Title:

"A CRITICAL ANALYSIS OF THE CONCEPT *CARE* IN THE PRACTICE AND DISCOURSE OF NURSING".

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"The pragmatic tenor of Wittgenstein's thinking ... is again in
evidence in the early part of the *Blue Book*.
We are advised at the outset to substitute for the question
"What is the meaning of a word?',
the question
'What is an explanation of the meaning of a word?', or
'What does the explanation of a word look like?'"

Ayer A J (1985) **Wittgenstein**
Weidenfeld and Nicolson,
London.

“A THUMB WORKING ON ITS OWN
IS USELESS.
IT HAS TO WORK COLLECTIVELY
WITH THE OTHER FINGERS
TO GET STRENGTH
AND TO BE ABLE
TO ACHIEVE ANYTHING”.

African Shona Proverb.[1]

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[1] from African students

Abstract for the doctoral dissertation:

"A critical analysis of the concept *care* in the practice and discourse of nursing".

This research sought to answer the question: "***What meanings has the nursing profession given to the concept 'caring'"?*** This was achieved by means of a three-fold approach: interpretive phenomenology combined with linguistic analysis [Wittgenstein's as interpreted by Bowden], and, a conceptual philosophical framework.

Narratives, from registered nurses working in hospices and oncology/haematology units, were obtained and analyzed through juxtaposing them with selected theorists, and each other, to construct 'family resemblances' and 'layers of understanding'. Their meanings, obtained by requesting them to draw on memories of being cared-for or caring, resulted in descriptive understandings of their use of the concept 'care'; and, to a relational ethic enabling the construal of a normative ethic: one allegedly embedded in the practice and experience of these practitioners.

The findings show it is not possible to give a simple definition to explain the concept 'caring'. The meanings, contained in the collected narratives, reveal strong 'family resemblances' in their usage of the term, verifying the Wittgensteinian observation: that no single meaning, no singular essence captures every cultural, individualized use of the term. The findings pointed to these 'meanings' being 'private' but not in the sense of being 'false'. Within the research one becomes aware that the term 'care' is not an ethical notion. To be ethical care is dependent upon context and responsible attitudes and actions. The discourses comprise the personal 'passion', an ethical ideal, held by most respondants; but, their ideal was not *always* the caring they were enabled to give in reality. Institutionalized care whether hospice or not fell below the ideal because of socio-economic contraints and concerns.

The original thesis question was from O'Malley: "[W]hether in encounter man himself makes his own meaning or is made by the meaning made of and for him ..." [undated:111]. This research led to the assertion that the reality of the practice setting shapes the 'public' meaning of caring these practitioners act upon, but, they shape their own 'private' meanings and implement it on a micro level. It is at the macro-level of care/caring that there should also be concern.

Although not true of all respondents, a possible reason for this less-than-ideal-type caring is the *possibility* that in institutions there are nurses who for some reason(s) fail to 'grow' - to develop in a fully integrated way that includes the freedom to exercise one's spirituality and to become morally caring not merely on a micro [one-to-one] basis but on a macro level [whole unit basis].

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Preamble: From whence this research?

This preamble gives background to the 'passion' shaping this present thesis. I can only give certain threads. As an Educational Manager in the UK [1978-89] I taught RNs[1] through post-basic, in-service and continuing education courses. In this position I had to investigate a paediatric fatality. During the investigation and the remedial course that followed, I discovered that many nurses did not know what they did not know. They nursed without reflecting upon their doing or being. A finding that Street [1992] also commented upon. Their lack of reflection affected their perception of themselves and others [students or patients] as knowledgeable valuable persons. Nurses degrade their experience and subsequent knowledge. Repeatedly I came across RNs with years of experience, for example, expertise in diabetes, leg ulcers or some speciality, diminished themselves by saying "I'm only a nurse". On courses they would downgrade their knowledge as if they had just left PTS [probationary training school: the old name given to the first three months of nursing]. This lack of reflection urged me to do further research.

I commenced my Masters Degree in Education at the University of East Anglia [UK] [1987-89]. Their motto was: "Do different" and this course opened the way for those who chose to engage in self-reflection, self-dialogue and self-discovery. My MA[Ed] was an attempt to understand how to create a reflective nurse practitioner [Haegert, 1989]. I had used Donald Schon's works [1983/7] as my framework. My action research had focused on enabling RNs to value their own experiences and their students' knowledge and abilities. My finding was again that nurses did not know what they did not know nor did they realize the need to reflect upon life experiences for their own growth.

When my colleague gave me the result of his research I realized what true self-reflection could do for a person especially from an educational point of view. Let me explain. Mark Vincent and I worked, with others, on implementing our Nursing College's interpretation of the Project 2000 [P2K] curriculum. From his thesis I learned how 'differently' he had done. He had attempted to create more than a mere awareness of the need for practitioners to be reflective. Mark's research bore little relationship to nursing. His analogy of reflection was the eyeball with its muscles changing its shape and perspectives. Herein lay the power of his existential reflection: the freedom to use his thoughts as grist for the mill of reflexive activity. He wrote, "I was prepared to take the risk of uncertainty and to move onto, what was for me, unchartered territory" [Vincent, 1989:25]. He realized that systems of beliefs could be the code of contradictory life and planning practices. Yet such systems determined what was important in our lives. He saw the need to distance himself from unexamined systems of beliefs so that instead he examined his motivations and the meanings imposed upon his own experiences.

My accumulated nursing experiences, the insights obtained through the many courses I ran and Mark's thesis [with its metaphors and images of learning and teaching] impacted upon my educational and nursing values [which I discuss in this thesis pp. 10]. I was concerned about the

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[1] Registered Nurses

standard of nursing. I wanted to investigate further but what in particular? And with what method? Reading Mark Vincent's thesis [1989] again I saw that it revealed a method of subjective self-reflection. In comparison my own MA research had not been subjective at all. My method had been dispassionate action research although I had wanted RNs and nurse teachers to reflect on what they were doing, and why, and as a result view themselves and others existentially. Now I began to realise there could be a way of understanding RNs if I could discover an appropriate research tool.

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APPENDICES

CHAPTER ONE: Introduction

1.1. Setting the scene

This dissertation sets out to discover two things. Firstly, answers to the question: What meanings has the nursing profession given to the concept 'care'? Secondly, a qualitative research method that would facilitate answering this question, particularly one that sustains and maintains the passion and compassion I feel for nursing. This method had to identify and analyze the way the term 'care' was being used by Registered Nurses [RNs], explicate the meanings RNs personally ascribed to care in the context of their nursing practice, allow the inclusion of philosophical discussion of any supporting elements around the concept 'care' and permit subjective material and discourses to be utilized. The term 'discourse' is a particular narrative construction that makes up and unifies a particular system of meanings. Theorist's who have explicated the concepts of care will be drawn into the method to enable comparison with and evaluation of these meanings.

1.2. Value commitments within the research

Lather's idea [in Street[1]] is that research should reflect the beliefs within the researcher's world so that its process allows for contemplation on the value-commitments inserted into this work [1992,15]. The following guided this research:

1. My own growth experience through this research. I have learned the value and reality of persons becoming creative agents through reflection on specific experiences. Frick [1987] and Frankl [1967] had felt that particular experiences led to heightened awareness, an ability to create meaning and enabled personal growth to occur [Frick, 1987:407]. This has been true throughout this thesis. It has led to my understanding of the terms care, vulnerability, person, health and spirituality and to a deeper self-awareness and self-knowledge.
2. When working as a nurse educator engaged only in accompaniment [teaching college students on their wards] students would tell about their experiences. For example, an excellent practical nurse told me he was resigning. I asked, "Why?" He answered, "What is nursing? I am on this ward but I have to keep looking for procedures to fill my quota. If this is nursing I don't want it". This second year student was on a medical ward but the procedures needed were surgical. He had to search other wards for patients and permission. Whilst talking we were approached and asked to see Mr. X. Nurses on this ward, including the RNs, had labeled Mr. X as rude and aggressive. Student and I went to the bedside and found an ill, angry patient in great pain, extremely anxious and highly embarrassed. Following removal of a rectal cancer two drainage tubes protruded from the patient's perineum. We were to do this dressing. The procedure was explained and pain-relievers given. With the nurse being gentle and sensitive, the patient's dignity

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[1] Where citations are given it is because the originals were unobtainable. This difficulty in obtaining literature is mentioned by Brykczynska [1997, vii].

was ensured. The patient responded as pain and anxiety diminished. The next day irrigations were ordered. Mr. X insisted ward nurses find the named student to do his dressing. When the student completed this, the patient asked that he come daily. This patient was grateful because the student made him feel, and I quote: "Like a normal human being again". This was a growth experience for this student. He had perceived nursing to be a set of procedures needing to be done. Thus far in his trainin, he had not been given a vision of compassion towards vulnerable patients who needed care. Once he experienced this, nursing took on new meaning. His experience of being compassionately caring[2] became a growth experience for this student [and myself]. As we left the patient the nurse said, "Now I know what you mean by nursing". He had learned the central essence of nursing: its compassionate-caring dimension. In this experience something ethical was 'added' [Noddings, 1984] to both patient and nurse. The nurse had learned this meaning existentially and experientially and through relating ethically patient and nurse experienced 'more-being' as persons [Paterson & Zderad, 1976]. This nurse finished his training with distinction.

However, I was left with a compassionate concern about care that called out for answers. This required reflection to discover a research question. My situation was not one of merely assessing students' competence at mastering certain skills; it was a question of how I understood 'care' in education and nursing. I had Freirian leanings and so appreciate the wider vision of education given by Schmier in his 'random [e-mail] thoughts'. He sees education as: "Developing hearts: character and values, not just minds; getting someone to know how much they did not know and to learn how much they have [in the way of capacities] to learn" [Schmier, 1996/7]. My passionate concern connected with clinical nursing. I became re-educated through my attempts to understand how much RNs knew about care.

3. Reflections like these resulted in creating an encounter with a student I will call Rachel. If I care as a teacher [whether in classroom or in the practical area] I need to see, and be receptive of, a student's needs: "the student is infinitely more important than the subject", affirms Noddings [1984:20]. She writes, "the cared-for "grows" and "glows" under the perceived attitude [or attention] of the one-caring" [1984:67]. Rachel came when I was busy setting Finalist examination questions. I had to hide the papers. Rachel is seemingly shy and introvertish not the sort of person that stands out in a crowd. Being legitimately busy, I could have asked her what she wanted, settled it and sent her away. But having read Noddings, I decided to 'discover' this student. She wanted to make a career change, to become a doctor once qualified and needed a transcript. I also discovered she trained people in First Aid. I had not 'seen' her as either of these or as community-minded. As I concentrated on her, she disclosed herself not as one student among many but as a remarkable individual. I shared with her that I

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[2] 'Care' on its own is neither good nor bad. Therefore I use the term compassionate-care to give it a positive connotation.

had no idea she was into these things and that I had failed to see her as a person in her own right. My decision to see her as a person led to discovering her value as someone who cared for others.

This shared discovery made us both 'grow and glow' as she acknowledged some time afterwards when I asked about her side of this incident. The act of reflecting on these incidents was part of my growth and value-commitment through centring on 'care'. I was learning about valuing care and compassion. Having completed the research and writing this thesis I can also explain why I use compassion specifically with 'care'.

Brykcznska [1997] links compassion with caring but does not explain 'compassion'. Richards [1985] shows 'compassion' as a response to need and an expression of love. Being moved by compassion [as a nurse toward a patient in need] can result in a turning point in someone's life. More about this will be said under 'health'. This use of the term 'compassion' has its roots in Scriptural interpretation, hermeneutics[3]. In hermeneutics, interpretation of meaning/s is obtained by comparing various uses of the word in different contexts. A word is enriched by discovering its different Hebrew or Greek origins. In this thesis hermeneutics and interpretive phenomenology play a part in the method employed.

4. The idea that caring was a natural capacity within my being was sown through reading van Hooft [1995], Noddings [1984] and discussions with Shutte[4]. Before this I had not perceived caring as a natural capacity. I believed our natures manifested a natural penchant to be anything but caring and that a definite attitudinal change was necessary to become caring. While engaged in this research I was attempting to understand caring as a natural capacity and found that engaging with my autobiography changed my attitude. I reflected upon the reason for my taking up nursing and realized as Richards [1985] explains compassion that at a particular point in my life I was 'moved with compassion'. This led me to realize that caring had been a natural capacity within my being but had become diminished through adverse circumstances during my early years.
5. Encounters like those with the students mentioned, the research participants, particular authors and my autobiography form the enriched concept of compassionate-caring that is produced in this thesis through the research approach taken[5]. I have come to believe that 'care' is not a fixed concept rather it is dynamic because insights into this concept are always incomplete. This is not a contradiction, nor a question of being absolutist. It is the difference between realizing an innate capacity within others and myself: understanding it, allowing myself to grow through the experience and having the ability to express the concept contextually.

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[3] A subject I studied for the Diploma in Theology [1966-8].

[4] Personal discussions

[5] To be explained in the chapter on the research method.

From a relativist point of view, the ideas one holds grow and change as one matures. From an absolutist view, there is something real in our natures that underlie 'care'. It is simply there and can be expressed in different ways according to social, cultural, situational or other insights [van Hooft 1995, Mayeroff 1971, Shutte, 1982]. Different ideas about it can be inexhaustibly understood. The important issue is that these different understandings and expressions themselves do not create care; rather they form different kaleidoscopic views of something that is there that gives deeper insight.

For this research my strategy will be to gather, interpret and analyze RNs discourses; uncover the understandings they give to care or caring[6] in the social-cultural settings of their practice; link these meanings with those of selected theorists and discover what concepts surround care/caring to give it its fullest meaning. Then I formulate those aspects that I take to be true about care in order to evaluate what is said by RNs. This is subjective and objective. Subjectively my beliefs [about nursing, ethics and what human beings are] affect the way I interpret their 'sayings'. Objectively understanding what RNs and theorists say influences the theory derived about what is reality in the context of nursing and its ethic. This will reveal the attitudes, beliefs and values held by RNs in particular socio-cultural contexts. It will also construct a conception of care that will be true to the reality of the actual practice and experience of particular practitioners of nursing. This is said from the perspective that the concept 'care' is neutral: in and of itself it is neither good nor bad. It is the context around the term that gives it an ethical meaning.

1.3. The chapters

Having set the scene, chapter one discusses chapter arrangement.

Chapter two discusses the problem to be solved recognizing the complexity of the term 'care'. It unfolds a research design that I believe is able to discover meaning from subjective data and nurses' discourses and to link these meanings with theorists to obtain a fulsome perception of care.

Part One discusses the methodology and method, paying attention to why the method decided upon was chosen using Wright's research as an example of 'being different'.

Part Two discusses the research participants, how data was collection and analyzed. It completes the research design.

Chapter three takes a brief historical survey of caring through literature concentrating on answering the questions: 'What is a nurse'? And, 'What is nursing'?

Chapter four explores caring from theorists' perspectives [nurses and non-nurses]. This is done to enable understanding of participants' narratives by juxtapositioning theorists and

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[6] Although I am aware of the different grammatical aspects of care/caring or caring-for and caring- about I do use the words interchangeably for convenience sake.

interviewees' discourses. Theorists giving particularly adequate conceptualizations of caring are used.

Chapter five gives the discourses of research participants, interpreting them phenomenologically, seeking to discover meaning. It is in four parts.

The first part: is a subjective account of caring for and being cared about.
The second part: contains discourses from a diverse group of people whose interview responses gave particular direction for the remaining interviews.
The third part is a discourse used as a paradigm case. It is interpreted using many cultural 'voices' to aid in the understanding of an ethic set within a South African culture.
The fourth part: gives discourses from the remaining participants, those in hospices and haematology/oncology units.

Chapter six derives particular 'dimensions' of caring from the findings and expounds their meaning in the light of phenomenological and philosophical understandings. These 'dimensions' are considered firstly, to represent a progressively more complete view of caring. Through discussing vulnerability, persons and caring the depth of caring-in-nursing is identified. Secondly, as such, they represent aspects that enrich the concept of care and reveal participants' 'layers of understanding' and unfolding values constituting an ethic of care. It centres on the discourses and links findings with theorists' notions of caring.

