having said that, I also think (laugh) sometimes when I’m busy, I know this in the back of my mind and I actually stay standing (takes breath in), you know, ‘OK temperature’s fine, pulse is fine, your blood pressures is fine, oh that tummy’s going down nicely, every thing fine then?’ because, I am aware that time is constrained and I’ve got to get on to the next lady and er, and err, I think she hasn’t got any problems, but you know, er (..) you miss problem, I think you do miss problems, of course you do.

VW So your ideal is to sit and //

MWT //Yea, my ideal would be to sit every time, you perhaps do the obs. standing up and then plonk myself down, check their tummy, check their rear end and make myself available to talk, that’s my ideal, but that’s not necessarily always what happens.

VW What, can you describe what your aims are, say when you do sit down and plonk yourself down on the bed, have you got any s, it might be difficult for you to identify them clearly, but standing or sitting back and thinking about what are you hoping to achieve by that part of the interaction.

MWT I think that, that you are achieving interaction as opposed to you’re just caring, that you’re actually, you’re sitting down and you’re saying ‘I care is there anything I need to care especially about’ erm ‘is there anything that worries you, I’ve got time’. I’m saying that I’ve got time by sitting down, even if I haven’t (laugh). Erm, I’m actually sort of sitting down and I’m saying ‘Look, you know, I’m not just doing this as a job (laugh). erm, I’m here because I care and if you’ve got a worry that’s what I’m here for’. I mean I sort of trot round saying ‘that’s what I’m here for’. Erm, because that is what I am there for, difficult though it may be at times and it is (..) erm (....) and it is difficult to balance one patient’s needs with another, it is and that’s one of the challenges, I think, because, erm we’ve all got ideals and we all know that those ideals slip (.)

VW How do you rationalise that in your own mind, that you can’t reach your ideals sometimes?
MWT Well it isn’t feasible I suppose. Sometimes you can accept it and you go off and think, well I did my best I would have liked to spend more time with Mrs X, but Mrs Y needed this, I just did the best I could under the circumstances and sometimes you go off and you think... oh, I could have cut her off a bit short there, I could have said, ‘Lovely, I’ll do what I can’ or ‘Oh dear, I’ll do what I can’ and then gone on to somebody else, and sometimes you feel that you haven’t shuffled it quite as well as you should and sometimes you feel, well you’ve probably done as well as you could under the circumstances and (brightly) sometimes you go off and you think... I think and I went off last evening and it’s a really nice ward in 7 at the moment, they’re all getting on really well, they’re all interacting and I feel that I’ve facilitated that to a certain extent er. and erm. they’re supporting one another and their children are getting on and all sorts of things and OK they’re mostly multips and I do think that’s probably a bit of a factor but er and I went off and I thought that was a really nice shift, you know, I feel and people were all saying ‘oh thanks T’ and they were all addressing me by, by name and saying ‘Oh, T, do you mind if I just ask you something’... and it felt good, I felt that I was supporting them all and they were all happy to share my care, you know that nobody was feeling out done by anybody else, that they were all feeling that they got what they needed from me, may be I’m wrong, may be somebody was secretly harbouring a grudge, but it came over that everybody was happy that, you know and that they were getting the care that they felt they needed. So that felt good, you don’t always feel like that, you definitely don’t always feel like that.

VW So you feel you ration out the care equally?

MWT Yes, I did last night definitely, I felt comfortable with that.

VW Can you identify what, what helped you to identify that it was an equal distribution of your time?

MWT Well, one factor, of course, was that we were quiet, er, I had five patients, no I didn’t. I had four and then I had five (…) and they were (….) there was one was a primip and the rest were multips (…) the problems that they were neither major ones, they were ones that with a bit of sitting and supervising of breastfeeding and things were all, you know, not too challenging (…) and (…) I was able, you know, it just worked out time wise that, how each person needed me I was there and I was able to say, because they were interacting with one another ‘I’m just going to go and see Joan erm. can I pop back to you in a couple of minutes?’ quite comfortably and people were saying ‘Yea, sure’ you know and you could see that they meant it, they weren’t saying ‘Oh, yes’ and not actually meaning it, so erm. you’d say (…) oh, I don’t know, I mean, things like that, you know erm ‘I just need to check so and so but I’ll be back to you in a minute, is that all right?’ ‘Oh, that’s fine’.

VW Do you think it’s because they knew one another personally, do you think that made a difference?

MWT Yea. I’m sure it does, I sure getting all the curtains back helps.
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VW Well, I noticed again today that the curtains are round

MWT Mmm

VW Is it, it's been quite new for me to observe the curtains being round such a lot, sometime they are and sometimes // not

MWT //Yea, I try to get them back as much as possible and, and last evening interestingly enough, the curtains were back; now today, they're all around again and I'm not quite sure why but they do seem to be interacting there or some of them do anyway er..

VW Do you think it's the mums, might it be the visitors or do you think it's the midwives?

MWT I think some, sometimes there's a tendency that the midwives draw them round then don't get drawn back afterwards erm (...) whereas, I think it's much better when they're back round because once you stay behind your curtains to breast feed for a couple of feeds the tendency is that you feel it's appropriate to draw the curtains round when you breast feed, whereas actually, by and large, there's no need erm (...) then of course when you get to visiting times, people, if they're breastfeeding they draw the curtains, they will have their visitors in, then the visitors are behind the curtains and the curtains stay round even when they've stopped breastfeeding. I mean, there's all sorts of things, you know, that do happen, but I do sort of try to encourage people to get curtains back because I think, it's very difficult to mix through curtains, isn't it? I mean, It's possible but it's not easy.

VW I was wondering if it's the way we're going in society or the expectations of people and if it was something to do with that.

MWT It may well be, because I don't think, when I had my daughter and she's nearly sixteen we were in a long ward at Mill road and there was the potential to have the curtains round, but you very rarely saw them drawn you know, and er, you know, we used to be plonked on the need of our beds in groups nattering, you know, and that was just what you did. I knew the girls sort of diagonally opposite about six beds down, you know, she'd got a `premmy' and I was sort of trotting across and chatting with her, because she was the one who'd got the worries. OK, partly that was because most of them knew that I was a midwife or picked it up quite quickly and and they were saying 'What do you think J?' you know, and things, but, we were all nattering together and, you feel you have to work a bit at it a bit here and I think it is a positive thing for the mums to support one another, I like to see it. It's usually positive, occasionally there is a negative side to it where people sort of wind one another up but usually positive I think erm And as I say, last evening it was really nice, the mums were all supporting one another and their children were all running round together, which, I suppose, had we been busy, might have been a negative thing but it was really nice and they were sort of all comparing notes and talking about what was going to happen when they got home and talking erm light heartedly about the sleepless nights and things that you know, they had obviously taken them on board and so it was really nice, there was a lovely atmosphere and felt, you know and someone came to me and she said, you know, 'I've been so lucky, I've had two babies and both times you've been quiet and
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she said, it’s so lovely, I really, really appreciate, the care I’ve been having’. Now I know when people come and actually make a point of saying like that, you know then, er she said ‘it’s such a happy bay in there’ and so, you know, I feel that was from one of the mums and she was actually saying that’s only, this last shift, you know.

VW Is that important to you to have some/

MWT //I think, you need some feedback, I think you need some. I mean don’t, you know. I don’t think you can honestly say that it doesn’t matter if people never say thank you because I think it does. I think erm (..) I think, you don’t know that you’re doing all right, if you just feel that you’re doing all right, but nobody acknowledges it, you could be completely off on a tangent, couldn’t you? You might think that you were doing wonderful nursing care, but in fact if the patients didn’t think you were, that wouldn’t be .... good enough would it, really? (.....) I suppose again on community, you knew, because you thought, you’d got all your feedback and you got erm, you know, people booking for the next baby, you know, when they’d just had the first one (joint laughter) and err, you know you had this, sort of, family atmosphere there any way, you know and I used to get quite worried, if I didn’t click with somebody and I felt that there wasn’t this click, you know, I felt that that was really important and I would work and work and work, to try and get it, sometimes, you never really did, whether it was just a personality thing, you just didn’t really ever, got to that point where you know you could give them a hug if they were a bit weepy, you never quite got through this sort of barrier erm..