Chapter seven continues studying dimensions of care. The chapter is divided into two sections: the first discusses 'health' as a necessary concern one prompting action towards the health of another. The second section studies the concept of 'spiritual'; a concept much in evidence in the discourses.

Chapter eight summarizes the findings concerning respondents' meanings of caring. It returns to the introductory narrative to identify whether persons act out their private or public values. The discourses show that in participants' usage of the terms a philosophy and an ethic are revealed. This depicts a relational ethic in nursing, one needing macro and not just micro expression to give it a sufficient and necessary meaning. This could constitute a normative concept of ethical caring close to the actual practice and experience of practitioners of nursing; one that could stand up to academic and critical scrutiny.

Chapter nine forms a summary for the whole thesis.

"The research design chosen needs to
access the meaning the experience
[caring] has for a person"
Philip Candy [1989]p.1

CHAPTER TWO: The research

Part I. The approach

2.1. Introduction

In this chapter, there is a specific orientation: the question directing the research and the strategy used to answer the question. The problem, and the complexity of the term 'care', is identified. The research design is detailed. The research strategy is a development of Peta Bowden's [1993/7] 'survey process'. It has been chosen for its appropriateness in accessing and interpreting the meaning care has for RNs [and a few other health care professionals] in State, private and hospice nursing institutions. The problem with formulating a definition of care is discussed, assumptions are acknowledged and the justification for using the particular design is given.

2.1.1. The problem statement

The choice of problem acts as a guide to the choice of strategy. Narratives are to be used as part of this strategy. Narratives have an historical turning point. In this thesis using narratives is like asking: "Is 'care' more important to nursing at this point or a previous point in time?" This 'turning point' is a moment imposing coherence and continuity onto participants care narratives. Each is seen in a particular time and place setting: cultural and historical. For this reason it is important to study 'care' with its ramifications in a chronological style.

This was done with the literature search and it showed a particular cultural evolution of the topic [for example the way feminists approach the Kohlberg-Gilligan controversy; or to come nearer to 'home', the meaning of care in South Africa in the post-Apartheid era]. Though theories of care in this work are spread over a time period from the 1960's to the present day common denominators can be seen as narratives and literature spanning this period are accrued.

Bruner used a question to help in construing reality from narrative: "What, in fact", he asks, "is gained and what lost when human beings make sense of the world by telling stories about it...?" [1996:130]. Construing the reality of care through narrative and taking into account cultural and historical settings one sees in the 1980's a fervent desire amongst nurse theorists to bring care to the forefront of nursing but amongst some of its practitioners a fear of a new phenomenon, 'burn-out' becomes evident. I turn to a narrative within Maslach's [1983] classic: "Burnout - the cost of caring" not only to help in construing reality from narrative but to identify the problem inherent in the meaning of care.

This narrative answers Bruner's question. Zimbardo [Maslach's supervisor] narrates an experiment that goes wrong. What he 'gains' by using this narrative for construing reality is a demonstration that intrinsic moral and human values can be overwhelmed by particular 'care-taking' processes. What is also 'gained' is the insight that dehumanizing others is not caused by burnout at all. What is 'lost' is the sense care-takers [Zimbardo's word] make of their world as revealed by their behaviour in this experiment. His story summarizes, for me, a significant problem in nursing that needs solving. It is a many-faceted problem. Are the values and therefore the meanings we make, influenced by roles others expect us to play? Do we construe meaning through the processes by which we are socialized? Are we willing to be shaped by our intrinsic desire to care compassionately or by the negative socio-cultural - economic demands of our situation and thereby willing to lose our 'ethical-selves'?

Zimbardo opens his narrative with a brief discourse on care. He declares caring used to come informally from family, neighbourhood and elders; "now care is packaged formally by institutions with trained ... personnel, called 'care-takers', who specialize in giving particular kinds of care to particular kinds of recipients" [pp. x].

His story recalls [pp. xiv-xv] an experiment conducted at a mock-prison. One "created by psychologists" to study the dynamics of the "prisoner-guard relationship". He writes: "Our mock prison was populated with 'good guards' and 'good prisoners', we knew this was so because we rigged it that way. Only normal, healthy, law-abiding volunteers were selected to role-play being jailors or inmates. A flip of a coin randomly segregated them into opposing sides. There was no basis in reality for any person to be either 'prisoner' or 'guard'. However, ... the illusion created merged with reality. The mock prison became real".

"Passive pacifist 'guards' became sadistic and brutal. 'Prisoners' chosen for their normalcy on a variety of personality tests, behaved pathologically because the fact of a 'prisoner's' existence justified degradation by the 'guards'. 'Prisoners' were perceived as troublemakers and dangerous. Parents and friends visited ... inmates looked awful and felt terrible. A priest visited and watched a prisoner break down sobbing hysterically. A public defender interviewed prisoners complaining about their incarceration. Secretaries, psychologists, people from TV and news media, janitors and others looked in to see this evil place gradually overwhelm good people acting out assigned roles... They were caught up in the escalation of *power to the powerful*, the suffering of the powerless, and *the need to control people* [pp. xiv]" [my italics].

On the fifth day, Maslach came to interview 'prisoners'. Her attention was drawn to blindfolded 'prisoners' shuffling along to the toilet under 'guard's' orders. As Zimbardo's student, she protestingly reminded him that these were not 'prisoners'. Nothing could justify what was being done to them. The experiment was out of control. Zimbardo comments: "Hers was the first voice ... to break through the reality of our prison. Her tears cut through the groupthink consensus isolating us from external normative standards and from our own moral and human values" [xv] [my italics]. Only Maslach had the courage to express a standard of ethical care. Zimbardo reveals the problem: the possibility for the ethical ideal of care to become a caricature of the real thing when "packaged formally by institutions with trained staffs ... " [xv].

There are similarities between this story and proper institutional care-giving. Both have a 'them' and 'us' aspect. The 'guards' [them] can be those normal, law-abiding health care professionals, particularly, nursing staff. The 'prisoners' [us] can be patients and students who suffer for being powerless, and become "caught up in the escalation of power to the powerful and others' need to control people". Believing Zimbardo's story to have significance prompted my combining his story with Kuhn's questions: "What is the problem I really want to solve?" and "Which problem is it more significant to have solved"? [1970:10]. Care-givers can lose their disposition to care. The problem I would like solved would be: Why? But, the "more significant problem" for this thesis became the question: Is the idea of caring in nursing no longer being a reality because the meaning construed by its practitioners has changed from the understanding commonly associated with the term by the public and others? Thus, the question motivating this dissertation became:

What meanings has the nursing profession given to the concept 'caring'?

2.1.2. Recognizing the complexity of 'caring'

The term 'care' is used in definitions, ethics, theories and models. There is a confusion that Morse, et. al. [1990/1/2], Allmark [1995], Crigger [1997] and others identify. The term is felt to be poorly defined, relatively undeveloped, not clearly explicated, and often lacking in relevance for nursing practice. Nurses are inclined to use the terms 'care/caring' from several perspectives, such as in the phrases 'bad care', 'basic care' or 'quality care'. Different understandings arise from different conceptualizations of the term. For example, Morse, et. al. identified five conceptualizations[7]. The concern in this thesis is to uncover meanings portrayed through RNs ideas, images, metaphors, impressions and values. Even the term 'meanings' is value-laden. It can convey different interpretations, social and cultural perceptions, presuppositions and practices.

Cognitively, 'meaning' is used to signify pure understanding: an idea conveyed to the mind or the relevance of a particular thing. Volitionally, it is what anyone purposes to accomplish or do, implying intention. Affectively, care can evoke valuable and meaningful emotions; but the opposite is also true. Any range of emotions can be called forth depending on the context of the term. Whatever dimension meanings arise from, what was required: the utterings of research participants - their meanings, could be determined only in the context of the sentences they used when discoursing upon the concept.

Different persons have different understandings of words. This in itself gives different portrayals of care. What one does, the subject of a person's care and the context in which it takes place, all influence meaning and give to 'care' different values.

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[7] Caring as a human trait, moral imperative, affect, interpersonal interaction, and an intervention.

The study will attempt to identify values being transmitted through the discourses of RNs. Bowden [1993] sees a particular set: values intimately connected with different specific practical, and one might add, cultural, contexts. There are also values resulting from social encounters or relationships between RNs and others that determine the caring [or non-caring nature] of individuals.

Narratives were explored to discover the meanings RNs gave to memories of care-giving and care-receiving. In using these memories it could be said that they form a type of theorizing. This 'theorizing' is like an interface: that between their actions and the meanings they impose on them. Bruner [1996] declared that the 'doing' detailed in narratives implies action. Action suggests motivation. The motive behind intentional states includes beliefs, values, desires and theories. The backdrop to any narrative is the physical event surrounding the action, motivation or moral circumstance and this is important to understanding.

2.1.3. Assumptions:

i) Kaleidoscopic perspectives of care can be used to develop meaning where care is embedded in behavioural, cognitive, emotional or moral aspects.

ii) The meaning of care does not lie in experience alone; experiences of care become meaningful when they are understood reflectively, when not taken for granted, or assumed to be understood by others.

iii) Individual perceptions of the concept of care may account for the differences in degrees of caring-for others.

iv) Nurse educationists imply that behaviourist curricular objectives for theoretical education and practical experience have diminished the spontaneity of care in nursing (Allen, 1990; Bevis & Murray, 1990; de Tornyay, 1990; Tanner, 1990; Diekelmann, 1992; Bevis, 1993].

v) Embedded in practice are hidden messages about the reality of care: its meaning, what is valued, and what is transmitted.

vi) What nurses think about care or caring will be revealed in how RNs use these words. Their actions, beliefs and attitudes may be shaped by these understandings and may affect their practice.

2.1.4. The lack of definition

There has been criticism from nurses [researchers, practitioners and educators] that the concept 'care' has not been sufficiently defined [Morse, et. al. 1990/1]. There are problems surrounding any definition but particularly that of care/caring as evidenced from the amount of literature on the subject. RNs' discourses and authors' writings lead me to agree with this point. However, care is not a static theoretical construct it becomes enlivened by reflection on its use and the kaleidoscopic pictures thus formed.

A kaleidoscope is merely a tube containing mirrors and pieces of coloured glass. But this tube of mirrored reflections creates patterns as it is rotated. Similarly, each human being reflects care in his/her idiosyncratic manner. As with a kaleidoscope, a particular pattern once seen is rarely seen twice so care may be with nurses. Caring-for someone is individualistic. Different facets of care are mirrored through this individuality and the values a person holds. These reflected facets, or 'family resemblances', will be described to obtain "different possible ways of looking" at care. By 'looking' in this way, it is hoped to show "the relationship between the concept care/caring and the life practices" [Bowden 1993:141] of participants through their discourses. Wittgenstein [as explained by Bowden] saw concepts, "as having blurred edges" but also "family resemblances" [Bowden 1993/7]. He showed how language could be used without reducing meanings to definitions. This gives the clue that a term may have many uses, meanings and perspectives. They indicate that different facets exist and are kaleidoscopic. [Bowden's explication of Wittgenstein is important to this thesis]. One way to illustrate the relationship between care and practitioner's life practices is by taking a paradigm case as Benner, Tanner, Chesla [1996] and Bambrough [1968] suggest. This method, they say, reveals particular 'family resemblances' when comparisons are made. This recommendation is followed and different patterns do emerge as each participant discusses what care means.

Having explored many angles on the subject of 'care' including the ethical given by Gilligan [1982], Noddings [1984], Benner [1984], Shutte [1993c] and others, I developed a definition. I found I could not search for this elusive thing called 'care' unless I had an idea of what I was searching for. The definition formulated acted as a 'lantern' to identify 'care/caring' until a fuller, richer description had been obtained. Bowden sounds a warning about definitions [1993/4] that I now agree with. Her concern was for those trying to apply a single concept or definition of care to the context of nursing. Single concepts or definitions, she felt, could seriously undermine the rich variety and 'complex-specific ethical possibilities' of nursing [1994:13]. The following statement introduces my value-commitments after some interviews and reflection:

> "Caring is a natural capacity that by valuing and commitment to a person intrinsically motivates one to be compassionately concerned and acknowledge need in another and by means of an empowering relationship leads one to act ethically towards the health of another (so as to promote and foster the personal growth of another by enhancing, diminishing or removing impediments to their health)".
>
> [Each point will now be discussed].
>
> The rationale behind these words demonstrates the change from my previous stance:

1. Caring is acknowledged as a natural capacity. All human beings are born with this capacity. The expression of this deep capacity within is personalized when it is put into action. The word 'capacity' is not the same as ability. I am saying, along withNoddings [1984], Shutte, [1993c] and van Hooft [1995] that caring is as natural a capacity as speech normally is.
2. Valuing is a way of saying I have respect for a person regardless of what that person is. It is like saying to a person: "I am glad that you are, that you exist". It is accepting that person as s/he is, not trying to change them, but enabling them to become all that they

can become. Their potentiality is developed by challenging them to be the rational, free, self-determining, self-transcendent and self-donating individuals they were born to be. It is having concern and being willing to be 'engrossed' [Noddings, 1984] towards an individual as I had been towards Rachel [given earlier].

3. Commitment to persons is a positive attitude. It is an act of the will: a willingness to commit myself, and to be receptive, to a cared-for, to open myself to another. Not just giving something material but, by my commitment to their care, a new dimension is 'added' to that person [Noddings, 1984]. This willingness to enable another to grow is to help them develop more as a person. As an act of the will commitment is like saying "I see you have need, I know I can make a difference, we will make a difference together". Through my act of willingness to another person I positively define, include and affirm that person. This is a demonstration of my compassion.
4. Valuing a person and being willing to be committed to that person is what motivates us from within to be concerned for and acknowledge need in another. The words 'compassion', 'concern' and 'need' are part of the meaning of care. Maslow's hierarchy of needs [1958] was constructed within the framework of motivation. Maslow [1958] saw motivation as a drive to fulfill personal needs, but there should be intrinsic ethical ideals that motivate us to care. To care is not an ethical ideal in and of itself. Care becomes ethical when we consider the object or subject of our caring compassionately. As nurses, our subjects are patients and other nurses. Not to nurture compassionate-care in certain environments diminishes the ethical ideal. I am not impoverished by giving myself rather I can be enriched. I 'add' to my own growth and to that of the cared-for [Noddings 1984, Mayeroff 1971].
5. The last point is that an empowering relationship leads one to act ethically towards the health of another. If this term 'health' is the holistic entity that we say it is, then it means: 'I want you to grow spiritually, physically, mentally, emotionally and socially'. However, it means more: it is wholeness, well-being and peace. In caring for a vulnerable person, I am firstly, wanting their complete wholeness. Jan Smuts created the word 'holism' as the highest form of integration to be found in the development of the personality [Lederman, 1970]. Secondly, I desire this person to experience health, this means being all that a person can be. Through a genuine, trusting, other-enhancing relationship the cared-for will be empowered [Haegert, 1995].

2.2. The methodology

Methodology is taken to mean the philosophical orientation promoting this research and enabling me to answer the research question. The particular methodology for this research is Wittgensteinian [as interpreted by Peta Bowden, 1993/97] and is used to explicate and analyze the concepts. Where necessary the works of Magee [1987], Block [1985] and Urmson, 1960] are incorporated. Other philosophers are used for conceptual analysis [Shutte and van Hooft's works].

Research strategy applies to method: the actual techniques I used in collecting and analyzing data. Thus, the crux of research is its method but the core of that method is its analysis. The method combines narratives with interpretive phenomenology. It uses subjective elements to verify essential concepts and to ensure the credibility and transferability of the work.