VW What sorts of thing did you used to try to enhance that relationship/>

MWT //Well, just trying to get to know them as people, because you can’t sort of erm .. you try to see what made them tick, I suppose, but they, it doesn’t mean that you can necessarily change yourself so totally that you actually fit in with what they want perhaps erm and sometimes they’ve got false expectations, I think perhaps of what actually they expect of you erm (..) and there are even some people who actually don’t want people, most people do want the midwife to be fairly erm.. chatty and familiar and, but some people actually don’t, they want you to be quite, they almost seem to want you to be quite (..) distinct, quite erm (..) they just don’t seem to want that closeness, whether it’s from their childhood experiences or whatever, you know it’s still quite erm (..) It was interesting that we had somebody in one of the side rooms recently, who was an antenatal patient actually, I vaguely alluded to her earlier, who’d had this child who was damaged at another hospital and er, having a perfectly straight forward time, this time hopefully, er and er, I worked quite hard with her initially, I thought that she was actually quite cold and er, erm (..) ut then I thought, we’ve just got to, sort of just see, how much her life experience has damaged her really erm (..) and how hurt she feels and let down by hospitals and even-thing and erm one time she just broke down when we were talking and I just put my hand on her hand because I didn’t feel that I could sort of say ‘Oh’, you know, cause it just didn’t seem appropriate but erm (..) you know, then she sort of looked up and made eye contact and you know, it was what she wanted but (.....) I think, it is difficult, isn’t it? but then that’s the same with any counselling isn’t it, you’ve just got to work through the .. you know, with all the counselling we did and the angry, angry parents we had at the hospice, they were so angry about what was happening to their children and they were trying to find
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someone to blame the whole time, and you had this anger to deal with erm (. . .) hurt anger. so , I suppose I’ve done an awful lot of counselling through that sort of thing, so

VW Can you identify with that lady, how you tried to get close to her, what sorts of things were you doing?

MWT Erm (.....) it’s getting on their level again, she would be sitting in a chair at the side of the bed and rather than actually sitting on the bed, I actually knelt down on my knees in front of her, to talk to her erm (..) because, it’s getting on her level I think not to be erm .. We always erm. well, I say we, I think it was basically me, found that I was up above somebody, I nearly always found it more difficult to counsel than if I was almost below them, or certainly on a level, erm and erm, certainly when you’re trying to get a point through or you’re trying to let them get something through, it’s all right to look a way, but you need to, to be making er, eye contact a lot of the time, because otherwise (...) as soon as your eyes avert and their eyes avert, you don’t know if they’re being direct with you, they are far more likely not to be, not to be telling the whole truth, I think, erm (..) or not to be letting all their feelings out, I’m not sure what I mean really, so

VW So that is body posture really isn’t it, or body positioning? So What sort of things might you say or what sort of things do you talk about?

MWT In circles really, I’m not sure it’s correct counselling in a sense, but I will go off about my family, if it helps (..) erm, negative and positive erm and then turn it round back around to theirs and erm, go off and come back to the subject, rather than, you know, to, to lighten it sometimes, almost erm (..) trying to relate things to other experiences without naming names, erm (..) both she and another lady who was losing an abnormal baby and had previously got an abnormal child erm, both found it useful to know that I had some experience along those lines and had seen similar, sort of, circumstances and I’d been involved in that and they both found that useful erm.. so, you know, where you would never itemise sort of distinct details, you know, you can say that you’ve seen something similar and erm (....) and (..) even, sort of (..)erm, let them know, that you know, how much it affects the family to be dealing with those sort of circumstances and then they suddenly will say ‘Oh, well, actually yea, we have had marital problems’ and that hasn’t come out before and things like that erm. (...) cause, you can lead them into things sometimes, you feel they’re there, so you give them an opening to bring things out? The trouble is so often you’re not quite even sure, you really have to look at things, what you’ve said to realise, whether you did do your best or not (..) I’m sure it’s not sometimes.... and you know, you can be disturbed can’t you, I mean (light laugh) I’ve just disturbed somebody for instance in the side room erm it wasn’t too drastic, she was just doing foot massage and stuff but erm (..) it (.....) you can be just getting somewhere and somebody says. ‘I’m really sorry, do excuse me’ and they’re perfectly polite and everything else, ‘Can I give you the key’s, I’m just going to so and so?”; broken (..) nothing personal involved at all, nothing intentional, but that line is broken and you’ve got to work really hard to get back to where you were (..) cause their sense of privacy and their sort of, talking with you has been broken.
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VW What about the people, you feel that you don’t, you’ve talked about clicking with people, what about the one’s you don’t click with in the end, and your approach to them?

MWT I’m sure there are people, I’ve never got through to at all, I’m just trying to think of some erm (...) (sigh) erm (...) there are people who you feel you just can’t help sometimes, I think, teat you, you know, you do really try to spend time with and at the end of it all, you don’t really feel that they’ve profited by it and you sort of say because they’re not trying to, but maybe it’s because of the way, you’ve given the care? erm (...) I don’t think, I’ve ever had a complaint made about me, I’m not aware that I have but erm (...) you know, I’m sure that there have been people who felt ‘Well, she was a fat lot of use’, I’m sure, you know, I’m sure there have been, you know, or (...) ‘Well, Mary Jane got that baby attached but she’s really been fiddling about trying to get it on this time’ or, you know, because we, we (...) erm (...) do things differently ermm

VW What about people that you don’t warm to, do you find that you don’t warm to certain people?

MWT Yea, I think that’s inevitable, erm (...) but I think ..(sigh).. well, I used to, again, this is back to the children’s hospice again, we used to say, the people you don’t warm to are the people you make the extra effort with (laugh) that’s not easy is it? (...) Because you have to really, I mean, you have, you have a duty to care to all the patients and erm (laugh) you don’t warm to some people, for very different reasons sometimes, I mean, erm.. there was, I don’t know if it was when you were her last time, there was that husband, (...) and I had decided that, how I would deal with it (...) was to go to him and put straight forwardly before him erm (...) the situation that he just has to realise that this is a busy unit and the doctor has other things to do, they have to prioritise their care and the fact that they hadn’t been to check his routinely well baby for discharge, was because they had other more important things going on. (Laughing) So I went off and he ‘whooooo0000’ straight up, so I, sort of, went in too heavy, straight in, I hit back at the same rate he was coming at me, because he had not met me before and went straight in about ‘I think it’s disgusting that there aren’t enough paediatricians, don’t you?’ and he wasn’t actually attacking me, but it was a direct criticism of the hospital and erm and I came back at him at the same depth, without working out, I said ‘If you could see these doctors, these paediatricians working on these tiny babies up in NICU, if you could see three of them standing round a baby trying to resuscitate it, you wouldn’t be saying, my baby’s more important to have a routine check’ and so I went straight in to kill, I was angry with him, and although I didn’t show overt anger to him, I threw back my top line straight, without working up to it, without talking about, gently talking about prioritising, I went straight in for the kill, I went straight in to the top line, ‘Look’, you know. ‘I have seen these’. you know, wild, you know, wild exaggeration if you like, the very worst scenario, is a tiny baby of 29 weeks being resuscitated by three paediatricians etc., I’m sure there wasn’t a twenty nine weeker upstairs, you know, I mean, I’m sure there wasn’t but that father... and the mother looked down and she was trying not to cry and (excited laugh). So, when the paediatrician arrived shortly afterwards, because we then monitored them, then the paediatrician did. he said, ‘Oh thank you, I appreciate you’re so busy ‘ and I could hear this and I because ?????? go up, I heard his reaction, and a few minutes later, the baby had been checked and everything was fine and was ready to go home and he came to the desk and he said ‘ I really would
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like to apologise to everybody’ he says (laugh)’ because, I feel I’ve been a bit unreasonable
about all this’, and you know, ‘We’re really happy and we’re going home and everything’
and, you know, he was wanting to sort of apologise and and say and then it was ‘Oh bye’
and he made a point, (laughing) I was still in the clinical room at this time but I was near
the erm the um treatment room, whatever you call it, over there and er, but I was near
the doorway and he said ‘Oh, Bi-ye, Bi-ye, thanks ever so much for everything’ and I
haven’t really done that much for that family really I just hadn’t actually been that, he was
making such a point of waving to me and saying ‘Thank you ever so much for everything’,
so that was as near as he got I think to saying ‘Yea, you made your point (laugh) you
know, ‘I do understand, I’ve taken it on board’.

VW That was quite extreme case though wasn’t it?

MWT Yea, and that was quite an extreme way of dealing with it, but because he cut in at a
high level with me, I cut back at a high level with him. I couldn’t shout, I mean, I wouldn’t
dream of shouting at him but I went in for the kill as it were on my, I suppose I was just
using the ‘be a reasonable human being’ tack and he did, he was perfectly reasonably, he
never crossed anybody, he never said another word after that (laugh). So erm, yea, you
know, I was, erm it worked if you like but I’m sure that less drastic tactics would have
equally worked probably although they hadn’t to that date.

VW Going back to what you said earlier about the people that we don’t warm to is more
the reason to work at it //

MWT // (loudly) I didn’t really (..) ff(..) I don’t think I did warm to him in a way erm, in a
way, I just felt that I dealt with him in the most appropriate way. I don’t think I warmed to
him ever, erm (..) but I was quite touched by the way that he stood down because I think
that was quite a big step for a man to make and to actually make a point and come to the
desk and saying ‘ I feel I should apologise’ that’s a big step, for somebody whose got
themselves all (....) knotted up err (..) So, you know, may be I did the right thing, I don’t
know, you never do, do you really ? Erm, with the mums you’ve (..) you’ve got to interact,
I don’t know, erm if, if mums start getting uppity and you feel there’s no reason, I’m just
trying to think of an instance really erm (.....) tt (..)I can’t think really (.....) we had, we had
a girl here, who didn’t appear to be interacting with some ????? and was very critical about
certain people erm

VW On the antenatal side was that?

MWT No I’m thinking of someone on the postnatal side actually erm, about the handling of
her breastfeeding and various things and she erm (....) that involved a lot of talk actually and
I was just lucky that I was on nights at the time and talking in the wee small hours, you
know, to her, but then she had always been reasonably positive towards me, so that’s not
quite the same thing erm (.....) tt (..) yea, there have been a few on the antenatal side who
have (..) (sigh) seemed to be perfectly, sort of OK when they were first admitted, but have
actually sort of risen as it were to be manipulative (..) because they have been there a long
time, they know how things run, they know how to use how things run erm (..) and they
start erm, feeling they’re part of the team almost and feeling that they’re, it is appropriate
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for them to say 'Why haven't you done so and so, why hasn't so and so seen me today' or 'Don't you think Mrs so and so should have her CTG put on now' or. You know, these aren't really appropriate to their position in life and you are bound to be niggled by that and some of the midwives particularly are sort of fuming, I think, at the end of, you know, or have been, not at the moment, erm, by the end of some of the shifts. Erm ( . ) er ( . . ) and I have felt quite responsible on some occasions, because I think I am often sort of, quite easy going and the danger is that I sort of let these people be a bit like that and I'm sort of saying 'Oh, don't be so cheeky, I'm the midwife round here'. So I let it go over my head a bit err ( . . ) 'Oh, yes, yes, in a minute' or something you know. almost getting almost too friendly with them, as it were in a way, erm so when I think, whilst somebody else complains and says 'I really don't like this', may be I've contributed to it, because I've been quite happy to, well not quite happy, but I've accepted it as part of their, almost, sort of institutionalised behaviour erm.

VW I suppose it's just different ways that people cope with situations, you've got that particular way, which works for you no doubt.

MWT Well that's the thing isn't it? and different things work for different people to some extent and we have our way of rising above situations that we don't find so tolerable I suppose errm

VW That's a personality thing isn't it? Perhaps when you take that approach, it will work for you, but not necessarily work for other people.

MWT Yea, but you're working as part of a team, that's the other factor isn't it? and if other people don't find that behaviour acceptable err ( . . ) mm yea, I think you've got to be aware of, you know, some people think you know, some midwives feel it particularly appropriate for them to be err ( . . ) regarded at all times as professionals er ( . . ) which we are of course and erm, but it's never appropriate to get over-familiar, you should never get to a point where patients are suggesting their care as it were err ( . . ) but I suppose, probably again because I was a community midwife for a lot of years er ( . . ) I always worked as a team with the mother so if she felt that err ( . . ) I can't think particularly, erm ( . . ) her, er ( . . ) I can't think, that won't really be relevant err ( . . ) I can't think of a situation that's particularly appropriate, but if she'd sort of, wanted to rationalise something with me, we'd chat it through, the pros and cons and then, if I still disagreed with her, I'd say 'Well, let's bring the doc in on this' and let's have his overview on it. So, you know. I'm almost playing myself almost as an equal with her and putting the doc as the boss err ( . . . ) because I can see her side hopefully as well and I can see where she's coming from and if I can put my point as a midwife because of my expertise that I've got, then she's still got the right to her opinion hasn't she?

VW Can I just take you back to holistic and ask you what exactly that means to you, as a basis for care, what sort of things are you trying to achieve ?

MWT Tt err ( . . . ) well, the whole thing of holistic care is taking the person as the centre of their world isn't it? So you're looking at all the factors affecting what you're doing err, so you're just not looking at the mother as a pregnant woman or as a newly delivered
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woman or whatever erm, you’re looking at her as a wife, the mother of any other children that she’s got and all the problems that that entails erm and the sort of daughter as well, which is sometimes equally relevant erm, er (...) so that you know, all these factors make the people that they are, don’t they? And everything may be going absolutely fine but if they’ve got marital problems, if the mother or father is dying at the time or whatever, then that’s very relevant to them. I mean we had someone fairly recently who er, his mother was diagnosed as having a brain tumour just before she went into labour and was admitted, was over on the other side sort of, at the same time as she was in and she really wasn’t too grand after the delivery, it wasn’t horrific, she hadn’t had a section or anything, she had a forceps I think, or a ventouse, and she was battered and bruised and, the baby was fine and she was basically fine, and she couldn’t wait to get into a wheel chair and get down to see her mother and she wanted to take the baby with her. Well, of course, that was the problem, because the baby wasn’t supposed to leave the ward and come back on to it really. But err, you know, we negotiated and we actually got organised and she was desperate that her mother should see this baby, it was very important to her and we had to work round that, er, she was terrified that her mother would suddenly, actually I think things did improve, er, she had some Dex. I think and er, things finally settled down and stuff, but er, she, she thought that her mother was going to die very quickly, you know, it was quite an aggressive tumour I think and she was terrified that she would be just that close that her mother hadn’t seen the baby (...) you know, it’s essential isn’t it that you get the baby there even if it breaking all the rules and she went, despite the fact that she was feeling like death warmed up erm, it didn’t matter did it, it was all relative, she was escorted obviously erm... so it’s that sort of thing, isn’t it? Normally you would have said, ‘No I should take it easy for a couple of days, my dear’ you know, I should just walk as far as the nursery.

VW I’ll make this the last question because I’m aware of your time, what do you want the women to get out of their experience of child birth, what would you say you are working towards when you care for them?

MWT Err, you’re working towards them looking back on it as being a positive experience not necessarily entirely pleasurable, but positive, erm something which they feel they could go through again, if appropriate, err, something which is the start of something bigger, which obviously it is erm... and yea, the start of a brand new era, which it is erm I usually make a point of saying, if I actually get, which I don’t very often these days, If I actually get to be the one to take the baby down, I usually make a big ceremony of it and I sort of say, ‘Well, this is a huge moment isn’t it, taking this baby home, I can remember when I took my baby home sixteen years ago. I can still remember the feeling and I was a midwife and I can remember and they say’ Oh, I’m glad you said that, because I was just thinking that I was being a real softy because, you know, I’m realising this big step, you know, I wish I could take you all with me’, that’s one of the favourite things isn’t it? I wish I could take you all with me, I want to go home, but I want to take this support with me. Now, if you feel that they feel that that was support and hopefully, you know, they feel that they’re going to more, but different support at home then it’s been a positive experience hasn’t it? An yes, they know they’re going home to a whole new adventure, but you know, it’s been positive erm, (...) cause it is, you know, it’s often sort of, ‘Oh well, you’re through the delivery’, that’s that, you know, ‘Well done’, that’s it, but it’s not, it’s just the start, so erm, yea, just
being there with them through that and hopefully being as much support as possible, but you can’t always guarantee that you have been can you? And then, erm, even through to when they leave the ward, sort of saying, you know, ‘Good luck, it’s a whole new era, this is your baby, you’ve done really well on the ward and I’m sure you still will and’ may be even slightly exaggerating slightly (sniff in) erm, you know, ‘And you’re going to have lots of support and everything’s going to fine and, you know, try and make it positive, even if in the back of your mind ‘I hope she does keep breastfeeding’, you know, trying not to put that sort of doubt into her mind, you know at that stage erm, so she feels supported. erm, so that’s, I mean really it. And sort of as a community midwife in the past, I knew. I could follow it through, so I was fairly happy that they were still breastfeeding at ten-fourteen days when I left and that they would continue and most of them did in those days. erm, if I’d got them as far as that, most of them did keep going, cause fewer mums went back to work erm .. so you know, you were doing something valuable, getting them established and getting them to feel that they were doing really, really well that’s this silly inane thing that I do when I’m doing demo. baths and things like that, ‘Oh, you’re doing really well, do you know, you’re really good handling that baby’ and I’m thinking ‘Don’t drop it now’ (joint laugh). Because half of it, is just needing someone to say you’re doing fine, as long as they’re doing reasonably well, you know ‘You’re doing great’ because, you know, it’s a big thing, isn’t it when you sort of hold that baby and think, I mean I was a midwife and I remember thinking ‘This is mine, I’ve got it for, how many years and oh my God’, you know, you know I think it’s acknowledging that we do realise, even as midwives that it’s a huge thing for them (…)

VW (..) and just giving them that confidence?

MWT Well, hopefully, yea. And if they’re absolutely awful, in which case, you have to step in ‘perhaps if you just held the baby’s head at this point’, (laugh) you know, but if you can be positive, because there’s something usually positive to it, isn’t there, ‘You’re really good with that baby, you’re doing really well’, you know, hopefully.

VW Good, I’d better let you go now, thank you very much.
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Example of Palliative care observational transcript i-vii
Example of Maternity care observational transcript viii-xvii
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**Palliative Care Setting Phase 2 Day 5 Tuesday 18th Feb. 1997**

NAA, Nurse C, E, F, NNA, MCD,

Pre-specified observation of:

- a) how nurses ‘leave take’ from the patients (it suddenly struck me yesterday that this seemed a bit vague) it’s just that this would seem to be a natural marker in change of interaction and yet it doesn’t always seem obvious.