Instead of using Street's type of critical theory [1992] as I had originally intended, I favoured the critique and linguistic interpretive sense of critical theory given by Wittgenstein and discussed by Morrow [with Brown 1994:8]. This critical theory had connections with linguistic explanation and the self-reflexivity of the investigator. It was a humanistic approach that had gained currency and prestige, according to Morrow. A danger I wanted to avoid was that the strategy, instead of opening up new discoveries, would constrict and trivialize the concepts the method was meant to expose. Montgomery had felt that the word care had became 'trivialized' [1993:9] to the extent that its adjectival form 'caring' was losing the emotion or feeling implied in its original meaning. It was felt that this combined approach would facilitate gathering RNs' discourses on care, allow for an interpretive linguistic approach and avoid either trivializing or atomizing the concept.

Wittgenstein is referred to by Gaut [1983], and Noddings [1984]. Like Bowden, neither applied his approach empirically. Griffin [1983] and Morrow point to Wittgenstein's method. Reading Benner [1994/96] and Gaut furthered an interest in this philosopher. Both obliquely refer to 'family resemblance' and linguistic criticism [Benner 1994:xiv]. Bowden [1993/7] enabled flesh to be put on the skeleton Morrow and these others offered.

2.2.1. Justification for a different research approach

A comparison of my research data with other phenomenological research made me realize that if I utilized phenomenology as Swanson[8] [1990], Drew [1986], Beck [1991a/b, 1992] and others had [even as Montgomery's grounded theory [1993]], I could end up with similar categories and themes. There would be little different about my research. Rather than 'reinventing the wheel' by using one approach, a strategy was sought that could revitalize the concept 'care'. Swanson felt nurses should allow their research questions to guide their methods while being aware their methods would shape their answers [1986b:60]. This statement prompted my decision to use the approach below:

1. Interpretive phenomenology
2. A philosophical-conceptual approach
3. Wittgenstein's linguistic analysis or theory of meaning [Morrowwith Brown 1994].

The following explains why such an approach has been taken. There are two accounts: a short one and a longer one. The short explanation is that there are distinct similarities between:

i) hermeneutic phenomenology using narrative and Wittgenstein's linguistic analysis, and

ii) the philosophical-conceptual approach and Bowden's 'survey' approach [her way of interpreting Wittgenstein]. Wittgenstein's work is a type of hermeneutic linguistic analysis

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[8] Swanson is also referred to as Swanson-Kauffman

searching for meaning [1968]. Both the philosophical-conceptual and hermeneutic phenomenology draws on subjective data to facilitate understandings. As I see it, the three approaches could form a triangle. Interpretive phenomenology forms one leg, philosophical-conceptualization the other and the base is formed by Wittgenstein's linguistic analysis, or theory of meaning. Bowden is in the centre of this triangle forming a link between each especially in the way she obtains and uses her material. The longer explanation will take each approach individually:

2.2.2. Interpretive phenomenology

Some phenomenologists believe subjective experience is to be suspended and not to be used as data at all [Oiler 1982, Omery 1983]. Others [like Toner, 1968; van Hooft, 1996; and Moustakas, 1994] see the value of first using subjective data and then comparing it with others' experiences. This acts to verify subjective experience. Interpretive phenomenologists use subjective experience as starting points to a hermeneutic process [Pieper, 1972]. For example, Toner is critical of phenomenological philosophy that sought to capture the concrete in its actual, inevitably very general, descriptions of common features of experience. He [and van Hooft, 1995] uses their experiences adding the insights of other writers to check that their subjective interpretations of a concept is that which other human beings share. Hermeneutic research implies using my own consciousness and research participants' experiences. The goal of using hermeneutic phenomenology in this way was to obtain discourses about care that embodied everyday practices. Discourses contain explanations and understandings that are based on everyday concerns, practices, commitments and meanings.

By studying phenomenological research articles chronologically and references to their sources, I found many nurse researchers had followed either Oiler and Omery's framework or that of Benner. Oiler and Omery see phenomenology as descriptive [which is what Toner had decried]. As I understand their view, 'persons' have lived experiences that are not reflected upon but, nevertheless result in gradual changes in perspective. Knowledge, in terms of this changed perspective, shaped experience for persons. In phenomenology descriptive data had to be, "allow[ed] to speak simply for itself" [Oiler, 1982:179]. In contrast Benner & Wrubel [1989], Benner, Tanner, Chesla [1996] felt the role of bodily experience was to shape knowledge. Such knowledge was to be laid bare through narrative: the reality was allowing the participant to speak for his/herself from embedded knowledge gained from experiences. Benner saw interpretive phenomenology interpreting this reality. The differences may seem small but are important because the separation of Husserl and Heidegger began with the concept of 'person' and the methodology of each results in different analyses. As 'person' became important for me, I needed a philosophical foundation that allowed persons to be what I believed they were created to be: able to speak for themselves.

Phenomenological research can become atomized when turned into theories and the contextual humaneness and sensitivity can be lost. For example a phrase like " Caring ... was an act of love" [said by one of Swanson's research participants [1986a:72]. Phenomenology is not one simplistic straight-down-the-line philosophy nor is there one way of 'doing' phenomenology. To counteract any possibility of atomization the research not only upholds hermeneutic philosophy and a Wittgensteinian approach but also the African[9] values contained in the term "ubuntu" [Goduka, 1996:35 - a concept to be explained later]. It implies that persons are self-interpreting beings with integrity who practice humaneness in the form of human respect and dignity.

Humaneness had marked Swanson's studies [1986a, 1990]. They showed the intuition, sensitivity and human touch of her research participants. One could participate in their stream of consciousness. Her first research gave a sensitive picture of human experience and caring [1986a]. Her second study showed how she combined qualitative methodologies. She even raised the dilemma of using intuition as a means to transform data into categories. Her answer motivated my using a method that was "as ardent and as sensitive as the human subject matter which we seek to discover and understand" [Swanson-Kauffman, 1986b:65, quoting Johnson]. Her clarion call in 1990 was "to communicate study outcomes ... congruent with the innovative methods employed" [pp.60]. But in 1991 she described an "inductively derived and validated middle range theory of caring". This seemed an antithesis of her previous research. Her research was reduced to theoretical tables, definitions, dimensions, and sub-dimensions. I felt like Wright [1981]: I wanted research participants' 'sayings' to speak.

For this reason the thesis is often written in the first person. This is in keeping with Wright [1981] and Swanson-Kauffman's [1986b] idea: allowing the research method to reflect humaneness. The research method used in this thesis and the way it is written, attempts to enable the reader to enter into the understandings and feel the emotions of the researcher and her participants as each discusses particular meanings of the concept 'care'.

2.2.3. A philosophical-conceptual approach

The philosophical-conceptual approach uses Bowden's [1993/7] 'criss-crossing' and juxtapositioning of one interviewee with another and with theorists to reveal not only the meanings RNs give to the concept 'care' but also various 'family resemblances'. This in turn leads to the discovery and interpretation of dimensions surrounding, and/or ethical concepts inherent in, the terms. That is, those dimensions emanating from nurses' discourses and integral to the caring role of the nurse were detected. Philosophical interpretations from Shutte, Bowden, van Hooft and others are used. Much of what was said under interpretive phenomenology, particularly that pertaining to subjective material, could be repeated in this section.

2.2.4. Wittgenstein's linguistic analysis or theory of meaning

Linguistic analysis identifies how respondents use words like care/caring, the relationship the terms have to context, and the influence words have on those hearing how the terms are expressed [Morrow with Brown, 1994:117]. This allowed the researcher to

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[9] African is used in a generic sense to refer to the Black population of South Africa.

determine the 'truth' or 'falsity' of meaning [that is, to make a comparison of participants' meanings with others for credibility and dependability; checking taken-for-granted or grossly different meanings for this 'falsity']. This linguistic analysis works in conjunction with the philosophical-conceptual analysis.

Each method, although supposedly having its own mode of data collection, processing and analysis, complements the other. Bowden's 'survey method' facilitates analyzing data whilst using the above approaches. Her method was not found incompatible with the other two approaches.

2.2.5. Bowden's Wittgensteinian approach.

Two aspects of Bowden's works [1993/7] are of particular relevance. Firstly, she uses Wittgenstein's ideas, especially his 'Philosophical Investigations' [1968], to open up a method, which she calls 'a survey', as a theoretical approach to the process of conceptual clarification. Secondly, she reveals how through investigating the caring practices of mothering, friendship, nursing and citizenship she applied her 'survey process'.

The following is an attempt to translate Bowden's epistemological approach into empirical research application. Bowden used 'caring' and 'ethical-attention' [1993/8].

1. A concept where the research process can lead to insights congruent with the researcher's experiences and to the discovery of new images and meanings is chosen.
2. The researcher derives a question/s to drive the research. From this questions for interviewing are generated if a [semi-]structured approach is taken.
3. Different layers of meaning: insights and oversights are obtained during data-collection resulting in changing understandings of the concept because of participants' and one's own motivational dispositions, actions, attitudes, beliefs and values. The research results in growth: self-knowledge and self-realization through living and experiencing the concept. Data generated by this growth process is also valid.
4. Every mention of the concept is combined into a narrative that reveals the participants' use, understanding of the concept and the context.
5. Participant's responses are linked one with another. By criss-crossing the research findings in this way and with authors' 'family resemblances' [and differences] are identified.
6. Kaleidoscopic pictures of the concept are incubated and interpreted using one's own and others' experiences. This reveals the multi-faceted nature of the concept. It shows different persons using different symbols; expressions, metaphors or word-pictures to describe their perspective of the concept and the 'family resemblances' give rich meaningful understandings of the concept.

It will be seen when discussing Wittgenstein's philosophy or epistemological approach that turning it into empirical research application opens up new vistas of 'care/caring'.

2.2.6. Wittgenstein's philosophy

For Wittgenstein learning or understanding a concept involved being able to recognize examples of its use and expression in practice. For a subjective concept like care, 'accumulating understandings' involves emotional and subjective understandings as well as intellectual uses and recognitions [Bowden, 1998]. Understandings of the phenomenon are gained by working through narratives dealing with one's own and others' experiences. Perception is focused in a special manner to capture participants' different thoughts and the researcher's understandings of the concept. Surveying examples in this way, the insights and oversights in usage are noted. Then the character of the concept being studied is conveyed and how it is understood by different role players is communicated. Research participants' richness of meaning is derived and preserved [Bowden 1993/7].

Wittgenstein [1958/68] attempted to show that philosophy gave one a special kind of understanding particularly in how words are used. This understanding gives a clear view of the world because the world of reality is grasped by means of the concepts of our language. His treatise was not only theoretical, he drew his ideas about knowledge in general and words in particular more from experience than theory.

He developed ways of doing philosophical analysis through linguistic analysis. I say 'ways' because when considering his philosophy one finds two distinct strands. One is from the 'earlier' Wittgenstein; the other from the older person he became. Each philosophy had its own distinctiveness [Magee, 1987]. However, he rejected his *Tractatus* [1961], the only work published in his lifetime, and "was led largely through self-criticism" to new developments of his ideas [Urmson, 1960:296]. Works published after his death include *The Blue and Brown Books* [1958]. These were preliminary studies for his *Philosophical Investigations* [1968]. This latter work attracts people today and influenced Bowden, and through her, this research.

Though Magee sees the two philosophies as incompatible, he concedes they "have certain basic features in common". "Both focus on the role of language in human thinking and human life; both attempt to draw the lines at which sense ends and nonsense begins" [1987:322/3]. This 'nonsense' comprises private meanings: assumptions, taken-for-granteds and presuppositions nurtured in the mind by not allowing the rules of public language to direct understanding.

What drew me to Wittgenstein's work, other than the introduction through Peta Bowden and the method lying within it, is his philosophy of meaning both in his earlier and later work which will be explained:

His earlier work

The key to understanding the *Tractatus*, his earlier work, according to Searle [Magee, 1987], is the picture theory of meaning. The names of things convey ideas to the mind. Sentences, because they contain names that correspond to objects in the world, become a disguised form of a picture: of a possible fact, or state of affairs. This brings about a relationship between the sentence and the fact. Language structure mirrors reality [the structure of the world] so it is possible for sentences to have meaning.

His later work

There is a paradox in the fact that Wittgenstein changed his opinion about his earlier work. The paradox lies in his idea that language pictures facts. He developed this as meaning there is a relation between the sentence and the facts. As he put it, "The sentence is not the thought" [*Blue Book*:7[10]]. The sentence ought to be capable of being a symbol for the fact. This relation between words strung together and facts he saw as pictorial. Nevertheless, this way of seeing the relation itself is said by Urmson to be absurd for: "this pictorial relation shows itself and what shows itself cannot be said" [1960:297]. This point was seemingly conceded to later by Wittgenstein for, in commencing with his *Blue Book*, 'picturing' became but one of several distinct ways of using language. These different ways of using language, Wittgenstein saw as 'language games'. How to play this 'game' correctly is the role of socialization, especially, one's training in childhood. Socialization processes occur in later life too. For example, every work context has its own 'language games'. These are public: learned as part of the socialization process into a particular discipline. There is a circularity of language and experience. Language is learned and from fitting the experience to the language, the public meaning for what has been seen or done is learned. For example, 'basic nursing', 'total patient care' are part of the 'language game' of care. As Diekelmann [1990:300] affirms, "In our conversations we both shape and are shaped by our language".

The context of nursing experience socializes one into its language [or 'language games']. Being familiar with the 'language game', for example, allowed me to feel more 'at home' in the discipline and enabled me to order and make meaningful new experiences not covered by the language already culturally assimilated. The danger in this socialization process is the unreflective use of language within its proper context, and violence can be done to the use of a word by forcing it into one pattern [Urmson, 1960:298]. Urmson uses 'hoping' or 'wishing' as his example of the language game people play. I mention this because concepts like hoping or wishing are in a similar class to caring.

This research will use the idea that 'care' in nursing is a 'language game'. Newcomers will be socialized into the public meaning of this word. But caring/care has many public uses, and cannot be forced into a generalized descriptive pattern such as a definition, theory or model. As Meleis [1997] contends, models are unable to answer all the needs of the clinical nurse in practice. And Wittgenstein wrote, "It has been said that a model, in a sense, dresses up the pure theory; that the naked theory is sentences..." [Wittgenstein, 1958:6]. The way research participants use 'care/caring' either in their language games or in generalized ways becomes the substantive material for this research.

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[10] One of two books of his notes [the Blue and Brown books] posthumously published which became the substance for the later book: Philosophical Investigations.

2.2.7. Wittgenstein on generalizing

Wittgenstein wrote about our craving for generality and attempted to trace this craving to its roots - its connection with what he felt were particular philosophical confusions [Bambrough, 1968:186]. He resolved this trend to generalize, what he called 'the problem of universals'.

Firstly, he identified the erroneous tendency to try to discover commonalities in all the usages of, and I use for my example, the term 'love'. If I compare the use of the term 'make love' with Pieper's [1972]. Lewis' [1960] or Fromm's [1957] interpretations of 'love' different meanings of 'love' evolve. These different meanings exist even when sexual love is discussed. There are multitudes of dissimilarities, yet the same word, love, is being discussed. The properties of, or characteristics of, the word 'love', do not have a common meaning especially when the context is different.

Secondly, he identified the tendency to think that once a particular concept is learned, say by definition, an everlasting, unchangeable general picture of the concept has been composed. This attitude leads to feeling that a once-for-all-notion of the concept and its features is possessed. The properties of a theory about care would be felt to be common to all care [and 'common' is an interesting word when trying to show the unique richness of each participant's care rather than an aggregate of the concept]. The tendency is to feel that by developing a composite of care this can be employed for all possible situations.

The word care, in and of itself, is a neutral concept as shown by [Bowden 1997, Allmark 1995]. The term has the potential to illustrate good and bad attitudes. Care becomes good or bad when we discover the ethical attitude being conveyed. This is in line with Wittgenstein's claim that one finds 'family resemblances' in the uses of a word but these resemblances give the word neither a good nor a bad association.