- b) Try to get more exactly the conversations (need some examples of different types of dialogue)

- c) the strategies patients use to control the interaction, maintain autonomy

Report from night staff: NNC and ?. The usual stuff on the whole - the sort of night patients have had and physical discomforts. A (from yesterday died at 6.40 hrs so we heard about what had happened and his wife’s reaction. He’d been turned and about 15 minutes later and started cheyne stoking - they called his wife in, who came with her sister and he passed away about 3/4 hour later. The wife was extremely emotional, the sister supportive. Coming back for death certificate PM.

Discussion re male B - not getting up, not taking his tablets that the nurse/doctor has told him that he needn’t take them. [You have to be quite firm with him]

Go into female bay: - A - MND 70 years, B - 77 years, very sleepy, C- lady in hospital up the road to return, D- 74 years very sleepy (dies xx March 1997). All need full care, A and B need two nurses to move. Hand out information sheets to A and D, I speak to B but no way is she in any state to read any information - may be later. I fetch A’s glasses and her light writer (LW) - she writes OK. I leave the sheet with D who I note has a look later, folds it in half and puts in a magazine.

08.05 MCD to A the gastrostomy feed machine is making buzzing noise [We’ll have to unhook you from this A.... cor blimey, it’s really stuck this is. leaves without really ending the episode, although she recommences care and then leaves.

Theory - perhaps if nurses think that they will soon be returning it is treated like one long interrupted care episode.

A has written something on her LW about the order she wants the suction and nebuliser in. Nurse C [are you sure you want things that way round - definitely? OK]. She draws the two sides of the curtains and goes out. Doesn’t take leave from the patient

Nurse E comes in [Morning, I’ve come to do your suction for you, all right?] completes drawing the curtains [ you haven’t got many catheters here, let me go and get some more catheters] leaves the room

08.16 Nurse E [Sorry about that A, couldn’t find the right size] Commences suctioning [OK, is that enough?.. {Have you had your drugs yet? We’ll get those sorted and flushed through] leaves the room to get the equipment.

Nurse F comes in with drugs for D, sits on the bed close to the patient who is asleep, just looks into the patient’s face smiling - wakens her gently by calling her name [D- how are you this morning?] She gives her lots of time, speaks gently, keeps smiling [have you had a good night?].... [I’ll come and see you in a bit then] leaves

08.25 NNA with breakfasts to D [do you want some breakfast sweetheart? what would you like poppet?] Asks patient about sugar on porridge, hot or cold milk. Sorts the side table to enable patient to get the food [You’ll need some help with this]

D - [no, I’ll be able to manage]

NNA- [are you sure?]

D - yes

NNA- [Do you have your tea in a beaker?]
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D- [no in a cup please] must pick up surprise from NNA [Sorry]
[I’ll come back and see how you’re getting on, all right?]

NNA goes to B, helps her sit up a bit (I can’t see her she’s behind the curtain) and leaves room with the trolley

Meanwhile Nurse E and C are busy with A meanwhile

08.31 Nurse F walks in with patient notes and put them on the table. Smiles briefly at D
Nurse C is in the room with B giving her pills

08.35 Nurse F comes back to B can’t here the conversation, but she helps B with her porridge

Nurse E comes in to see to A’s nebuliser. Once this is going, she sits on chair to sort out gastrostomy- drugs and flush (nurses E is part way through her pregnancy)

She stands by the side of A, (who is sitting up in bed) puts her right hand on front of A’s left shoulder, looks into A’s face and asks [A shall we take this off?] i.e. the nebuliser. A shakes her head so it stays on a while longer. Nurse E continues to do Gastro flush. Patient is looking down, breathing steadily, Nurse E adjusts face mask- A is allowing care to be given.

[Sounds like it’s about done A] Nurse E takes off the mask and wipe saliva away from A’s mouth [you’ll be done by the time H (her husband) gets here, won’t you?] A makes noises-throaty MM MM and moves to write something on LW [can you reach it? Do you want it moving over a bit? Shall we move it over here?] nurse E holds it for her, leaning over A and looking at the machine. Crouches down., leans against the bed with her armpit and arm on the bed. A has asked if cranberry juice has been given down the tube. Nurse E explains that she has given that with the tablets. [Is it OK to the bath run for you in a little while, Is that all right?] {You look sleepy, have you not had a good night? If you’re still drowsy after your bath, you can have a nap in the chair. You never know, the bath might completely revitalise you} .

A makes throaty MM sound. [ I’ll leave you to get a little nap while I get the tablets]

08.50 A is writing something, B alone in bed says [gosh], D is asleep in the bed, has had her porridge and put the plate back on the table, although she had to reach to achieve this) but not her tea.

Nurse E with 2nd breakfast trolley (toast and more tea) puts her hand on B’s shoulder, looks into her face [Would you like any toast B, another drink of tea?] B is sitting quite high against pillows, head on left side, extremely sleepy. None is served.

Nurse F comes in to finish breakfasts, comes to D sits on bed at the top, leans over her. Nurse E with 2nd breakfast trolley (toast and more tea) puts her hand on B’s shoulder, looks into her face [Would you like any toast B, another drink of tea?] B is sitting quite high against pillows, head on left side, extremely sleepy. None is served.

Diagram:

Goes to B- same posture and position [Do you want some toast B? [A cup of tea?] gets her a beaker of tea from the trolley, checks the top is on OK {I’ll leave this her for you} leaves it on the top of the table- (highly unlikely that this patient could get this - may have been a hint to the other nurses)

A has nurse E’s and MCD’s attention and remains difficult to make comfortable- they try to reposition her in the bed- They wait while she puts something on the LW- and reads [paracetamol]. MCD - [Your spelling is about as good as mine] laughs and wipes saliva away from A’s mouth with tissues [ it’s a good job we know what you mean]. A doesn’t
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smile (although she rarely does, I suspect those who nurse her a lot can decipher when she’s amused etc. as I’ve heard them joking with her)

Nurse E [I’ll go and get you some]

09.05 Nurse E to A paracetamol via gastostomy tube, leaves and returns

Nurse F (co-ordinating) comes in to sort out who’s doing what care. Speaks to MCD who wonders if Nurse E would rather not ‘do’ A because of the lifting

Nurse E returns and starts with A again- nurse F goes over to discuss work allocation over patient, she leans against the bed, rubs the patients hand and speaks to A

Nurse E to A [your paracetamol is nearly finished now] (meaning its all nearly gone into the tube).

Time for A’s bath- Nurse E gives A lots of choice e.g. ? Jacuzzi Vs normal bath, does she want her hair washed, checks it’s OK for the bath now

MCD sorts out clothes for her, these are taken out of the wardrobe-[this is my favourite] holding up a skirt and jumper hanging on a coat hanger. Nurse E [Those don’t go together though]. A spells out the bits to take for the bath- talc, spray

0919 MCD and Nurse E leave to take A’s bits to the bathroom [right]

A starts to spell something out which they note when they come back [put machine on charge] MCD [OK- can I take this home with me, it would be useful when my husband ....].

Nurse E wheel the wheel chair up to the bed, draws curtains round

Nurse E [Ready, steady go] you can hear them lift her [move your legs round] [That’s it - well done]. MCD [There we are]

09.40 MCD with laundry skip to do A’s bed [What’s the matter B? You’ve gone all lop-sided. Can I just sit you over this way mah darlin’] B moans. MCD [I know, I know]

MCD to D [Are you going to slip out of bed?] D-[No]

MCD [Are you all right, don’t you fall]

D gives brief quiet laugh- huh huh

D stirs, sits up picks up glass of fruit juice and pulls face says to MCD [Is this old ? I think this is from last night] MCD-[Well I haven’t poured you a fresh one this morning. I’ll get you a fresh one after I’ve done this bed]. She gets called away by Nurse E to bathroom before she does it so I wash glasses for D, pour her water and pass her fruit juice.

10.00 Nurse F comes into D, sits on bed, just above halfway, facing D, right arm reaching across the bed with hand on the other side, looks into her face(D has her legs out of the bed on the opposite side.

Diagram:-

[Can I help you with a wash?]

D-[yes you can. My leg is painful this morning].

Nurse F [What the corn pain?]

D- [No not that... (can’t make out)]

[I’ll go and fetch you a bowl] Goes to fill bowl at sink, is called away by nurse E.
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10.05 Nurse F to D [Sorry about that D, I ran off and left you didn’t I?]

D-ha ha

[You look tired this morning, are you feeling tired?] Draws curtains round

D- [I’m just ... ] [can’t hear]

[Do your ears feel better today?] D says that the main problem is the leg
During the bath, they talk about different things—toiletries, the dressing for D’s sore skin, is she going to have her hair done. I can see Nurse F’s feet under the curtain and it is evident that she is kneeling on the floor.

MCD asks Nurse F to look at another patient’s wound [all right] She’s just applied something to the skin [This can be working while I’m away] The three of them talk about the sensation of having the cream applied. D says that a previous cream was uncomfortable because it felt so cold when applied. Nurse F to D [Are you all right for just a second. I won’t be long] goes off with MCD- returns quickly [Are you all right?] [I’ll pop you on the other side so that I can do the other half of you] They talk about D’s tablets, I hear something about suppositories. Nurse F goes for something [I won’t be long] Returns [Would you rather stay in bed today?] (she must have picked up from the patient that it was going to be too much to sit out)

D- [Yea]

Nurse F [I’ll get you padded up and everything and see how you feel].
Nurse F asks to borrow nurse E (who is with A) for a minute. Nurse F explains to D that she and Nurse E will roll her. It appears that Nurse F picks up that she’ll be waiting a while before Nurse E has finished with A. To D [I’ll just nip off and get some cream- I could do that couldn’t I?].

Nurse E and F are behind curtains with D. Nurse F to nurse E [She’s so exhausted]. They plan what they will do (again the patient is allowing the care to be given)

? nurse E or F [D, we’ll just need you on your back one more time sweet]. Sound of straightening pillows [Ready, steady ...] hear them lifting her up the bed Nurse E leaves [OK].

Nurse F to D [Do you want me to get you some Coproxamil?] D [If you could just get me some ....]

Nurse F goes away returns and discusses D’s skin area. Nurse E refers to Nurse F re. work left to do- Nurse F suggests Nurse goes for coffee.

Nurse F to D [I wonder if it would help the leg to be on a pillow or something] D- [I don’t know]

[I’ll put some cream on this bit. That’s a nasty bruise on the back there]

D- [That’s where ???? caught it]

Nurse F goes to get some gauze (10.45) returns [I’m making a mess aren’t I?]

D laughs

[I’ll tidy it up before I leave. I promise. What are we going to do with your teeth?] [Do they come out D?]. [Is this sore at the back, where it’s bruised] [Is that comfy there. what do you think?] Nurse F is walking round the bed? tidying the bed (I can see her feet). Can hear Dr [Hello D, how are you today?]

D- [Sleepy]

Nurse F [You have a poorly leg as well haven’t you]

Dr [Have you had breakfast?] D-[It’s a sort of spasm pain]
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Dr [Let’s have a look at your mouth]

Curtains are opened and I view Nurse F putting drops into patients mouth. D has her mouth open and Nurse F gently puts the drops in, concentrating intently on what she is doing. [All right?]. D looks into her eyes. Nurse F cares for the environment. She tidies up, picks up bits from the floor, re-arranges things on the bed table, puts them down quietly to reduce the noise as she’s finishing up, she looks at D whose eyes are closing- seeing D is falling asleep, she takes one last look at her and leaves the room. She says to me at coffee that she thinks D looks poorly and she keeps having to look at her in case she’s passed away)

While all the above between Nurse F and D has been going on, Nurse E has been caring for A after bringing her back from the bathroom in wheelchair Nurse E [Here we are]. Says that she’ll wheel her in the corner and dry her hair (can plug in dryer there) and then put her in the comfortable chair. (this is a recliner which can be controlled electronically by A). A is grimacing, screwing up her eyes, saliva comes from her mouth. Both Nurse E and MCD look at her but continue. Nurse E puts on the hairdryer, MCD carries on doing the bed- after a short while Nurse e asks [Do you want some suction A?]

A nods. Nurse E wheels her forwards and draws the curtains around her. The suction starts. When the curtains are opened again, Nurse E says [The sun is actually shining now]. A has her head down, looks more comfortable but has a slight frown on her face. Nurse E says [your shampoo smells nice] A coughs- Nurse E puts mouse on her hair [We’ll get this done quickly] starts using the hairdryer. A continues to have excessive secretions- Nurse E continuously wipes them away. [Are you going to be all right for me to finish doing the other side-yea?] A nods. Nurse E dries the hair, brushes it gently with one hand and smooths it down with the other.

[You’re half asleep aren’t you?] Nurse E puts her face close to A’s. A doesn’t look at her (she looks tired). MCD helps Nurse E to put A into the chair, A points to the cushion on the chair seat Nurse E (picked up the cue)[do you want that off?] and moves it. MCD and Nurse E lift her together Nurse E to MCD [what are you doing?] MCD had thought A was going to stand, Nurse E was ready to lift A. The lift was therefore awkward and A started to pull a face crying MCD- [All right darlin, oh dear]

Nurse E to A [Just relax] wipes saliva from A’s mouth. Nurse E leans, crouching over A reading what A is writing on the LW. She waits patiently to see what A wants- its something about the control on the chair. MCD leaves with the wheel chair. Nurse E stays looking after A who writes splint on the LW. Nurse E finds this and lifts A’s arm very gently to apply it. There is some difficulty with this and a search ensues for a second wrist splint.

Puts this one on [Is that better?] Puts A’s sponge bag back in locker. A is writing another message- Nurse E goes to D Nurse e goes back to A [All right] Puts some kitchen roll under A’s chin [do you want this - OK there?]

Nurse E to A [Do you want your walkman on? Do you want to listen to one of your tapes?] Finds her one out, puts it in the player and places the headphones on gently [All right?]

A gives eye contact, head nods a little, Nurse E leaves.

Theory- since nothing is said as for e.g. with nurse F and D, is it because it is assumed that care will continue later?]
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A is writing something on to her LW, MCD takes a few seconds to respond and then leans over A to see what the problem is- A’s bra is uncomfortable. She tries to manage it on her own i.e. leaning her forward, she is a little rough because of the effort needed. The ‘lemon lady’ (volunteer) comes to help her. MCD- [It’s on the end hook-that’s made it about 1/2 inch longer. Is that OK is that better?] and moves away. A starts sending another message but MCD is unreceptive and leaves the bay. Dr joins A, kneels on the floor, leans arms onto chair arm rest. A writes as the Dr looks at the machine- Dr looks to see if the bra strap is twisted.

Nurse E with MCD giving B a bed bath Nurse E says to B (this patient always has her eyes closed- see phase 1, day one drug round.
[Let’s give you a little wash down below sweet heart, round your catheter]
MCD-[Is that what I think it is?]
The catheter has caused a skin sore Nurse E [ I must admit, they do tend to cause sores in patients ?????] MCD [Is it sore B? That’s perhaps why you’re fiddling with it]
Comment about B’s abdomen
MCD [I thought she was about to give birth]
The nurses plan how they are going to put B in a chair.
After some wash/ dress activity MCD [well done, lovely job, that wasn’t so bad was it?]
[What are you feeling for? the soap- you wash with that, you’ve had a wash, we’re all done with that] [Come on B, I’m going to put your glasses on, you can open your eyes and you’ll be able to see]. They get her into a chair- she moans. MCD [Do you want your legs covered B?] She does this tucking the blanket around B’s legs. She makes the bed.
12.03 From behind B’s curtain Nurse E in response to A’s LW [We’ll be with you shortly A] [ A I’m just busy with B at the moment, I’ll be with you in a few ticks] Comes out from behind curtains [let me get you some tissues] gets these and wipes A’s mouth [Do you want your tape turning over?] Does this [I’ll pop back as soon as I’m finished with B, all right?]
Returns after a while [What can I do for you A?] Crouches with knees bent by side of recliner arms crossed leaning on arm rest- face looking forward (at me) goes and returns a little while later with cranberry juice and water for gastrostomy tube. Husband has arrived meanwhile. 
Nurse E [OK E (A’s husband)? Just let us know if there’s anything else] Nurse E leaves the room.
I overhear A’s husband- he talks about the various events of yesterday’s visit which had meant that he had not been unable to give her as much attention as usual and that it should be better today. Asks what sort of morning she has had.
I went into the Office before leaving where Nurse E and the Doctor were discussing A. She may be staying in the XX. There was some discussion about the stress she causes. Nurse E wondered if she could go to another hospital where they are used to patients with MS and MND. She identified that A like a previous MS patient. [She’s beginning to cry more easily, which pulls at your heart strings and it’s frustration when you can’t get things right for her].

Theory: While I tried to address my intention to speak to the patients about care, it is questionable if this is going to work. Patients are either confused or extremely drowsy. I attempted this today but it was difficult to communicate as anticipated. I tried to chat with
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B, but with little success. After she had been bathed and sat out in the chair for lunch I went and sat on her bed and made a general comment about her sitting out- had it made her feel better [Oh yes] Would she have preferred to stay in bed? She said that it was good to get out of bed for a change rather than staying in bed all the time. She is rather incoherent at times but she responded quite definitely.

I popped to see B in the male ward (from yesterday) to see if I could get some impression of his perception of care. He said first of all how things keep repeating and that is one of the reasons he doesn’t like some of his pills. To me he is incoherent at times or at least I think we are talking at cross purposes or on a different wave length. I asked about his views of the care he was receiving- picking up from the nursing staff (as noted) that he often refuses care and medication). He said several times [that’s a difficult one to determine isn’t it?]. He said it was different to being at home and when asked for further detail he said that they get you to do more. At home you’d go into a corner. I asked light-heartedly if he thought they were bossy- he said [not really, in fact it’s probably the other way round]

Then go to chat with D who was sitting out in the chair. When I asked him how he is he said [I’m feeling depressed today] he climbed on to his bed looking very stooped and poorly. I said something about his partner Carol coming in to see him -He closed his eyes- I waited a few seconds and said I’d leave him to rest.