Wittgenstein's idea of relationship is relevant. There are complex, diverse patterns of resemblances in different concepts. This can be shown by reading research on care. These complex patterns relate to one another in different ways. Instead of finding characteristics common to all care, "a complicated network of similarities overlapping and criss-crossing: sometimes over-all similarities, sometimes similarities of detail" can be found [Bowden, 1998]. These are what Wittgenstein calls family resemblances.

Wittgenstein used the term 'game' as an example to show how wide a concept can be stretched in order to see these family resemblances. Wittgenstein's answer to generalization is that the same word applied to different ways of expressing care [to use my research concept] brings out different degrees of the concept, some looser and less straightforward than others. By searching for the application to which a concept is put, its use in language, and an understanding of that concept can be gained. Then it will be seen that there may be a central paradigm case linked through to other family members by varying direct or indirect ties. 'Family ties' reveal logical connections, analogies, similarities and differences within the concept [Quinton, 1964:12].

Wittgenstein's 'language of meaning' reveals that although variations on the theme of care can be discussed, the absence of what some might call a 'vital feature or features' is still compatible with the notion of family resemblances. Even if a person said to care, reveals no 'common' feature yet what is being rendered by the person being so judged are acts of care [in that context or culture and to that patient]. Her particular mode of, or discourse about, care shows 'family resemblance' in their totality [Bambrough 1968:190]. Leininger's work [1980] in different cultures illustrated the point that no two cultures need have any caring feature in common for there to be care. A family resemblance of care is what the patient, or any other person judges as care.

In summary, the main antidote to generalization is what Wittgenstein saw as the taken-for-granted aspect of any concept. Because the meaning of a concept is taken-for-granted, it is often overlooked. Taken-for-granted aspects can be learned only through observing similarities and dissimilarities: not only of actual, but possible, instances of 'ordinary' care. 'Odd' features are not only looked for or studied rather, the whole taken-for-granted shape makes this concept resemble that of the 'patriarch'.

2.2.8. The philosophy behind the use of narrative

As has already been said the research [and each of its approaches] is dependent upon narrative. According to Bruner [1996], grasping the 'right' narratives does not just happen. The process, beginning as a story, or as a question leading to such stories, is an art. The art is in keeping a topic alive. Narratives used to interpret care meaningfully should reveal aspects about 'persons'. These persons demonstrate, through intentional states, their desires, beliefs, knowledge, values, and commitments. To keep the topic alive RNs were asked to narrate stories about memories of care-giving or receiving thereby obtaining different examples and understandings of care-in-nursing. These narratives show how persons organize and transmit their experiences and knowledge mentally. These narratives form the discourse material and relate phenomena: facts and experiences. These experiences are interpreted by nurses in various expressive ways as they have mastered the 'language game' of nursing. As phenomena are recounted they imply a process of evaluation by both narrator and listener [or reader]: "This is what care means to me", the narrator. Where this process of telling and evaluative reflection is employed [as shown from Benner [1994], Drew [1986], Swanson [1986a], and Beck [1991a/b,'92] significant insights and meanings are made. Their research construed the reality of nursing. Narratives became the tool to learn the meanings conveyed in the term 'care/caring' because of the mental pictures conveyed.

They are participants' accounts: the pictures they paint. Symbolism, parables, analogies, anecdotes, metaphor are used to convey mental pictures. Narratives are the antithesis of clipped, formal definitions. To explain further why 'definitions' are not appropriate for 'care' and how interpretive phenomenology combines narrative with a subjective approach I use the analogy of a race.

2.2.9. Combining three approaches through narrative

A race has a starting line. This line is like a dictionary definition of the phenomenon, running a race. It defines where one begins. 'Rules' are spelled out. Conformity is expected. Everyone starts at the same time, same place. But, that is where similarity ends. Each person prepared for the race in his/her own way. They move off, each with pre-conceived ideas, goals and dispositions. Different positions are taken. People run at different speeds with different styles and ambitions. What this race means to each is individualistic reaching the goal is the common denominator.

Meaning depends upon who is 'reporting' and how: what the point of reference is. The race can be reduced to a descriptive commentary of how the body of people ran collectively. It can be reported on phenomenologically: the lived experience of individuals. What makes it more individualistic is what each person brings to the race: their history, culture, their frame of reference and previous experiences: emotional, physical, even spiritual. These are mixed with socio-cultural perspectives and memories. Motivation and immediate physical feelings play a part. Though, feelings and emotions [weariness, joy/despair] may take over the other aspects some time during the race.

Interpretive phenomenology would take each human being running this race as self-interpreting. Their understanding of this race, their feelings and actions, as narrated, are discovered and interpreted by the 'commentator'. If the commentator has been a runner then the commentary is from the perspective of his/her subjective experience. In knowing about running, the commentator knows about the internal world of others. S/he would include this framework in the commentary. From the commentary of human action and feeling, the conceptualization of running at the finishing line would be quite different from that of the starting line. It 'penetrates the phenomena of things', captures its 'possibilities' [Bowden, 1993]. The meaning the race has for each, told as their own narrative, is dependent upon the above facets and is captured in their discourses.

Narrative reveals cultural perceptions, attitudes and shared experiences. People are, though not entirely, cultural products shaped by their culture but culture is shaped by people's experiences, perceptions, and thinking. A picture is given of how the concept is for the teller. Culture influences the values and beliefs towards that concept. Stories reflect this culture. Culture also becomes the framework of the participants' assumptions and their interpretations. These assumptions are how persons make sense of their world. This reflection of reality may differ widely from others, but it is that person's construction during social interaction. This cultural framework includes home background that may or may not be the same as the culture one socializes in or the culture that exists at work.

People communicate narratives in an "I'll tell it as it is" manner. What a particular concept becomes depends on the form it takes. That is, if it is a 'doing' concept then it becomes what the person does in relation to it and how the person sees herself 'doing' the activity. Narrative becomes an oral account encapsulating past actions, memories, feelings, and experiences.

Through other persons, they learn of verbal and visual experiences, the intention, and ways, of modeling the concept. There are other reasons for using narrative:

1. Human beings use words as tools and pictures to express themselves.
2. Human beings acquire understandings of words not by private ascription of meaning but by learning their 'public' meaning [Wittgenstein, 1958].

Bruner too discusses universals; his are those of 'narrative realities' [1996:131-47]. These are not generalizations but narrative time unbounded by clocks. These 'realities' were the unfolding of crucial events and relevant actions occurring within the limits of 'humanly relevant time'. Narratives indicate "culturally specialized ways of envisaging and communicating about the human condition" [pp. 136]. Danger lies in listener or reader not working in parallel with the storyteller because of different cultural and historical perspectives through which they view the narrative. Every narrator has a point of view and no story has a single, unique construal. The listener, or reader, has an inalienable right to question: this questioning can lead to different meanings.

To balance possible different meanings hermeneutic analysis opens a way for giving a convincing non-contradictory account of the story's meaning. Credibility is given to the interpreted meaning once parts of the narrative are read, as in phenomenological research, more than once. The meaning of one part is juxtaposed in relation to the whole, but dependent upon other parts and their functions and ultimately on the whole narrative.

There is an implied legitimate norm in a narrative: a norm running according to rules, policy or principles. A sound narrative vies with this authority. As Bruner says, "Breaches of the canonical are often as conventional as the scripts they violate". These types of stories can lead one to "seeing what had never before been 'noticed' ... the ordinary is made strange" [1996:139/40] An example of this 'violation' I believe comes out of Frieda's narrative [discussed under discourses].

There are questions like: "What is this narrative about? To what is it referring?" where one must establish meaning from context. Bruner uses the example of the word 'board'. Whether it fits as an aspect of carpentry or corporation, is dependent upon its setting. A dictionary only suggests possibilities, ambiguities remain. Certainties evolve from the narrative structure. Within a narrative, there is an inherent negotiability: a question of 'suspending disbelief', of seeing the narrative as 'real life', not just as a cultural version of a particular reality [and to interpose again: the narrative Bekkare relates tells of this 'negotiability'].

Bruner felt narratives had a true to life sensitivity expressing time and circumstance in'sensitivity to changing norms'. There is not a 'once and for all' history or culture to a narrative. If it reflects this to the degree that others can identify with it and feel it is their story being told rather than the narrators in some fixed period that is an advantage to its use. For this reason I find the research of Wright [1981] and Hodgson [1980] relevant. Hodgson is discussed later in the thesis.

2.3. Comparison with Wright's research

This research was useful because of the insights obtained into method and the significance of theme words occurring in interviews with a group of Black social workers at Baragwanath Hospital.

2.3.1. Wright's method

Wright [1981], like Becker et. al. [1961] began with a loosely structured interview technique. My intention, like Wright's was "extraordinarily 'non-specific'", except for the desire "to listen to what people said" [pp. 2]. Wright's motivation was the paucity of research material on 'Black perceptions of urban life' or 'a university-educated elite' [1981:86].

Despite the oppressive political climate in the late 1970's, Wright sought to explore perceptions of Black female social workers concerning their profession. Social workers were seen by some sociologists as a middle-class "African bourgeoisie". She included the perceptions of where they lived [Soweto] and of themselves. Two points are salient: her writing in the first person as Drew, and Swanson suggest and, for this research, the idea of viewing black *Registered* Nurses as members of an African middle-class.

A positive for Wright was that although there was some research in the same field, it was different in methodology and method and when researched qualitatively it produced different results [1981:87]. The 'tentative nature' of her research, led her not to attempt to define the features she discovered but to suggest ideas for further research. [1981:52]. I was searching for a framework to uncover features from narratives and Wright's approach appeared intriguing in this connection. She used extensive quotations from her interviewees. She wrote, "'What was said' is the focus of this research and it ... having been said, is not to be relegated to a footnote, an extract, or a numbered reference" [1981:3]. In this research, I use extensive quotations for the same reasons.

She interviewed the eleven social workers at this hospital for Black patients. In discussing the influence of the researcher on participants, she refers to the 'selves' present at an interview. These were: being white, a student and uninformed [about social work] whereas her interviewees were black, professional and informed. She was aware of the possibility of filtering and screening words [pp. 97]. Such possibilities and dangers lie in any research particularly in my interviews with Bekkare and Prudence [African interviewees], although I was neither a student nor uninformed. My whiteness and being a nurse-researcher could have disturbed some interviewees but, from comments made, being a nurse educator influenced RNs more than my whiteness.

2.3.2. Research participants' 'sayings'

Parts of her research would be useful when analyzing and interpreting Bekkare and Prudence [two Black RNs]. An example is Wright's explanation of the dire poverty amongst the Blacks and the concept of 'dumping' that her interviewees used. These have relevance when reflecting on those suffering terminal illness who were 'dumped' in hospital. An example of Wright's findings on 'dumping' was the social worker who felt she had not enough money to take her grandfather to outpatients daily [as his condition demanded]. All she felt she could do was "to come and dump him in hospital ... for his good" [1981:49] as a non-paying patient. This poverty affects persons who come nursing for many are the sole breadwinners for their families.

Although Apartheid is supposed to be past, remnants of 'them and us' and 'separate development' thinking remain. Such thinking made a clear distinction between survival and living. The words: 'survival' and 'living' were seen by three of Wright's respondents as 'different modes of existence'. 'Survival' being the black mode and 'living' the white mode. Survival was concerned with basic issues: foods, shelter, clothing ... Whites were perceived as being on a higher plane of living. Living for them was changing cars, or going overseas. Black *individuals* could possibly rise above their situations to these higher planes but the group could not. The group prescribed, they had to think of survival, in terms of basic things [1981:62]. These last two sentences indicate not just groupthink but the kind of collectivity and conformity that is the norm in African culture.

The meaning of the word 'dumping' as Wright interprets was "associated with life and death, survival and destruction" [1981:49]. It was also used in terms of, amongst others, negation of the self, denial of personness, and destruction. An interviewee gives a picture of the difference between Black Township and white city life [pp. 51]. In the former feelings could be freely aired. In the city she became another person: one having to be "polite, cultured, not her real self". "Your ego ... and all the potential in you is destroyed, you are meek, submissive and don't become your true self" [pp. 51]. 'Dumping', she notes, referred to varying groups of black people including individuals. It carried the sense of: to burden, be discarded, abandoned, brushed off, infringed upon, lost dignity. [pp. 52]. This feeling of being 'dumped' has a bearing on the concepts 'personhood' and 'vulnerability' to be discussed.

Another relevant point is that of 'wholeness'. There were references to restoring wholeness to the self. In a community clinic context, one respondent felt she was "in a better position of not looking at a patient as an individual but as somebody who belongs somewhere..." That this 'somewhere' was intended to be the community, is illustrated by her feeling that there "we are so close together, integrated ..." [pp. 76]. These community references relate to Jabavu's [1960] and Goduka's [1996] discussion on collectivity. They reveal how store is set on the individual's value in belonging to a community.
Wright's work gives insight into ways of using alternative research pathways

2.4. Summary: no one meaning.

This research aims to reveal what people do with words: their multiplicity of uses, the variety of meanings one word can have for different persons. A word is a tool expressing action and feeling. There is no one meaning associated exclusively with a particular word. Each draws a different selection of features from a common pool [Magee, 1987:329].

This common pool is the 'family resemblance' Wittgenstein refers to. Like family portraits, this common pool of features contains similarities but also differences. Thus, a dictionary or universal definition of a word like care or caring can prove to be unsatisfactory. The concept may be demonstrated or discussed in a manner that might be less than recognizable by the originator of the dictionary definition; nevertheless, it will have 'family resemblances'. No word or concept has a static meaning (Griffin, 1983).

Wittgenstein felt philosophy's role was to reveal "the aspects of things that are most important to us ... hidden because of their simplicity and familiarity" [Griffin, 1983:290]. I believe care's meaning has been so hidden and because the concept is important to nursing this research is an attempt to reveal practitioners' and my own understandings of the concept, using an approach able to clarify these meanings.

2.5. Conclusion

This chapter is divided into two. Part one has detailed the research design and emphasized its particular methodology. The next section: part two reveals how data was collected and analyzed.

CHAPTER TWO: The research [continued]

Part II: Data collection

2.6. Introduction.

This chapter describes the research approach: the data required, how it was acquired, problems that arose and how data was analyzed. It ends by discussing the credibility, trustworthiness, transferability and auditability of the research process.

The critique of my first proposal was that it lacked preciseness in forecasting data required to answer the question posed. This shortcoming was partly due to a reluctance, on my part, to use preconceived theories, partly because I believed phenomenological research allowed data to unfold as one explored, which did become the case. The theoretical side of this journey [findings from literature] was suspended until all data was collected then authors' 'sayings' were linked and compared with those of the research participants. They are assembled in chapters four to six.

The contextual setting of 'care' and perceptions of that setting were necessary for as Lave & Wenger asserted, "Activities, tasks, functions and understandings do not exist in isolation; they are part of broader systems in which they have meanings" [1991:53]. They saw learners moving from 'outside' to 'inside' their chosen careers through gradually increasing their engagement and complexity by means of learning the 'shared meanings' of their community. These 'shared meanings' within the practice of nursing were what was sought. Field summed up their importance: "If one accepts the assumption that the core of any profession lies in its practice, then to understand that profession it is necessary to study its practice within its contextual setting" [1983:3]. It will be noted that I used several 'settings'. The reason was to maintain confidentiality. This is discussed further later.

2.7. Data obtained

Data consisted of discourses from RNs. These were transcribed verbatim from audiotapes by the author who listened to these tapes and reread the transcripts frequently. This enabled the discovery of content and context: those social and cultural practices surrounding a narrative and relevant to understanding RNs care practices.

Data was obtained using an interpretive phenomenological approach combined with a philosophical-conceptual approach. This involved learning experientially and philosophically about particular issues identified as dimensions of care [e.g. vulnerability, health, person and the spiritual] concurrently with data collection.

As much time as possible, of my three two-weekly study periods during December or January [the longest periods I was able to obtain], was used to observe the units chosen for research. Observation was in four hospices, one State haematology and two private haematology/oncology units. Other time was also spent. This amounted to hours rather than days. Some interviewees were singled out [with their permission] and observed as they went about their work, whatever that entailed. Interviews were, in the main, booked outside of this observation time.