Theory- I initially felt that I was being considerate and that I was the active agent in the interaction, but on thinking about it there was also the realisation that he was the active party, that rather he was withdrawing himself from the interaction. If he had been well and turned his back on me, I dare say I would have been put out, but because he is ill, allowances are made (accommodation) which equalises the power base somewhat. So what other cues are there which limit interaction? Closed eyes, head down lack of eye contact, although this could indicate self-pity/provoking sympathy / attention.

What have I achieved today and what do I need to focus on tomorrow? Recheck research questions and data required from observations.

Targets for tomorrow see 19th Feb.
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Wednesday 11th July, Day 6 maternity care setting

On arrival Midwife D (MWD) is on the computer playing solitaire, NMM writing up notes re. the night’s events, 2 night Nursing assistants are at the station

Midwife J (MWJ) comes to speak to the midwives at station, she had been involved with a ‘problem’ mother during the night (my term)
07.05 Bay 7 buzzer goes, Nursing assistant (NA) attends
On day shift Midwife T (MWT), Midwife D (MWD), Midwife B (MWB), Nursing assistant P (NAP) and Nursing assistant S (NAS) (on at 8am, sit taking own notes from bed state, I don’t see any one give any instructions), ward clerk J (WCJ)
At the beginning of the hand over, the night midwife (NMM) gestures to us to move closer, she hands over in a lowered voice.

See notes for details. 2 antenatal women in side rooms, 3 antenatal in bay 5, 1 for CS today, 4 in bay 6, 1 for CS today, 5 mothers and babies in bay 7, 4 in bay 8, total 18.

hand over information giving except for following.

MWD seeks information on SR1,
While discussing 5C phone rings, enquiry re. woman, NMM says she’ll ask the mother to phone them back.
MWD queries the well-being of 6B’s twins since 3 midwives were unsure of the CTG traces.
A baby is crying, a Nursing assistant (NA) picks up and soothes.

Main story relates to 7A NMM [She broke my heart during the night]. NMM explained that she had been concerned about the baby’s feeding and the lack of feeds detailed on the feed chart and had decided that if the baby didn’t feed next time, she would need a formula feed. She said that when she suggested this to the mother [She just glared at me and said ‘I’m doing this’. There was complete denial that there was a problem].

SR1’s partner is buzzing at the door, the door is opened [What’s he doing here at this time in the morning]. He knocks on his wife’s door and goes inside, He comes out later and asks if his wife can get a shower and takes two coffees in to the room.

Back to 78A. NMM said that the mother had questioned her assessment of the baby [‘That’s your opinion’- basically ‘what do you know’]
NMM said [I gave up at this stage, she was getting aggressive with me, there was no talking to her. she said that she was going to complain and I asked MWJ (senior midwife) to come down] The mother had wanted to go home and NMM thought that she had an unreal view of the situation. [She that the baby hadn’t lost 10% of the birth weight and thought that meant that everything was OK, she doesn’t realise that if the baby isn’t feeding there is a problem. She accused me of going behind her back in calling the paediatrician, she should have been consulted]. NMM had called the paediatrician, when the baby hadn’t fed to get advice. [She accused me of being aggressive and bullying her, ‘everyone has
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been positive during the day and now you come on’] 7A criticised the break down of communication between health professionals.

NMM said that the National childbirth trust (NCT) breast feeding counsellor had written inappropriate comments on the feed chart, i.e. that the baby had a sore head and that’s why the baby wasn’t feeding.

[The mother refuses for the baby to have a formula] NMM said that she was concerned that she didn’t think the baby’s feeding was good enough to go home. She said that the mother said that she would get help from the community MW, but had to ask MIVJ who this was. [The paediatrician will come to see her before she goes home and it may be an idea to ring the Community midwife beforehand to explain what’s been happening. [It was a horrible night with her]. MWB said that she had had a very intense day with her, that because the NCT counsellor had had 2 hours to spend trying different positions, 7A had assumed that MWB had the same amount of time to spend. NMM suggested that if she stayed, it might help for her to go in to a side room.

[That’s her and she kept us going during the night.

During coffee break conversation between MWB and NCT breast feeding counsellor concerning clash between night MW and 7F.

MWB started by telling her how valuable 7F had found the 2 hours that the NCT counsellor had spent with her and that she had spent quite a long while also, and had as a last resort got the baby feeding from a nipple shield. She said how 7F was very much against the baby’s head being held and her breast and nipple being forced into the baby’s mouth.

She identified that there had been a personality clash between the night MW and 7F and to make things worse the MW had referred the baby on to he paediatrician without saying anything to the mother. [And of course what did he say- to fed the baby 4 hourly and give her formula. Well of course 7F wasn’t going to have any of that and good for her, neither would I]

They agreed that there seemed to be plenty of milk and MWB said that while 7F didn’t want to use the electronic breast pump, she could use the hand pump. NCT counsellor said that she had shown her how to hand express. I got the gist of it and left.

Note: - there was hence little loyalty or support for the night MW who had seemed to be concerned for the baby’s well-being and the NCT counsellor’s comments re. the baby’s sore head were way beyond her role.

Report continued-

8B MWD asked [Did she give you any grief over night?]
NMM [She was a lot better]
MWD [Well compared with the other]
8C NMM queried if Warfarin was given yesterday and if so at what time since it hadn’t been signed for. MWD and MWB said that they hadn’t given her any.

At the end of the hand over, NMM continues talking about 7A [She doesn’t want the baby traumatised, if the baby cries she just wants to cuddle the baby. she needs help to fix the baby, but won’t let anyone help her with this] MW who delivered her came to help her for an hour. MWB said that the NCT counsellor had spent 2 hours with her and wanted the MWs to do the same. We’re unable to give that sort of time here, we’re too busy]
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Bay 7 buzzer goes, no-one stirs initially, then MWT says as she stands [there's a bell]. MWB goes to answer it

She returns and there is discussion who is doing what. MWD [Can I do ‘antes and the side rooms’?] made a remark during the hand over which suggested that she was going to work on that side, although MWT was there yesterday morning.

MWT [OK]
MWB returns [Am I doing 7?]
MWT [I’ll do 8]

(when I asked MWB about 5E yesterday, MWT said that she had been fine, MWB said that she had caused a fuss again in the afternoon. She had grown impatient for her scan and when MWB phoned the scan dept, while 5E stood over her as she made the call, they had told her that they were having to cancel scans. MWB arranges that they would phone back if they could fit her in. 5E (from yesterday) had become annoyed, banging the flat of her hand on the table and said that she was going to go to see the doctors, [‘I know where they are, they’re in the clinic’] and she had set of for the clinic. Meanwhile the scan phoned to say that they could fit her in and someone was sent post haste to tell her. In the finish, the scan dept. didn’t do such a detailed scan as was required, but anyway 5E went home.

07.50 MWT goes in to bay 8 to take blood samples, MWD asks her if she would like her to do her drugs
MWT [Absolutely]

NMM is still at the station writing up her notes from the night’s events.

MWT and MWD are both at 8C’s bed side to check her drugs. Both midwives stand at the end of the bed, the mother is sitting in a chair to the left of the bed with the IV stand on her left also. The cot is on her right.

As MWD and MWT check the tablet for her MWD comment [Oh, that’s a colourful one]
MWT agrees
MWD [Aesthetically pleasing]. She takes the tablet in the pot to 8C (have you got a drink for this). She checks she has one.

8F calls to MWT wondering about at what time she will be able to go home. MWT stands initially at the end of the bed and then goes to half way down, nearer to the mother’s left hand side. The mother is sitting up in bed, with the baby feeding at the left breast. MWT achieves face to face ‘contact’. She nods as she is listening. The mother explains that her husband has to get a lift, so needs to have a specific time.

MWT tells her late morning /lunch time.

She moves back to the end of the bed and explains that since the mother has had a normal delivery, she can send her home and she’ll need to get letters ready for the GP and MWT but the paediatrician will have to see the baby.

8F [The paediatrician has seen the baby. Yes, he’s seen the baby]
MWT [There’s no hold up there then]
8F [I just need another Rubella shot before I go]
MWT [we’ll soon get that organised, that won’t take much organising at all]. MWT looks for 8F’s notes at the bedside [I can’t find your notes]. Leaves for the midwives’ station
8A opens her curtains, walks to the bin near the window to dispose of a nappy, says ‘Hello’ to 8C and 8F, they smile at her and say ‘Hello’.

08.05 there’s lots of chat at the station. NAP comes in to the bay to 8C with her breakfast tray [I thought you’d put your own nightie on ]
8C [I had, they put this on again]. NAP [How are you getting on with the Sudocreme?] Mother nods.
NAP [It’s quite good isn’t it?]
8C to NAP [Could you help me to sit up please?] NAP goes to help her, helping her to sit forward and rearranging her pillows behind her on the chair. NAP then puts the tray on the bed table., lowers it and moves it towards 8F [I’ll let you put you own milk on - everyone’s different, some like it swimming....] NAP leaves the bay.

MWT carries the 8F’s notes and stands at the end of 8F’s bed and asks her details ready to go home- who her community MW is, checks the address. The mother is up and making her way to the end of the bed. As they are talking, the baby sneezes, both women smilingly, look at the baby and say jointly [Aah]. MWT says to the baby [That was a good sneeze]. The baby yawns MWT [Are we keeping you up poppet?]. MWT to the mother, [I’ll do your check sometime]. 8F [I’m going for breakfast, if that’s all right], MWT [Absolutely], she leaves. The mother pushes the baby in the cot into the nursery and then goes to the day room.

MWD is standing with 5D in front of the MS removing 5D’s venflon, I hear MWD say as she puts on a dressing that it might ooze. She finishes and says [OK that’s all done].

MWT comes to 8A’s bed, who is not there. She leaves the notes on the bed. She then goes to 8E and tells her that she is in the bay today. She checks when she intends to go home during the day.

Anaesthetist arrives at the station, MWD [Do you want to see your section ladies?] He takes the notes, goes into the antenatal bay, returns after a while and writes in the notes standing at the station. MWD is chatting and sorting out notes. The doctor uses the phone.

The NAs come in to bay 8 to do the beds. NAP goes to 8C [Have you finished?]. Takes the breakfast tray away.

08.25 8A is making a neat pile of baby clothes on her bed, 8C is resting on the bed, 8D is walking around, 8F in the Day room at breakfast. 8C has got back in to bed.

MWB is at the station dealing with drugs in the clinical room.
MWD is still at the desk, she warmly welcomes doctors as they arrive.
MWB says that she feels she needs a drink of tea, does anyone else fancy a drink of tea? There is a mug of tea for everyone after a few minutes.

NAP and NAS help 8C out of bed into the arm chair. NAS put pillows in to the chair, smoothes and plumps these. There is concern that her night is blood stained and her nightie
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is drying. NAP goes to see if there is a fresh hospital nightie for her, she returns. [We’ve been lucky, the laundry has just arrived]. She has a fresh one for 8C. The NAs do 8C’s bed and chat between them, they tidy round i.e. NAS fold her dressing gown neatly and places it on the bed, puts her nightie in to the linen (I interfere, concerned that it is the mother’s own nightie, and it is). NAP when they’re ready [Right], and they collect toiletries for the bathroom. NAP goes to get MWT to unplug the IV.

MWT attends 8A, she kneels on the floor, forearms on the bed, notes between. The mother is sitting on the same side with her legs over the side of the bed. HER torso is angled towards the MW. MWT discusses her discharge, mentions drugs to take out (TTOs) and looks at the prescription sheet. The TTOs have been written up by the doctor [That will save loads of time. people can wait ages for pharmacy, I can tell you].

As with 8F, she checks home address, tells her about the letters, advises her to phone if the midwife doesn’t arrive tomorrow [If by any chance it gets to the afternoon and you haven’t seen anyone, do ring us, it only happens rarely] writes something in the notes. She explains that one the notes are done then things get underway, prepares to leave. 8C calls her over- she is fidgeting, is flushed and sighing (looks in pain). She is waiting to go to the bathroom and asks if MWT will unplug the pump. MWT looks at the piping [No, the plug]. MWT sorts this out. The mother says that her abdomen feels tight, WCJ calls MWT to the phone MWT sees 8C on to her feet, [I’ll just help you on your way]. The NAs arrive and take over.

5D is back at the MS where MWT is patching up the venflon site, which has started oozing. she is putting a folded gauze swab on it. the mother, as before is standing, holding out her arm.

08.55 MWT returns with 8C from the bathroom, carrying 8C’s toiletries, the mother follows behind pushing her drip. MWT sits on the bed at the top end [Where does your wash bag go?]

8C [In there], MWT [I don’t know where it goes]. The mother tells her. MWT cheerfully [let’s plug you in again]. 8C sits in the chair - drops into the chair with a sigh. MWT [It’s a job isn’t it?]. 8C thanks her. MWT [You’re welcome, no problem]. She climbs out between the bed and the chair, pushes a side table towards 8C, [you can use this]. (There is a bed missing and this table is surplus for the time being)

MWT leaves her in response to being called by 8D, meanwhile 8C is raising her legs, pulling the drip stand towards her, to give herself something on which to rest her feet.

8D asks MWT if she can bath the baby (her second child at home, premature fusion of the fontanelles and cerebral palsy as a result. is on the at risk register, there was no problem with her first baby). MWT looks in the cot [That sounds like a good idea]. The mother says that she watched her being bathed yesterday, [I don’t know if I can do it myself today]. MWT [I’ll organise someone to be around while you’re doing it] (This is usual practice to build the mother’s confidence). MWT speaks to the baby [Are you going to have a bath? You don’t think it’s a very good idea do you?]

09.05 The Reg. is discussing the antenatal women with MWD. MWT is sitting at the MS, ‘doing’ notes.

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09.07 the doctors visit 8C, draw curtains round. [How are feeling?]. I don’t see the midwife go in with them.

09.09 At the station, MWD asks if MWT will help her push a bed into the corridor, she agrees, MWD says sarcastically [Are you sure, you look pale], she’s sees me smiling and points. they go and return shortly afterwards.

I have a chat with 8C she is 6 days after a Section, which was followed by a pulmonary embolism, she has been prescribed Heparin for this which is likely to the cause of her wound oozing. I ask her how she has found her time in the hospital. She tells me that they’re good in the day but not very good at night, they make you do things for yourself more, It takes a lot before they’ll take the baby out to the nursery.

She mentions this contrast between day and night staff several times.

Note: material I have on bonding Probably Billings 1995, suggests that the theory of bonding may be taking things too far.

there is also reference made to this by palliative care patient in those notes i.e. contrast between night and day staff.

I ask her what she has found most helpful- she says being helped to the loo during the day - she was given no help at night really. I ask her if it has been consistent- every night or if it depends on who is on, all she says is that the past 2 nights have been bad.

I ask her a little later who she sees during the night, whether NAs or MWs. I check that she knows the uniforms and says that the NAs where brown [They’ll do anything for you. They are very good, they’ll take the baby, do anything. it’s the one’s in the blue uniforms, they have a lot to do I suppose. I ask her about how things were in labour. She told me that her labour lasted 23 hours and as had happened with a previous labour, the cervix dilated to 6 CMS then stopped. She said that she didn’t remember anything then until she came round from the GA. I asked her if she’d had Pethidine which she had and this had made her feel drowsy. I explored a little more, her perception of her care. [I don’t think they realise that I am as much pain as I am]. [I’m fit, I’m fit to move around, they don’t realise. She repeated, the day staff help you to walk backwards and forwards but the night staff leave you to get on your own. They treat you as though you’ve had a normal delivery, rather than a caesarean. They expect you to do as much] During our interaction, she asks me to remove a pillow from beneath her, she has difficulty in getting comfortable.

I’m writing up our conversation, MWD comes in to the bay in response to 8C’s buzzer [Is someone buzzing] 8c [Me, my wound is bleeding]. MWD draws the curtains round, she covers the mother’s legs, starts to lift her nightie [I’ll have a look, is that all right?] She stands at the side of the bed and leans over the mother, angling her head to look at the mother’s face. She is gentle and moves the clothes away slowly in order to see the dressing. Between them, they pull down 8C’s knickers to uncover the dressing, 8C holding on the top (she says that she doesn’t want them to roll on to the wound, while MWD moves these below). 8C explains that it had bled during the night, [they said it didn’t bleed much, but there was a patch of blood on the bed] She rubs the sheet near the top of her left leg, where the stain had been, indicating the size. (See hand over, NMN did mention that the wound had been quickly packed. 8C commented that she had been surprised that this sort of dressing had been applied, after the clips were removed. MWD asks when the dressing was put on. 8C said last night, but it was late shift.
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MWD [It really needs to be taken down and re dressed ] [We'll change your nightie]. [I'll get MWT, she's your midwife for the morning - all right?]
[Do you need any pain relief?] 8C says that she does, MWD can't find the drug sheet and goes off to find this. She comes back- stands at the end of the bed, explains that 8c can have Voltarol, but not the others for another half an hour. MWD asks if the Voltarol have helped before and tells her that she can have 2, which would be double the pain relief [Do you want those?] MWD goes to the MS where MWT is and updates her on her events.

MWT brings the TTOs to 8A on her way to give 8C her tablets. She stands half way up the bed on the mother's left, looking at the mother's face. She hands her the pot and checks that she has a drink, she goes to the other side of the bed and passes her the water. She goes to set up the trolley for the dressing and meanwhile the phlebotomist goes behind the curtains, she has a blood test request form. MWT comes along with the trolley and identifies when the same test was done and says that the test isn't needed so soon.
While MWT tends to the dressing, 8C looks frightened- her head is unsupported and she moves her head back, breathes out of her mouth and looks up to the ceiling from time to time. She comments on how much it has been bleeding and asks anxiously [Has it bust open?, I'm sure it's bust open].
MWT standing on the mother's right hand side half way up the bed, speaks calmly and works slowly and gently. She angles her head as she looks at the mother and explains what she is going to do i.e. take the gauze off first, then the plaster. the mother comments about the clips being removed and that she is surprised that the plaster has been applied- that the wound was bleeding too much, the wound would get wet.