The following data was obtained:

i) Discourses on interviewees' care experiences [memories], including my own were probed and examined for presuppositions, beliefs, attitudes and actions towards care.

ii) The above comprised pictures of care from 'insiders' and 'outsiders' points of view. 'Outsiders' were non-nurses, other health care professionals, interviewed and a particular group interview. Their transcript was treated in the same manner as (i) and (iii).

iii) Participants' affect, reflections and my own feelings during the research [through journal notes, jottings] were included. Drew's work [1989] discussed this emotional aspect of interviewees and interviewer. If the word 'care' stimulated subjective feelings, they were captured and brought into the discussion of that research participant.

iv) To obtain insight into the social-cultural context of the units I visited, I talked to my gatekeepers [matrons, nurse educators and a medical superintendent]. I also interviewed [as much as I was able] other matrons, chaplains, social workers, doctors, nursing staff, volunteers and a hospital schoolteacher in the various units to get background information. Different perceptions [of these hospices and haematology/oncolgy units] were possible because I traveled outside my home limits. I do not list these places to maintain confidentiality but they comprised five hospices, two private and two State haematology /oncology units. This may seem excessive but some units comprised one ward and therefore few RNs [and not all were met]. I felt this approach to be necessary not only to maintain confidentiality but also to compare how hospices in particular were managed. I wanted to know if the contextual findings in one prevailed in others and if they did whether the problems were from similar sources. This is discussed under the relevant units.

v) Supportive data came from peer group discussions and documents from units visited [e.g. mission statements, newsletters, and visitors' packages].

Initially I had chosen to observe participants [and obtain narratives] from one hospice and one hospital oncology ward in South Africa only. The idea was to compare the care rendered in these two units, and their nurses' narratives. A hospice, I had thought, would show the epitome of care, it would be of the best quality [whatever that meant]. Collecting data changed that naive view. I soon realized that compassionate-care was the prerogative neither of nurses in general nor of hospice nurses in particular.

2.8. Research participants

I discovered how busy hospice and State oncology wards were at the times I used for observation. My decision to enter Private institutions meant interviewing a greater number of RNs than anticipated: twenty-seven persons from nine units. This had the advantage of building in dependability because these many 'voices' confirmed findings and broadened understandings. Most RNs interviewed had been nursing for an average time of 21.93 years. The majority were mature persons: average age being 43.87 years. Many had experienced life crises. Some talked about those they had been through or were going through [e.g. divorce, moving house, losing a parent, a sibling being chronically ill, mental break-down].

Two interviewees had degrees, some had done the Hospice Association of South Africa course [HASA], and one was doing a post-basic oncology course. Both courses involved basic research, theories of nursing and ethics to some degree. The majority of interviewees had not had the benefit of continuing nurse education. A breakdown of participants is given in Appendix I. Each interviewee is introduced before their discourse.

2.8.1. Selection criteria

There were no selection criteria other than participants were RNs who gave permission to be interviewed. It was a convenience or purposive sample. I met mostly unknown persons during the research journey. Some interview arrangements were made through 'gatekeepers' [authorized permission-giver]. This allowed free access to placements. Interviewees' participation merely reflected willingness and off-duties. Staff would be met: sometimes individually, sometimes two or three together. They were told about the research.

Where I was unable to choose or observe participants because I was visiting an institution on a short-term basis, I asked the 'gatekeeper' to decide on interviewees. In one instance, because of being unable to tie staff down to an interview time [the Christmas 'rush' in these units] the 'gatekeeper' suggested an alternative unit enabling me to continue. [The consent form used is given in Appendix II].

2.8.2. First group

All nurses start their careers from 'outside' of nursing, gradually absorbing the 'inside' shared meanings and ethos of the profession through socialization processes. Kramer [1974], Menzies [1970] and Revans [1964] write of the negative aspects of this process. They felt nurses generally and students in particular were being made to conform to nursings' traditions, cherished ideas and routine. There were RNs who came from that era when critical thinking, meaning making, time for reflection or being creative was discouraged. More by coincidence than by design some from this generation of nurses became the first group I interviewed [but in retrospect they acted as directional 'sign posts']. Two were about to retire: a chaplain and a ward sister after each had had more than thirty years experience. There was a 'breakfast group' comprising a hospice doctor, a social worker, another chaplain, and the mother of a nurse. I include myself in this group. They were used as a sounding board. I tested my interviewing using structured and semi-structured questions. I call them the 'first group' merely because I analyzed their transcripts first and realized how much insight I had gained.

2.8.3. Main group

The main body of participants [twenty-three] was drawn from oncology/ haematology units or hospices as planned. Permission was granted to observe staff in these units during times that coincided with my being there. Familiarity was gained. Participants became used to me and I to their setting. They were knowledgeable about their work because most had been in the work place for years. Although the socio-cultural data is used to some extent not all data was used. Seventeen RN narratives are used in this thesis. The choice of those selected for inclusion represents participants from each hospice or oncology unit in order to compare different examples and settings. One narrative bridges hospice and State hospital and is used as a paradigm case. This is Bekkare's narrative. Participants are discussed further in the relevant sections.

2.8.4. Issues of confidentiality

Although my research was cleared by an ethical committee maintaining confidentiality was a problem if only one placement had been used as originally planned. Having interviewed most of the RNs at one hospice, I was asked how I would maintain confidentiality. Then I discovered how easily they could be identified. One hospice nurse said: "Research with hospice nurses is not easily concealed. We know each other so well".

With personnel assured of confidentiality information that could identify participants had to be dealt with sensitively. However, having said this, points about participants' characteristics are discussed where appropriate. They were asked to sign a consent form and interviewed according to arranged times. These times were not always kept for reasons on both sides: theirs and mine. The list of those interviewed between September 1995 and April 1996 and further interviews in January 1998[11] is given in Appendix I. These times may seem a contradiction but I could only interview participants at odd times. Participants' names have been changed. Personal names rather than numbers have been used to maintain the personality of participants.

2.9. The interviews

Discussion about the interviews and interviewees takes place under each discourse.

2.9.1. The structured interview schedule - [see Appendix III]

The questions aimed at being straightforward but perhaps were too simplistic. However, they acted as a starter to acquire answers and get participants to elaborate further on care. Most of the data was obtained on a face-to-face basis using the set questions for most interviewees but not all. Three times I met a person who was willing for the interview to take place immediately. This sometimes caught me without the questions. Remembering them, I

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[11] The gap between these dates was due to personal ill-health [a back operation, and two bouts of pneumonia].

used these opportunities for a more informal approach. I left the schedule with some participants. When completed, and where time made it possible I asked questions arising from these answers. Sometimes the schedule was only given back at the interview. If I had time during the interview, I would check what had been said with what had been written. Otherwise this was done when transcribing. Checking what was said with what was written proved useful especially with interviewee Frieda. With a few participants I tried what I could call Spradley-type questions [1979] [see Appendix IV, page 3 for an example]. This approach was abandoned after the third attempt because it led along a route that, because of time, I could not pursue.

The first two questions were devised because of reading Noddings' [1984] work. She believed one could not care for others unless one had been cared-for oneself. That questions one and two were possibly ambiguous is discussed in chapter five under 'Frieda' [a participant].

Questions three/four on feeling fulfilled and its meaning was asked to obtain data on what the interviewee felt about the context in which she cared-for others, its ethos. The questions related to whether being caring was the essence of their professional/personal satisfaction and whether being 'fully fulfilled' acted as a motivational reward in itself. Would question three indicate whether the type of unit they were working on, which many had chosen for its supposed emphasis on caring, allow or enable them to be the carers they wanted to be? As one interviewee stated, "You have to give yourself permission to care". Question four served to elicit the meaning nurses gave to the term:'fully fulfilled'.

Question five: asking about changes was relevant. It formed a bridge between the previous two questions. Some talked about caring as taking risks, needing courage, being tough. If nurses were dissatisfied with the context in which they nursed, would they risk making changes? Were they content 'just to follow orders' [Reverby, 1987]? Would their intrinsic desire or motivation to care override the status quo and enable them to change the traditions, culture or routines of the ward should they be unhappy or unfulfilled?

The last question "Why did you become a nurse" was to gain a deeper understanding of the interviewee.

2.9.2. The notion of 'paradigm cases'

Benner [1984, glossary] uses this term to mean those examples that become part of a practitioner's 'perceptual lens'. She says, "[T]hey are reference points in their current clinical practice" [pp. 296]. Later she uses the term 'a classic case' [Benner, 1989:93]. I had sought narratives that represented care in different institutions. Generally, the discourses are particularly Western but Bekkare's is used as a paradigm case because it is culturally different but also because it has classical elements within. These elements serve as reference points for other practitioners' perceptual lens. Bekkare's background is rural African. This is important in discussing care in South Africa in order to understand cultural, particularly ethical, aspects. Bekkare's narrative and its cultural setting and implications could have become a separate thesis. It is included to add cultural-contextual richness to the 'family resemblances' of care. It is infused with ethical aspects.

Under method, I discussed that to understand a concept, the application to which that concept is put is searched for: its use in discourse. These uses are linked with other clinicians' and academics' discourses and 'crisscrossed' in the search for different levels of understanding. In this way, a paradigm case can be identified and linked to other carers' narratives by direct or indirect ties. These family ties reveal logical connections and analogies as well as similarities or differences within the concept and its dimensions.

2.9.3. Supportive interview data

I reflected on what I was hearing, reading [in the transcripts] and experiencing. I kept a journal. Initially I used Moustakas' [1994] modified version of the Stevick-Colaizzi-Keen method of phenomenological analysis and wrote descriptions of my own experiences of some phenomena [person, vulnerability, spirituality, rejection and my own nursing in a gynaecological ward to compare with Bekkare's experience]. I took interviewees' transcripts and repeated this process using their sayings and the essence of their experiences of care. Some of this material is incorporated herein.

Nancy Drew [1989] reveals from her own research how she viewed her own predispositions, values and experiences of interviewing as data. She felt the subject of choice for her research journey arose from these aspects. Not only does she include these, she examines them for the part they played as the study unfolded and in the results [1989:431]. This too I did and some of the results are woven into the discussions on and dimensions of care/caring. To validate the idea of what it was like to nurse in the 1950/60's, some peer group discussion took place and this is utilized as data.

2.10. Data analysis

The idea of using Bowden's method of surveying [1993/4/7] different examples of care to study the relationships, connections, similarities and dissimilarities between RNs' discourses came during the analytical stage of this research. The value of Bowden's 'survey' method for this thesis lay in the discourses becoming the 'objects of comparison' that led to greater understandings of nurses' meanings. These would widen a formulated definition. The resulting insights would bring to light patterns of connections and revealed dimensions of meanings previously hidden or taken-for-granted. This method centred on individual kaleidoscopic views rather than on composite pictures. To analyze the data...

i) Every mention of the concept in its context was mind-mapped[12] using loose categories and re-written as a succinct individual, but composite, whole forming that interviewees' memoir on care. This revealed the interviewees' use, understanding of the concept within a context and other dimensions that participant used.

(ii) Each interviewees' transcript was rewritten as narrative [working with transcripts and mind-maps] in the style given by Moustakas [1994]. Chunks of narrative were used to illuminate particular care facets.

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[12] Jetter M (1994-6) Mind-mapping. Future Communication Systems.

(iii) As much of the historical socio-cultural context [the participants' work background] as confidentiality allowed was included.

(iv) Participants' use of the concept: their language pictures and meanings were kept. The results, together with selected authors' works are juxtapositioned and criss-crossed one with another at points in the thesis that highlight, interpret and validate facets of care. These results could be presented 'as is' and left to the reader to draw their own conclusions but this is why interpretation is important. Otherwise, the reader is denied the context in which the survey was done, the acquaintance the researcher has with the data and the research subjects and the accumulated insights obtained during the research journey.

(v) Portrayals of care were synthesized into wholes. That is, they were not reduced or atomized into themes rather an attempt has been made to reveal the wholistic nature of an individual's conception of care/caring. The participants' understandings of the concept were wanted, not an amalgamation of a set of care properties. Care-giving is unique to the individual portraying the 'family resemblance'. The uniqueness that care had for each individual was retained. It became a collection of different and similar family resemblances given by each interviewee.

(vi) Results were evaluated and compared with the 'family pictures' of theorists' experiences and writings about the concept. [Benner [1984/9], Bowden [1993], Drew [1986], Roach [1987] Leininger [1980], Montgomery [1993], Nouwen [1979/94/95], Swanson [1986a], van Hooft [1995] and Watson [1985] are some the theorists referred to].

(vii) Elements surrounding and supporting the concept were sought. These relationships, patterns and connections were constructed as being the reality of the concept for nursing practitioners and to obtain a rich description of that person's perception of care/caring [see example: Paula: Appendix IV]. The relationships are not those between themes or variables but rather pertain to the relationship construed from the concept care/caring and its dimensions.

2.11. Limitations

These can be discussed from different perspectives.

1. Those affecting data collection

(i) The units I at first chose to visit [one hospice and an oncology ward] limited the research. This was due to not having a large number of RNs to select from, time being in short supply and the availability of staff willing to be interviewed [but only in State hospitals].

(ii) Financial constraints and skill-mix. RNs [full- or part-time] had been drastically cut because of financial constraints. In State hospitals staff were offered voluntary severance packages. Many RNs left. Shortage of staff was experienced. In hospices, the lack of State funding and reliance on diminishing public donations led to downsizing the staff. In contrast, it was noted and discussed during my visit to Australia that hospices enjoyed State subsidies and support from Cancer Association. The difference this security gave to staff could be seen and felt. Australia, I was told, was able to draw from a healthy volunteer bank whereas in South Africa the economic situation caused many volunteers to withdraw.

(iii) My time- and work-restrictions when not on leave hindered traveling to places for data collection. My research was allowed only outside working hours and I had to juggle with participants' time. RNs were unwilling to be interviewed off-duty. A further problem during the research was being seconded to a hospital further afield, which restricted observation and contact time. Eight participants only were interviewed twice.

(iv) December/January was not a 'normal' time in these units. Relatives wanted to enjoy Christmas without a dying person present. I could not get a picture of State RNs' hands-on care because they were busy with the management of two wards with 32 patients in each and fewer staff. Many who said they were willing to be interviewed could not give an interview time though approached on several occasions. Staff in private and hospice units seemed able to give of themselves more willingly. Much could be told about participants' care through these experiences.

(v) It *may* have been useful to have elicited non-caring aspects thus providing the opposite or contradictory moments of care, or what caring is not. Irurita's study had focused on this aspect. It was a whole thesis in itself. I was aware that Montgomery had attempted to interview non-caring nurses and failed.

2. Limitations of the method.

(i) I am aware that Van Hooft [1995], and Jecker and Self [1991] distinguish between caring-for and caring about; Gaut [1986], and others between care and caring but these grammatical differences do not form part of this thesis. To use the Wittgensteinian approach and Mind-mapping all grammatical uses of the terms care/caring had to be analyzed.

(ii) I should be able to answer: how efficient was the design in terms of it achieving results? There is a relationship with this question and the following section. The research involved particular individuals at particular times in their own life's journey, in particular places, and in particular socio-cultural-economic contexts. Each of these aspects is subject to change and change they did. Participants left hospices and others took severance packages. Any method using interviewees is dependent upon continuity but having volunteered for the research they were free to move.

For confidentiality reasons I chose a few hospices. More credibility would have been acquired had I been able to check more transcripts. However, I believe the results reveal the wide-ranging, complex, many-faceted aspects of care/caring. They compare with subjective and authors' experiences. The method brought out 'family resemblances'. I believe it could be used for other affective concepts. It would be more efficient if I had been able to spend more time observing and discussing Mind-maps and interpretations with participants. It would improve their reflection and critical thinking and act to affirm them as knowledgeable practitioners in their own discipline.

The research relied mainly on acquiring persons' uses and meanings of words in context not always on observation because of the lack of time. Perhaps this could be seen as a weakness rather than strength. What a person says is not always, what they do. This is where obtaining the affect behind the words uttered was valuable [Drew, 1989]. It served as a check on the person's attitude towards the topic. The lack of time may seem a contradiction seeing that I went to units away from my home base. However these excursions were for business reasons and the forays into the units were part of my busman's holiday.

2.12. Credibility, transferability and dependability

Firstly, in relation to credibility concern is with accuracy and truthfulness of the findings.

Secondly, taking dependability, the question is: Can this research be replicated or transferred to another context?

Nursing literature reveals the difficulty of these two aspects in qualitative research. The problem is exacerbated when using multi-qualitative strategies certainly with developing a 'new' method. An example is Sandelowski [1986] citing Giorgi [pp. 29] who stated, "Method frequently interferes with meaning". Moccia [1988], also writing about research methods felt nurse researchers who desired to express their human essence and spirit through their research activities had a choice to make between rational and dispassionate research and entering into a dialogue and dialectical engagement characterized by innovation and unpredictability. This research design sought to centre on finding meaning in the research product through such engagement. The researcher's choice, she felt, should reflect not compromise their philosophies and world-views.

Specific points are commented upon:

2.12.1. Credibility

1. Researcher status position, i.e. the researcher's social role within the group/s being studied. This I was aware of and reference to this was made under Wright's research but to my knowledge, my status caused no problems.

2. Informant choices: the criteria used were of the minimum: interviewees were to be RNs in hospice, or oncology/haematology units. I did not seek 'expert' care-givers, or non-carers. I took them as they were and eventually 'measured' them against the statement of care I formulated. That this was subjective was born of necessity. If they were available then they were interviewed, no more no less. There was nothing special about the persons interviewed or the choosing. The selection was convenience or purposive sampling.

3. Social conditions and situations i.e. the background or context of the research situation is delineated. These points have been considered and are discussed as the thesis develops. But, South Africa in general and nursing in particular is changing almost daily because of cutbacks. Therefore, the context of the research situation changed as mentioned below 6(i).

4. Discussion of analytic constructs, premises and identification of the assumptions and meta-theories that underlie choice of terminology and methods of analysis should be raised. These points were explicated earlier. Terminology, as such, is not a feature. What has been chosen for linguistic discussion, are the concepts: care/caring and those concepts surrounding them and this continues throughout the thesis.

5. Specifying the methods of data collection and analysis has been discussed.

6. Identifying the effects that obstruct or reduce a study's comparability and translatability. Some have been mentioned. Other aspects are discussed as the research proceeds.

i) The context. Schon [1987] used the Chinese proverb: 'you cannot step into the same river twice': meaning the infrastructure remains but the problem moves. This was true of research respondents' and their places of work. The actual units remain but many of the staff changed and therefore situational problems have changed.

ii) 'Growth' of persons resulted in my self-awareness, self-realization and spirituality increasing. Participants could enjoy emotional, psychological and spiritual growth through their life experiences if they reflected upon their own discourses and care. Some do.

2.12.2. Dependability

1. Agreement is sought on the description or composition of events. Participants' narratives utilized in this research were verified by eight interviewees. These willingly checked their transcripts and corrected mistakes or misunderstandings. A few were seen more often whilst observing the context in which they worked: particularly in the private hospice and haematology/oncology units. My supervisors read transcripts. Informal peer group consensus was also sought. Additionally, my own subjective experience and that of authors used as authorities, confirmed understandings of the subject and other concepts.

2. Confirmability assumes conceptual categories have mutual meanings between participants and researcher. Categories were not used in the way normally done in qualitative research for the reasons given. The objective experiences of research participants and those subjective experiences of the researcher were validated through reflective analysis. They were found to match the experiences of other researchers and authors. Findings were consistent with the collective experiences of others and structured by shared cultural understandings.

3. Shared cultural understandings form participants' behaviours and norms in different socio-cultural contexts and are discussed particularly in the case of Bekkare.

4. The reaction of participants to the research(er) is assessed. These are dealt with under each participant.

5. Seeking and maintaining contact with a diversity of participants. Time and other constraints have hampered contact especially where staff left; but where possible contact was maintained and with the institutions.

2.12.3. Auditability

Qualitative research is criticized for failing to pass the test of methodological rigour. To strengthen credibility and verifiability, research can be confirmed through the process of auditing. To audit research the following is borne in mind:

1. The representativeness of the data is examined. I felt this research data was typical of RNs' portrayal of care and could be validated by other phenomenological research. Typical and atypical uses of the concept 'care' were represented, discussed and interpreted. Frieda's conception of care is of the more atypical variety.
2. Data sources and collection procedures could be replicated even if the method were used with some other abstract concept.
3. Eight subjects validated their transcriptions, the interpretation of their discourses and the research findings from their data.
4. To establish genuineness ways to enable another to follow the progression of the research in a logical manner and to be able to reach the same conclusions are sought. For example, could it be said that the dimensions of care, the African proverb upon which many concepts are based, proceeded from the transcribed discourses? Were these examples wishful thinking or the result of literature read and discussions held? The answer is that the dimensions pervaded the transcripts. They were near the surface: to be read and identified. The joy lay in discovering meanings and linking them with authors.

2.13. Conclusion

This concludes part two of chapter two. In this chapter, what data was needed and how it was collected has been discussed. The limited criteria for selecting research participants, the detail surrounding interviews and maintaining confidentiality was revealed. Lastly, an attempt was made to show how credibility and transferability would be demonstrated. RNs discourses will form a series of intensive audits of relatively independent care narratives in a variety of areas. These discourses draw attention to the particulars of their settings and the specific kinds of relational concerns those settings bring to bear on the form of care [and non-care] expressed.

Having described the research design, the next chapter gives a brief historical survey of literature dealing with the concepts care/caring to set a mini-historical background for engaging with RNs' narratives.

"The nurse as practicing an art in her ever-changing task, making constant appeal to her imagination, upon her intelligence, and on her organizing powers. Where nursing was seen as stimulating when it could be done as nurses wanted nursing to be done, distressing when the art could only be practiced if time and circumstances permit, dismaying if nurses were not able to pick out the essentials, and satisfying if they could". "The Art of Nursing", Nursing Times Editorial, 1945

CHAPTER THREE: A survey of literature

3.1. Introduction

This chapter underwent many changes. Originally, it was to be on the history of the definition of nursing: various definitions from theories of nursing pervaded that chapter. The purpose had been to show nursing's attempt to become professional because many criticize nurses' quest for professional status. This thought appears in some discourses in this thesis. The former chapter had traced the process of nursing developing its 'own body of knowledge' through research and its development of ethics. This knowledge resulted in nursing theories [often borrowed from other disciplines] many of them attempting to answer the questions: "What is nursing, and what is a nurse?"

Instead this chapter seeks to place the answers to these two questions squarely in the everyday reality of nursing because as Praeger [1995] stated: "Our experience in the world of health care is the foundation for understanding the nature of nursing and what it means to be a nurse" [pp. 302].

3.2. Historical aspects of the concept 'care'

Nursing, as a practical occupation, began with Florence Nightingale. Daring to nurse, she proved to be a role model: providing compassionate-care and comfort in hygienic environments. Her emphasis lay in nursing humanely and transmitting her skills to others through training. Nightingale believed "every woman is a nurse ... every woman must, at some time or other... become a nurse, i.e. have charge of somebody's health..." [meaning a child, a parent or spouse][1952:13 preface]. Her point was, before one entered nurse training one would have restored somebody to health. Nursing, [as she named this task 'for want of a better' [Clark, 1995] was not the prerogative of professional persons. Nightingale discussed what to her was 'careful nursing': putting the patient in the best circumstances for Nature to heal him/her. To her this was the 'art of nursing'.

Lucy Ottley [1952] writing the foreword to Notes on Nursing understood Nightingale's 'total care' [a term commonly used by nurses of that era] as meaning: "a *human being* to be nursed; a *situation* to be dealt with; ... [a] *patient's powers* to be conserved ... to be restored to *complete* health" [Ottley's emphasis 1952:7]. These quotes point to the fact that caring and nursing were used interchangeably particularly in the terms: 'total [or 'basic'] nursing care'.

Nursing has traveled various stages and milestones since then, its emphasis being on achieving a service for humanity. Many of nursing's past doyens emphasized the need for curricula that stressed education and clinical expertise [rather than training], administration, and later, research. From this came the questioning of the nature of nursing: its essence, role, function, and purpose. It was thought a theory or a model would *unite the whole spectrum of nursing.* [Meleis:1997 my emphasis]. The complexity of nursing, in particular its practice, resulted in the failure of this endeavour. Nursing practice was felt by theorists to contain unscientific, unexamined, habitual, taken-for-granted traditions. These were the offspring of bureaucratic repertoires, reliance on rules, policy and procedure manuals [Street, 1990a].

Nurses ventured into philosophical areas. As a result, previous nursing research began to be seen as having limits especially in its paucity, quality and use as an evaluative tool [Meleis, 1997]. By entering the philosophical domain, questions were raised as to the nature of science, human beings, holism, different ways of knowing, and research itself. Epistemology embraced ontology and provided multiple means to question the values, meanings and realities of nursing especially clinical nursing.

The journey to maturity took nursing from practical areas through theories of research, epistemology and philosophy, and back to the clinical world of nursing. From this came a willingness to question, and to combine, "multiple philosophical and theoretical bases" [Meleis, 1997:32]; to discover what nursing, especially the reality of its practitioners' experience, was about [Street, 1990a/2, Benner 1984, Benner & Wrubel, 1989].

3.3. Care as the essence of nursing

Talk of 'care as the essence of nursing' came about in the 1970's, mainly in North America. McFarlane [1975], in England, talking to the Royal College of Nursing in 1975 leant on her American counterparts in discussing the art and science of nursing [particularly Henderson's [1966] definition of nursing]. In this talk, McFarlane conceded she found the distinction between nursing and caring confusing.

My attention was drawn to the works of North Americans on caring through my educational interests: particularly their discussions on a proposed transformed curriculum and the emphasis on care within such a curriculum. This led to reading Bevis [1993]. The fact that she changed her stance from behaviourism to a Freirian approach made me feel there was something real in this caring rhetoric. Bevis' work led me to Watson's [1979] and Leininger's writings [1980, '81, '91] where care became more practice-oriented and embedded within specific cultural contexts. Being familiar with Benner's 1984 work, I read her other writings.

Other relevant books were Street's 'Inside Nursing' [1992], Noddings' 'Caring...' [1984], Larrabee's 'Ethic of care' [1993], and, Tronto's 'Moral boundaries...'. [1993]. When I was in Australia a computer search revealed what became ten kilograms of journal articles on the subject. Many articles were about care/caring: research methods [mainly phenomenology]; philosophy, and responses to Gilligan's [1982] ethic of care by nurse theorists and practitioners. Many of these journals were unobtainable in South Africa.

What constitutes the reality of nursing is its practice through its practitioners. Watson [1985], Benner & Wrubel [1989], Bevis & Watson [1989], and others wrote that caring was central to nursing. This ideal of nurses practicing their skills with care, of being concerned and compassionate became damaged by reports of 'rough-hand care' and "non-caring attitudes" discussed by staff and public alike. Criticism was leveled at nursing's practitioners, administrators and educationists for the fall in standards the lack of care implied. There was an apparent willingness to expose patients to heightened vulnerability: to treat them like objects similar to the depersonalization process that Goffman [1961], Irurita [1993], Rieman [1986], Drew [1986] and others identified.

What nurse academics thought about the terms 'care' and 'caring' was conveyed in the literature resulting from discussions about these concepts. Articles are still being written in response to the 'ethic of care' stimulated by the Gilligan-Kohlberg controversy [the critique on the genderized psychology of moral development [Harbison, 1992].

3.4. Confusion of meanings

Morse, et. al. [1990/1], Gaut [1983], Griffin [1983], Mayeroff [1971], Paterson & Crawford [1994], Street [1992] and others have attempted to give meaning to the word by tracing its evolution. But Morse et. al. [1990/91] and Crigger [1997:217] appear to be right in their analysis: there is confusion within nursing about caring particularly as to its meaning. A vague but essential something eluded explication. Some of it was perceptual: the concept being viewed differently by being the recipient or giver of care. The literature shows authors analyzing the concept into different categories. For example, 'care-givers predispositional qualities', care components, care behaviours [concrete action], basic caring dimensions, caring ideologies and a caring climate [Montgomery, 1993; Gaut, 1983; Griffin, 1983; Morse et. al. 1990/91, Paterson & Crawford, 1994].

Researchers and writers also approach care/caring from different perspectival approaches: that of anthropology [Leininger, 1991]; education [Bevis & Watson, 1989; Noddings 1988]; politics [Tronto 1993]; gender-sensitive ethics [Bowden, 1993; Fry, 1988]; ethics and philosophy [Benner & Wrubel, 1989; Drew, 1989; Gadow, 1988; Griffin, 1983]; practice based research purposes [Swanson, 1986a/b and others] and psychological foci [Fromm, 1957; Mayeroff, 1971]. These are examples of the many angles from which writers approach 'care' and should not be seen negatively.

Voices other than those of nurses experience what it means to care or to be caring. To use Wittgenstein's 'language of meaning' as interpreted by Bowden's 'survey process' [1997] as my pathway to researching care, I wanted to survey many different kinds of examples because each input was important. Other important narratives were those of Henri Nouwen [1994/5] [as will be seen from the quote at the beginning of the next chapter].

3.5. Discovering the present meanings of care/caring

Bruner [1990/1996] wrote of culture as 'folk psychology' and 'acts of meaning'. In nursing these 'acts' can be identified as those traditional beliefs, values and symbols assigning meaning to nursing [and caring] in different settings and in particular situations. This culture provides 'tools' for organizing and understanding the meaning of care, thus nursing's practitioners define and reinforce meaning through this nursing culture. 'Acts of meaning' shape and are shaped by the minds of its members. Whether one is taking an ethical, economic, social, or historical view nursing takes its meaning-making from its own members. Earlier, nursing had been dependent upon insights from other disciplines. Attempts were made to fit 'ways of knowing' to nursing's needs. This created changes in the culture of nursing. Some of nursing's protagonists felt a depersonalized mechanistic mode of nursing resulted. This created a paradigm shift with attention centring on developing a humanistic emphasis and care was seen as the function, purpose and primacy of nursing [Benner & Wrubel, 1984; Paterson & Zderad, 1976; Watson, 1985; Leininger, 1981].

Authors often use the terms nursing and caring interchangeably. Watson [1979] emphasized caring as the moral ideal of nursing. The context was her own theory of nursing. Watson was saying caring, within the context of nursing, was imperative. Montgomery expressed the feeling that nursing practice could be more caring and involved than orthodox theory and formal professional discussion ordinarily indicated [1991:91]. Watson and Montgomery are two examples from many nurse examples. If the qualities they identified are removed from nursing, if they pertain only to care, or if caring and nursing are treated as disparate entities, then nursing becomes the cold, detached, technological, mechanistic approach to persons that nurse protagonists feared. This approach, according to Watson's statement, would make nursing amoral. In antithesis care should be the expression of the capacity inherent in individuals a creative art: warm, human and moral.

To discover the meanings of care-in-nursing necessitated exploring RNs discourses to learn whether the terms caring and nursing were used synonymously and whether there were differences in usage by practitioners in clinical areas. Individual narratives alone would not portray the ultimate of care but taking RNs narratives and putting them alongside one another would give different levels of understanding. There are shortcomings in some perceptions but these form the dissimilarities between individuals. There are similarities and they portray not just 'good intentions' but a passion for the values upheld in their nursing. They illustrate RNs meaning of nursing. They express emotion and volition. It seems appropriate then to discuss the questions: "what is a nurse, and what is nursing"?

3.6. What is a nurse?

This discussion will enable comparisons to be made with others' representations of nursing and caring. As shown by Nightingale and to be demonstrated from Nouwen [1994/5] [discussed later], persons other than nurses can nurse [in the sense of deep nurturing care]. The questions "What is a nurse?" and "What is nursing?" have been asked many times and answered in many ways. For this thesis I will use Carol Montgomery [1993] as my 'authority' for the first and Patricia Benner [1984] for the second.