MWT prepares the dressing pack, then goes to wash her hands. The mother is very anxious as the dressing is removed. Once the gauze is off, and MWT begins to unpeel the plaster, she asks if it can't be soaked off in some way. MWT said that it was probably wet anyway. As it is removed, blood trickles over the mother's thigh on to the bed. As the dressing is removed and placed in the disposal bag, blood goes on onto the bed [I'll clear that up, I promise].
MWT places gauze over the wound, to absorb the blood.
before the dressing is off, MWD is heard to be in the bay and MWT calls to her and asks her if she can get the doctor to come and see the wound. Soon afterwards she returns to say that the doctor will be [half an hour sooner or later].
After the dressing is off and MWT has run a swab over the wound (there is a moderate sized blood clot along the incision line), she asks me to ask MWD to get the doctor to come sooner.
MWT reassures 8C that she will redress the wound with gauze and a little strapping so that it won't be painful when it is removed.
When I return to 8C the doctor has been and MWT is sitting with 8C. MWT is sitting in the chair to the mother's right hand side, 8C is crying, drying her eyes with a piece of blue paper roll. Her husband has been on the phone, 8C asks [Did you tell him that it has split?] MWT [No, I couldn't really discuss it with him, he said he'll phone in about half an hour to see what is happening.
MWT reassures 8C that the main thing is that the Registrar said was that the wound had healed well underneath that was good and the reason why it wouldn't need resuturing.
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MWT was going to contact the wound care nurse, who specialises in problems such as this and they'd see what she suggested. MWT takes a swab of the wound.

8C asks [Is there any chance that this pillow under my head could be moved?]

MWT stands up straight away, puts the notes off her lap at the end of the bed [Of course]. She helps the mother sit forward, hooking her arm under the mother's and sits her forwards, she encourages the mother to push herself back up the bed. She looks more supported to me. MWT asks to check the wound [I'll have a little peep]. It's OK. 8C says [It doesn't bleed then when I move, just when it feels like it]. MWT seated again, [Yes it's difficult to say....] the baby cries loudly, MWT interrupts her sentence, gets up and goes over to the cot. [Oh, we'd better get you a feed]. To the mother [There may be an auxiliary who can sort him out, while I do the swabs and sort things out. She leaves to fetch NAS who comes behind the curtains through a gap at the corner. She says to the baby [You're grumpy] then to the mother [Is he grumpy?]. She picks him out of the cot and cuddles him. [Someone tells me that you need your nappy changed. Someone tells me that you need a feed, are you hungry?] She says to the mother that she'll take him into the nursery and asks 8c if there are nappies in the cot cupboard. [Do you need anything?] the mother says that she is fine, MWT is still elsewhere.

10.55 8C's husband arrives. He says something about his phone call, not knowing what was going on, she tells him about the wound specialist who is coming.

8F hasn't had her check yet and is hoping to go at 1pm, [people are coming to collect me?] 8A and 8D are asleep.

MWD comes in to the bay looking for MWT who then arrives to check 8F. She firstly goes behind 8C's curtains, she looks at the wound. there is some discussion between them about 8C's mobilising. MWT says that they are encouraged to walk round, the husband says that she needs not to move round so much. MWT [There's the notes, I've been looking for them everywhere]. She remains, standing, opposite the husband, who is sitting on a low radiator to the left hand side of 8C, she writes in the notes placed on the table at the end of the bed. Silence is interspersed with brief comments re blood tests, rain outside. [As long as it's better, I'm going away on holiday in 2 weeks]. 8C [Where are you going?]
MWT [South Devon] silence
Husband [Whereabouts are you going?]
MWT talks quite a lot about her daughter and her friend- and how where they go suits both the teenagers and her and her husband. [I'm really looking forward to it]
The husband comments on the part of the country.
Silence
Husband [Paington is nice]
MWT [we went down there ......] the conversation goes on
NAS returns with the baby, holding him in her arms. MWT [Has he had a good feed?]
NAS [He's had a brilliant feed]
8C [How much has her had?]
NAS tells her [We changed his nappy while we were at it, may as well get it all done]. She leaves. MWT continues with the notes. After a while, [If you need anything, just let me know. You just rest].

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As MWT leaves she says to 8A who stirs on top of her bed [I am coming to you honey, I haven’t forgotten, honest].

She returns and goes to 8F puts curtains round (I over hear the conversation, I am not observing directly). [When the baby stirs, let me know and I’ll give him a quick once over, before you go]. Asks 8F if she has made her arrangements to be picked up. The mother tells her. She does temperature, blood pressure and pulse

MWT Now, I’d like to check your tummy please, have you got any stitches?] 8C [Not on my tummy]

MWT [Just go on to your side, So that I can just check your stitches please]. Silence.

[That’s fine, they’re not pulling ? they look really flat, that’s fine]. Says something about washing her hands. [How’s your loss now?]. The baby has stirred and the mother says that she can’t hear what MWT is saying.

[How much are you losing?] 8F describes this, MWT summarises [A moderate amount, OK, urine? bowels ?]. The mother has been MWT [I’m impressed, very impressed]. [I’ll just go through the discharge check list. Contraception- [You need to think about this. Can get pregnant before you see a period], community midwife’s visit (at least 14 days, up to 28 days, health visitor, birth registration- 6 weeks to do that, [So no rush], Postnatal appointment with GP, medication, During the information giving, 8F responds in the following ways- [Right], [Good], [Fine], [Mm Mm], [OK], [That’s no problem].

MWT finally explains that she has to sort the letters [But I’ll get that one sorted out for you and back to you]. [Just let me wash my hands and I’ll check the baby] returns and does this. [That’s all I need to do, give him a quick once over]. The mother asks about using salt water foe a moist cord, [Is that all right?] MWT advises her to keep it dry. MWT [Let’s just put your ticks in, little man]. MWT completes the notes.

I join MWT as she is doing the transfer check ‘on’ 8A mother and baby. She looks at the baby first- she leans over the cot, standing at the narrow end, hands caressing baby’s head. She is gentle and talks to him, checks his cord [Oh, that’s wonderful] Asks the mother when he was weighed last, asks if she would like him weighed, she would, [We’ll take him into the nursery and we can check his nappy at the same time]

Note: - it makes me wonder how other mother’s feel when the responses to the baby is so different.

The mother starts to push the cot, but there appears to be a problem, MWT checks to see if the brake is on. The mother says it’s like a super market trolley. MWT jokes that the mother has got a funny one.

In the nursery, MWT and the mother stand on opposite of the sides of the cot, looking at the baby. MWT puts paper on the scales and zeros these. She returns, starts to take the vest off the baby, asks about his last feed realising that he may be sick if rolled too much. She looks at his napkin area. She picks up the baby and supporting his neck and head in her left hand and under his knees in her right, places him on the scales. She says what the weight is and asks the mother what the previous weight was, she tells her [very good]. The baby looks ready for a feed. before putting him back in the cot, she holds him at arms
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length, looking at him [What are you like? What are you like? Trying to tell me that you get no food]. She puts the baby back in the cot starts to dress the baby, asks the mother the mother if she wants the same nappy to go on. the mother wants to change it but the clean ones’ are by the bedside [Do you want to do that?]. the mother pushes the baby back to the bedside, while MWT gets the work box.

At 8A’s bed, she is cleaning the baby’s bottom with baby wipe, MWT comes in and writes up baby notes on the bed, she crouches down as she does this. Then she asks the mother to get on to the bed. She checks her temperature and pulse, having to fetch more tops for the thermometer. She places this in the mother’s ear. Afterwards she prepares to remove the section stitch. MWT asks her if anyone has explained what will be done. They haven’t. She explains slowly, indicating on the stitch itself that she will remove the bead and then pull the stitch through. She stands at the side of the bed, at 90 degrees to the mother (who is facing forwards) and angles her head as she looks at the mother’s face. She prepares the trolley and goes and washes her hands. On return she says that she can’t say that it won’t hurt a bit but it shouldn’t be very painful. She is very gentle, the mother doesn’t flinch at all and says that she didn’t feel anything. MWT says that the wound is so clean it doesn’t need cleaning and neither does it need a dressing. She tidies the things on to the trolley and prepares to go through the rest of the check. [I’ll plonk myself down next to you if I may]. Does so. [This is comfy isn’t it?] Each has her bottom towards the centre of the bed, with legs over the side, MWT’s right shoulder a few inches apart from 8A’s left, both are facing the end of the bed, MWT has her left leg over the right. They have to look slightly over their shoulders to achieve facial ‘contact’. MWT writes in the notes which are on the end of the bed in the centre. It looks comfortable. MWT goes through the check list, explains things clearly, asks if there is anything that the mother wants to know, gives plenty of time for a possible response. The mother doesn’t ask anything.

Before I leave the ward MWT mentions to me about 8c saying that it’s difficult when someone is like that and she feels it best to keep calm.