3.7. Montgomery's predispositional qualities

To answer, "What is a nurse" I use Montgomery's "predispositional qualities". This may seem strange in the context of deriving the meaning of care/caring. Her 'qualities' are relevant. If I can show nurses revealing these qualities, then it shows nurses are not 'just' nurses but concerned caregivers. Any nurse possessing these predispositional qualities becomes like one of Montgomery's caregivers.

Her term 'predispositional' is explained as "an existential way of being" [1993:41]. This can be interpreted as a free and responsible agent having the disposition to determine his or her own behaviour and development. This is not given as a 'quality' by Montgomery but in view of my research question, it has significance. Benner and Wrubel [1989], in contrast, see a person not as wholly free but as an agent fettered to some degree by their culture or situation. I feel that it is possible to break out of a cultural mould that is detrimental to normative caring standards. Conformity or otherwise depends on how a person has developed as a person; how s/he allows her/his existential being or natural capacity to develop and be utilized towards others. Many nurses conform through following orders that could be damaging to others [Reverby, 1987].

In this section, aspects from interviews are juxtaposed with Montgomery's points. Interviewee's names are in brackets. Only excerpts are given, full quotes follow later in chapter five. These then are Montgomery's predispositional qualities:

1. A care-giver is person- rather than role-oriented.

The care-giver is other-person oriented, characterized by a willingness to give and share on an intimate personal level. The interviewee May describes this willingness to give and share on an intimate personal level. This quality of 'other-person orientation' is shown as

> "a need that could be filled by someone caring. Being there and talking of spiritual matters. Not evangelising, but meeting the person where they were. And that's caring. Caring really is getting alongside the person with healing" [May].

May could not separate caring from nursing. She had wanted to engage in a person-oriented approach in her role as a nurse. Permission to act this way was consistently denied. She therefore left the State hospital, started her own nursing home for the elderly and built care-giving relationships. Her care is oriented towards 'healing through communication' such as Montgomery writes of.

2. There is concern for the human element of health care.

   The concern is for the whole person: their dignity and humaneness. Whether in a highly technological environment or not, care-givers treat persons with respect and avoid dehumanizing. They are aware of the possibility of, and seek to alleviate, vulnerability:

   > "If you focus on one's own skill in nursing and you take out one's attitude to caring and love then you are going to lose caring".[May].
   > All a really sick patient expects from a caring nurse is to feel safe in the environment; well cared for ... " [Sr. W].

3. They have person-centred intentions. They seek to presence themselves. They are willing to be there for the person in a committed, concerned and connected manner. May displays this in her "we". She shows the willingness of her staff to adjust, to give and to share of themselves with the elderly:

   > "we had to adjust the bare reasons for living, their patterns of living, and what purpose [the elderly] could find in their present state: continuous, glorious old age ..." [May]

> "Caring is a conscious willingness to meet their needs at any level ..." [Susan]

4. Care-givers transcending judgement about persons.

   They are able to accept the HIV/AIDS patient, the prisoner, the down-and-out unconditionally and allow them to act as persons able to make choices about their own lives:

   > "You do not judge a person ... " [Brenda]
   > "You're not here to judge anybody" [Susan]

5. They are able to supply and evoke a hopeful orientation.

   Montgomery's care-givers find positive meaning, possibilities and hope in situations. This gives them courage to get involved and sustains them during involvement [1993:47]:

   > "We communicated sympathy [empathy had not been 'invented'], expertise, confidence, hope and healing over a dressing or even with a bowel evacuation or skin preparation prior to operation" [Diana].

6. There is a lack of ego-involvement.

   These nurses are not there for the sake of others. They are able to enter another's world.

   > " ... the sick must be nursed as one would have nursed Jesus Christ if He had been sick. Praying for one's patient was part of caring too" [Sr W]
   > 'being there, and being aware of people's needs; their needs, not yours. Theirs". [Her emphasis]. You've just got to be a presence, and let them know that you do care for anything they want. It doesn't matter [what][Susan]

7. They have expanded personal boundaries

   Caregivers have a heightened sense of self where interests are "defined in terms of others and themselves" [1993:50]. Montgomery likens this to Gilligan's highest level of moral development. According to Gilligan [1982] this is "characterized by an awareness of... interconnectedness and interdependence, such care becomes a creative form of self-expression": one enhancing self and others. Being defined in terms of others and one's self is the crux of a person becoming a person through other persons.

   To summarize: these predispositional qualities of care-givers can apply to any health care professional and can, as Nouwen shows, also apply to lay-persons. Nurses displaying these qualities in their nursing are showing care-giving, not any type of care but compassionate-care that is ethical and legitimate. This leads to the question:

3.8. What is nursing?

Patricia Benner's research [1984] provides insight into expert nursing. It is validated as such by Bowden [1997] and Shutte [in print]. Nevertheless, it has been criticized for representing ICU and not general nurses.

Benner's seven 'domains'

1. The helping role
2. A teaching-coaching function
3. A diagnostic and patient monitoring function
4. Effective management of rapidly changing situations
5. Administering and monitoring therapeutic interventions and regimens
6. Monitoring and ensuring the quality of health-care practices
7. Organizational and work-role competencies.

These are universal broad areas of any RN's role. Under each domain Benner gives specific roles and functions the expert nurse would fulfill. Some of Benner's points overlap with Montgomery's qualities, the reason being the difficulty of separating what a nurse is from what she does. This has also been the problem in trying to separate 'nursing' and 'caring'. If Benner's domains apply to caring in the way they do to expert nursing then the answer to 'what is nursing' should apply largely to 'what is caring'.

Benner sees the 'helping domain' as: finding meaning, interpreting pain, providing pain relief and comfort; presencing, maximizing patient participation and there are other facets.

These roles and functions, with their detailed aspects, illustrate the practice of nursing. They reveal ideal nursing at a cognitive, skilled, competent, volitional and emotional level. Swanson [1991] used them to validate her middle-range theory of caring. The narratives Benner chose, particularly her paradigm cases, revealed nurses engaging in the 'personal, social, moral, and spiritual', what Watson called 'human care in nursing' [1985].

3.9. Conclusion

The research narratives in chapter five show participants meeting the criteria of the 'helping domain' of the expert nurse. These have defined nursing but the participants in this and Swanson's research show this 'helping' in their caring-in-nursing such is the family resemblance between the two concepts: caring and nursing. This chapter has shown a distinct similarity between ideal nursing and what many nursing 'voices' desire care to be.

To make more sense of care and its contribution to the reality of nursing, the next chapter draws on selected authors. These authors were chosen because they facilitate the comparison of the words and meanings implicit in care. Their insights and oversights are employed. This allows the research to develop a rich language description and shows the family resemblances of understandings of care-in-nursing. This latter term is used to distinguish the care that takes place in nursing from laypersons' care.

"When we dare to care nothing human is foreign".
[Nouwen, 1994]

CHAPTER FOUR: Understanding the meanings of care

4.1. Introduction

This chapter attempts to give meaning to care by using selected authors. This gives a base line against which to measure the language and meanings of 'care' used by RNs.
Benner [1987], Clark [1995], Barker and Reynolds [1994], Morse, et. al. [1990/1] and others feel there is a need to spell out a language of care. Caring has been described by Watson as a science [1985] to the chagrin of Barker and Reynolds who could not fathom one iota of the scientific about the term. The theorists selected may answer the critique of Barker and Reynolds while also constructing the reality of care.

Theorists chosen are not the authors of theories or models of care in nursing. Narrative, turned into categories and key themes, runs the risk of losing the richness of practitioners' language and their meanings. Undergirding the approach in this chapter is the theoretical direction Bowden took as explained in chapter one. The following authors' works will be used: the reason will be explained later:

1. Dolores Gaut
2. Patricia Benner
3. Carol Montgomery
4. Henri Nouwen
5. Stan van Hooft
6. Peta Bowden

The first column consists of nurse authors, the second are those who deliberate on care/caring from meditative, philosophical and ethical perspectives respectively, though these are not mutually exclusive divisions.

4.2. A description of care from theorists

4.2.1. Dolores Gaut

Gaut is chosen because of her approach to the language of care. She began philosophically with an analysis of the semantic use of care/caring. First, she sought typical uses of the terms care/caring in ordinary language. Secondly, she applied the results to nursing practice. In Wittgensteinian manner Gaut points out: "The uses of a word do not always fit a single definition but consist of a 'family of meanings' and 'resemblances' - "the sharing of some features or other, enough to show the resemblance, by any two members of the family" [1983:314 citing Kaplan]. Her search was not limited to one definition to fit all examples but included searching for the many different senses the term had acquired over time. Her analysis gave me understanding of the sense in which caring had been commonly used. These were:

i) attention to or concern for;
ii) responsibility for or providing for,
iii) regard, fondness, or attachment.

Then she sought to determine the sense in which caring was used in scholarly literature [in the 1970/80s]. She wanted to know if scholastic use clarified the term and whether its use was concurrent with common usage. What became evident from her study was the notion of caring becoming important. In its evolution she saw it related to ordinary actions such as feeding, touching, and talking to. When grouped together these constituted caring actions. Finally, she arrived at an 'action description of caring': one possibly able to determine if such actions were caring or not.

The goal of her analysis was to identify conditions 'necessary and sufficient' for the employment of the term "caring" [1983:322][my italics]. These were: knowledge of the person; identifying the need for care; choosing and implementing action based on the knowledge that improvement would be experienced by doing these things. A caring action had to be intended to bring about positive change based on choice. [This would, I feel, give such caring a volitional aspect similar to Montgomery's 'existential way of being' and van Hooft's evaluative-proactive level (to be discussed)]. Finally, the recipient had to benefit from the caring action; improvement had to be noted[13].

Some of these conditions are stressed by other authors; for example, Benner [1984] shows how important it is for a nurse to really know the patient: their condition, family and community. Identifying the need for caring action needs further explication. Sufficient to note that it can be aligned with attention and coupled with choice, which will be discussed. The 'improvement' and 'intention to bring about positive change' seems to place these conditions in a framework of cure rather than care if one considers nursing the physically handicapped, or terminally ill unless the deeper meaning of 'improvement' is applied.

Practically, these 'conditions' should apply to good nursing, the meeting of them should, according to Gaut, make for caring-action. If by applying these conditions to the nursing care of a particular patient: for example, Sue Baier [1985] (a patient nursed in an Intensive Care Unit {ICU] when suffering from Guillain-Barre syndrome), then the language and meanings Gaut revealed should validate caring-action in a specific nursing context. Applied to nursing practice it should distinguish nurses as care-givers or non-care-givers. Legitimacy is given to Baier's story because it corroborates the type of care/non-care discussed by Drew [1986], Irurita [1993], my research participants and her story is used by Winland-Brown [1996] in teaching caring to ICU students.

If Gaut's 'development of a theoretically adequate description of caring' and her 'necessary and sufficient conditions' [1983:313] are used in this context they show how little attention some ICU nurses paid to Sue's needs. These non-carers [including some health care professionals] failed to get to know her [on any level]. They lacked the will to notice improvement [or deterioration] in Baier's general well-being or, that improvement would have been experienced if they had done certain things deliberately. They often chose short cuts and non-caring actions. Not only would Sue have gained spiritual and intellectual benefits from being cared-for, but her carers would have benefitted and enhanced their personhood.

Baier was not mentally but physically handicapped. She could only communicate with her eyes. Baier's criteria to show 'necessary and sufficient conditions for the employment of caring' were: did nurses

1. look at her with intent: to determine her needs and not what they thought these were?
2. communicate with her using her system of blinking and not the conventional verbal manner?

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[13] The word 'improvement' is given the meaning: 'to supply with spiritual or intellectual light' according to the Ami-pro [computer program] thesaurus - not a meaning Gaut attributed to the word but a meaning showing relationship with van Hooft's spiritual dimension. Source: The Oxford English Dictionary (2nd ed.) pp. 893-4.

3. be there for her when needed, especially in emergencies?
4. do the basic essentials when nursing her: e.g. leave her in a comfortable position and with her means of communication?
5. have knowledge of the needs of a paralyzed patient? Sue realized little was known about Guillain-Barre syndrome.

Baier's story shows that many nurses abysmally failed to meet these criteria.

Had Gaut used her analysis: that of the sense in which she found caring was commonly used, then Sue Baier would have felt she had been cared for, especially in the light in which Gaut's usages will be expanded later in this chapter. Gaut's research took place before 1983: before Carol Gilligan or Nel Noddings had written their 'ethic of care' works, and before the caring literature industry. Their findings, in relation to moral development, placed care and its particular language in the affective domain of individuals.

This was a language bespeaking contextualized responsibility, compassion, sympathy, engrossment, and responsiveness. It was in contrast to the normative cognitive language of moral development: rationality, rights, justice, impartiality and oughts. Noddings [1984] wrote that in meeting the other, [lets say someone like Sue], in knowing her, becoming committed to her, a nurse [using my example] discerns his/her own morality. But in Sue's case it would be important to know whether this morality was of the cognitive variety: with its decontextualization and detachment [which in fact many nurses showed]; or of the affective variety where one would be open and attentive to the vulnerability and consequent pain of the one-being-nursed. It should have beeen care done volitionally from a generous spirit and not out of obligation.

Picking up on the idea of pain, van Hooft [1996:87/8] shows how a caring nurse could respond at all four levels of their being [levels to be explained later]. At a biological level the nurse would know the person well enough to recognize that the facial expression of the patient had changed and would seek to identify the cause. At his perceptive-reactive level the nurse would identify pain behaviour, express compassion and have knowledge of the cultural aspects of pain relevant to this patient. At his evaluative-proactive level the nurse would be making a practical response, deliberate- and plan-specific action. The spiritual level leads a nurse to understand suffering in the context of life and cultural beliefs. Baier's story showed nurses who failed to reach even the lowest of these levels.

To return to Gaut, her resources were, from her references, psychotherapists: Erikson, Freud, Maslow [1958], Sullivan and Mayeroff. Leininger is mentioned; Watson, and, Paterson & Zderad are omitted. The latter three had been writing since the 70's. Her omission of these, and of Rollo May [psychologist]; Paterson and Zderad, Travelbee [1971] or Peplau [nursing contemporaries]: where they show caring leading to relationship, growth, becoming more fulfilled, and as 'therapeutic use of the self', is curious. This may be because Gaut's emphasis was from a theoretical rather than a practical stance. Her 'survey' attests that the meaning of the word caring has changed since her study. It is secured in each domain of human nature, especially that of the affective domain and with strong ethical roots.

Dunlop [1994], using Rollo May's 1969 definition, shows the word has assimilated this emotional connotation: "Caring is a feeling denoting a relationship of concern, when the other's existence matters to you; a relationship of dedication, taking the ultimate terms, to suffer for the other". This meaning, entering nurse education through its use by Bevis, and its emphasis as a human need in Leininger [1981], is missing from Gaut's analysis. If Gaut's language of caring is juxtaposed with the other domains of one's being a deeper meaning of the concept evolves.

4.2.2. Patricia Benner

Benner is an acknowledged authority on the subject of expert nursing [Bowden, 1997], and doing nursing [Clark, 1995] in the sense of practical informed activity. She provides rich descriptions of the nature and context of nursing practice grounded in real experiences. Of interest is that she felt nurses' language needed to match the reality of their practice and experiences [1984]. The following perspective is taken from a synthesis rather than an analysis of Benner's many works [q.v.]. Her approach is to uncover nurses' knowledge, their sense of possibility and the language they use to embed this ideal picture of caring in clinical practice.

Benner sees nursing not as a simplified, linear problem-solving process. Where nurses have unreflectively appropriated this meaning there has been conformity with limited understanding resulting in a lack of the 'excellence and power' in clinical practice that she writes of [1984]. Where a nurse has risen above conformity and used nursing's excellence and power to build relationships based upon mutual respect and genuineness then positive qualities: those of transformation, personal integration, advocacy, healing, participation, affirmation, problem-solving [Benner, 1984:210] and an ability to cope with stress [1989] have emerged. The abstract inherent in principles and problems becomes concrete as one relates to others, shares concerns, protects vulnerability, maintains honour, dignity and courage. Her 1984 research, centred on developing an evaluative tool but takes one through various domains that point to nurses being experts where they meet certain criteria.

Taking her "helping domain" for the purpose of analyzing care shows expert nurses:

- Creating a climate for and establishing a commitment to healing;
- Mobilizing hope;
- Finding an acceptable interpretation or understanding of the illness, pain, fear, anxiety, or other stressful emotion;
- Providing comfort measures and preserving personhood in the face of pain and extreme breakdown;
- Presencing: being with the patient;
- Maximizing the patient's participation and control in his/her own recovery;
- Interpreting kinds of pain and selecting appropriate strategies for pain management and control;
- Providing comfort and communication through touch;
- Providing emotional and informational support to patients' families;
- Guiding a patient through emotional and developmental change: providing new options, closing off old ones: channeling, teaching, mediating;
- Acting as a psychological and cultural mediator;
- Using goals therapeutically;
- Working to build and maintain a therapeutic community. [Benner, 1984].

Benner, drawing from narratives of expert nurses, maintains that nurses who are not experts cannot give rich accounts of their practice. Narratives, as Bruner [1996] maintained, constitute a person's understanding [in this instance] of what it is to be caring and/or an expert nurse. Benner comments on Beverly Dyck's [1989] 'The Paper Crane' and underlines this understanding. Dyke learned, subsequent to nursing a Japanese lady and after being a nurse for six years, what nursing really meant.

Her story is a picture of caring: dealing with significant issues. She was invited into the patient's most private thoughts and moments: moments laden with spiritual and intellectual insight for both. Dyke learns from the patient how she prepares for death, the importance of silence and tears. "All essential", comments Benner, "to the caring practices of nurses". The nurse feels appreciated, renewed from sharing in and facilitating the patient's strength and courage. This exemplifies Nouwen's: [1994] "When we dare to care nothing human is foreign". Her story reconnects the reader to the wordless, private places in nursing that nurture our own caring practices [1989:826]. This caring-type language is used by Benner, Montgomery, Nouwen and van Hooft [see later].

Non-experts' language is found to be technical, factual and without these rich nuances, or the ethical comportment inherent within caring. Benner is aware of the need for an interpretive approach to narratives. The intentions and understandings of narrators: their shared world of meanings is made explicit and structured through their contextualized description of the situated meanings, or interpretations within. Such meaning, as situationally relevant, becomes limited and cannot be objectified or made context-free implying different situations have different meanings, which is true to life.

Writing after two major research works and the above papers Benner discusses the role of experience, narrative and community in skilled ethical comportment [1991]. She embeds caring squarely in both clinical practice and ethics. Ethical practice is seen as having common meanings: a notion of good embedded in commitment. She asserts that to examine 'what it is good to be' one must study the everyday ethical expertise and narratives illustrated in the practices of communities.

The practice of ethics in health care must start, she feels, with a practice-based understanding of 'what it is to be a person'. This in itself structures the relationship: the care and responsibility rendered toward another. The ethic discovered by such study corresponds with that of Gilligan's ethic of care. Benner's definition of care is that of Gadow's: 'alleviating another's vulnerability'.

Benner adds other salient features to caring: "the promotion of growth and health, the facilitation of comfort, dignity, mutual realization and the preservation and extension of human possibilities" not only for individuals, but "the family and their community and traditions" [1991:2]. She feels care necessarily focuses on the particular good of the one cared for" [1991:19]. These skills of involvement: becoming 'in tune with others', "skillful focused attention", listening and ethical comportment that is faithful to patient and family concerns, are learned experientially. [Though Purkis (1994) takes her to task about her explanation of experience and language].

For Benner learning was context dependent and contingent upon the development of skillful moral comportment [1991:11]. Ethical caring is not merely words, intentions, beliefs and values; [though as van Hooft showed these are important]; but includes attitude, touch, commitment, the orientation of one's thoughts and feelings fused with physical presence and action [1991:2]. This idea would overcome Morse's [1992] and Dunlop's [1986] critique that caring is often not concerned with the body.

Benner's ethic of care, the comportment she expects, runs parallel with the picture she gives of the expert nurse. It is as if she is saying: in being an expert nurse one is being true to caring. But not all care-givers are absolute experts. Care-giving becomes ethical when it is freely chosen, done for the patient's sake and embraces knowing a patient [and family] as persons and community [1991:3/4], a point confirmed by Nouwen.

Discussing the narrative of Dana Marshall, Benner [1991] reveals the importance of a spiritual dimension for dealing with suffering and death, where hope is mobilized, dignity preserved and the sense of control and autonomy is within the patient's grasp. She feels Dana's narrative is that of a beginner RN [like interviewee Diana's narrative - given later] filled with beginner's questions, but the experience transforms the nurse. She learns of timing, openness and the ethical obligation to the 'community of memory' [1991:14]. Again like Diana, it enables Dana to confront her own fears of suffering and death. The experience enables her to discover the worth of her work, and improve her self-image.

One can see family resemblances with Gaut's work but the concept of care can only be enriched by being embedded in practice and by having a strong ethical dimension. What must be questioned, for example, is how much understanding nurses have of ethical comportment.

4.2.3. Carol Montgomery

She studied the nature of caring: the nature of the relationships inherent in caring communication from the care-givers' perspective.

Montgomery's research background is relevant: one grounded in clinical practice. A psychiatric nurse for 22 years she realized her nursing had changed so much it no longer fitted within the frameworks of psychology and medicine with their emphases on science and objectivity. She "often suppressed her instincts and compassion". "Her clients affected her in deeply significant ways", but she "minimized these experiences because they "fell outside of [her] realm of understanding". She writes, "[M]ost of us who have worked with patients seem to know on some level the only time we have really made a difference was when we were willing to get involved in a way that mattered to us as well as to our patients: a way that went beyond the boundaries of theories, science, or the treatment plan". She reveals: compassion was viewed with suspicion in her discipline of nursing [1993:1].

Disillusioned with nursing she began studying. Her work refers to authors [Belenky, Jordan, Gilligan, Noddings and nurse authors: Watson, Gadow, Benner & Wrubel, and Leininger] who validated for her a way of understanding and helping; emphasizing the importance of relationships, connections, feelings and compassion. [1993:2]. Through reflection on these authors, what was at an intuitive level led her to understand more about her feelings, more about caring and inspired her to study communication in caring. This was a type of implicit communication she sought to make explicit through caregivers telling their experiences of caring [1993:2]. Other health care professionals are shown as care-givers too.

Her research centred upon the nature of caring communication in nursing from the perspective of caregivers, and what this experience was like for them [1993:2]. Informants talked about caring using stories. Contrary to her nursing experience, in her study, she learned nurses [her study participants] shared a language and common understanding about caring [1993:3]. She reveals her study participants were selected by others for their emphasis on caring. Nurses, expert in caring, were her initial sample. Her earlier study sought those who did not care but these were unwilling to be interviewed [1991:92]. What she found in her nursing experience was true in her study: certain nurses cared others did not.

She identified those who were perceived to care "but behaviourally did not present themselves as caring" and those who felt negatively about caring. These included "burned-out" nurses" [1991:92]. She drew from these groups and less experienced nurses. "What emerged", she writes, "as a theme ... of caring, was the experience of spiritual transcendence: experiencing oneself in relationship as part of a force greater than oneself". Caring included a deep sense of personal involvement [1991:92]. What she experienced in her previous care-giving relationships had offered little support for personal involvement.

Montgomery found that overt concern about communication skills and techniques did not teach nurses about developing particularly caring relationships especially where detached objectivity resulted in a lack of compassion [1993:15]. Patients required committed, competent and knowledgeable persons and their caregivers needed "sophisticated relational and communication abilities to handle a variety of interpersonal and relational challenges and demands" [1993:14]. She indicates how "relationships [can] become ends in themselves, rather than means to an end". She cites Thompson, 'Communication is the relationship' [1993:18] hence her concern about healing through communication as the practice of caring. She elaborates, "Helping clients to express and clarify feelings may or may not be helpful". Prudence [an interviewee] illustrates such non-helpfulness when she discussed the reaction of a client with AIDS at a home visit. In typical African fashion Prudence role-played using the harsh voice of her client:

> "'What have you come here for? If you have come to ask me how I feel when I was told I had AIDS go away. A doctor in the hospital asked me, 'How did you feel when you were told you had AIDS'? They always ask the same question. The same question. So I absconded. How would you feel? Please don't ask me that question".

Montgomery concurs with Noddings that caring is a natural capacity developed through experiences of being loved and protected, though she feels a natural capacity for caring is not enough to effect professional caregiving. This is important when looking at care-in-nursing. Initially, I can say that where this natural capacity develops in a person it should lead to volitional, emotional and cognitive desire to reciprocate care in a caregiving relationship. Ideal caring is tripartite: volitionally I care of my own free will; emotionally I care for the sake of an other and cognitively I should care intelligently.

Montgomery writes of the phenomenon May, [and many nurses in this present study], discussed. RNs who trained in the 1950/60's narrate memories of nursing where

1. they performed task-centred routinized basic nursing care; this normally meant bed-bathing; hair-, eye-, mouth-, and pressure-care. It was physical-bodily care, it excluded the idea relationship has since acquired.
2. they were not allowed to sit and talk to patients who needed someone to relate to and to listen to them, even when requested; no overt caring communication was allowed.
3. more attention was paid to physical needs than aspects like the emotional, psycho-social, or spiritual. Some were taught about these aspects in class but many found classroom teaching did not correlate with what was taught in practice.
4. the authoritarian manner of nurses in charge often dehumanized nurses and patients. [Peer group memories].

Many research interviewees were not mature enough then, they were without enough life experience, or, were too protected to be able to make sense of these negatives yet alone their own meaning at the time their narratives took place. Out of that era came nurses who wanted such approaches changed. They freely made significant choices [e.g. Montgomery, Benner, Watson, Leininger and many more]. Her term 'caregiver' describes the ideal: the nurse willing to care 'morally' to use Watson's word.

Other nurses who continued their daily practice in such environments as listed above, were denied the profound significance of experiencing themselves, in van Hooft's sense, as being-human with the possibility of constructing meaning, the chance of personal growth to a spiritual level of integration and the professional satisfaction and fulfillment inherent in having a caring relationship such as Montgomery describes.

She found the over-riding theme of [ideal] caring an experience of spiritual transcendance. She defined this as "experiencing oneself in relationship as part of a force greater than oneself" [Montgomery 1991:92]. This force was considered to be critical in terms of nurses' satisfaction; one that offered an explanation to the paradox of 'distance' and 'closeness' inherent in the helping relationship. This idea of distancing oneself from the patient in contrast to becoming close will be seen in interviewees' narratives.

Montgomery's paper is a discussion of the properties she felt formulated a spiritual dimension of caring. These were:

i) The nature of the connection;
ii) The source of energy;
iii) The effect on the care-giver.
These properties will now be discussed.

i) She discusses the nature of this connection, or relationship. The care-givers entering such a relationship feel a deep sense of personal involvement: it is a deep expression and relationship of oneself with another. It allows being emotional: revealing a depth of feeling, showing tears and sharing the silence discussed in the 'Paper Crane'. These care-givers, like those to be discussed, used words like 'unconditional love' and 'falling in love' to describe the depth of these relationships. They were willing to enter into, and be receptive of, the experience of the cared-for, not in terms of empathy, which Montgomery rejects, nor by setting 'boundaries' but in union with another: becoming one in the experience.

She discusses the concerns in connection with burn-out, the supposed 'cost of caring' [Maslach, 1983]. The conventional model of nursing involvement, she felt, was detached objectivity. She is emphatic that this connection with the patient was not at a level of doing something to promote the ego or feelings of achievement. Rather she understood this connection as something greater that went beyond self to the level of spirit, our common humanity that fundamental sacredness and unity of all life [1991:95]. It was volitional willingness to connect with a patient and to own the patient's experience where appropriate. It was part of a deep growth experience. As one participant described it: her caring was a 'sort of pulling from abundance', 'going with the flow', 'being there' [1991:97]. There was a spiritualness about it, a sense of ministering to the spirit of the individual, a relationship that went beyond the physical, that had the possibility of lying dormant for years [20 is the figure given by this interviewee].

ii) Montgomery discusses the source of energy required for caring, a source seen to come from outside oneself. It was, as she repeats, a 'pulling from abundance' that sustained the connection between patient and client. Consistent with Benner's idea about burnout is Montgomery's idea that it is not caring but the lack of caring that results in burnout. By not caring a person could not draw on this source of energy and become renewed, therefore burnout took place. A source of energy gave personal empowerment in the form of improved self-esteem, confidence, and inner healing. This, in itself enabled openness to others rather than distance and closure.

iii) The effect on the care-giver. Montgomery felt these care-givers had a philosophical or spiritual understanding that allowed them to face their own mortality and the possible inhumanity of others. This was within a pre-existing religious framework for some, others found deeper meaning when religious assumptions were challenged and faced. The implications of such exposure could cause a negative wearing down of the spirit, or, positively could enable one to gain wisdom. RNs would learn through this helping relationship to 'see people differently' and, 'let go' unselfishly. They learned intersubjectively from others, gained self-knowledge and meaning from the experiences. They expanded their consciousness. These aspects resulted in renewal allowing them to transcend personal loss.

4.2.4. Henri Nouwen

As a Harvard lecturer in psychology and theology and a priest, Nouwen writes meditatively in rich descriptive language of his lived experience of caring. His work is referred to because his 'wisdom' about caring comes from reflecting on nursing the mentally disadvantaged Adam [1995]. Nouwen gives insight into a deep meaning of caring, for example, he learns care means to 'empty our own cup', allow the other to come close to us, to take away barriers preventing entrance into communion with the other. We have to dare to care, open our ears to each other and form a new community. To show the kind and depth of nursing Nouwen was engaged in, Yancy [1995] comments it was the total nursing care of an epileptic: Adam. Yancy verifying what many said to Nouwen wrote, "This young man was considered a useless person who should have been aborted" [1995:120].

Applying Gaut's criteria Nouwen shows acute awareness of Adam's need for care yet little physical improvement [as she used this term] would result. Nouwen daily made choices in determining his nursing actions yet they did not bring about physical change. He could only hope Adam benefitted from the caring attention received. Nouwen writes of the total attention he paid to Adam's breathing, eating and his steps. But, it was Nouwen who benefitted from Adam: looking attentively for what could not be expressed. It was Adam who self-donated a gift of peace through being cared-for. Nouwen learns that caring becomes the privilege of every person. Caring is the heart of being human, of loving attention given to another: living and caring being one entity. He shows care is not because of need, nor for pay, nor out of duty but because of being in community. Not to be cared-for, Nouwen felt, leads to persons falling into the temptation of self-rejection or abandonment, having feelings of uselessness, or of being a burden.

Nouwen's notions of caring reveal something lacking in Gaut's conditions. They are not absolute 'sufficient and necessary conditions' for the employment of the term caring. They need the addition of the perceptions and language of Benner, Nouwen, Montgomery and van Hooft. The latter to be introduced.

We learn from Nouwen and Montgomery about caring through healing communication and more: that deep speaks to deep, spirit to spirit. Nouwen states that caring well for someone asks for a choice for us to use our gift to care. When we choose to use it, and offer it, then only does care become visible. The willingness to use this gift overcomes fears we may have about being caring. Like Sue Baier, Adam could not communicate with sound or speech. This is the most difficult, the most profound, way to learn the 'healing communication' Montgomery writes of. Studying Nouwen [as carer] we see Nouwen being healed through caring communication, not Adam. The meaning of caring for Nouwen was being made through his care of Adam. Like others he found difficulty in articulating the experience of caring, but he learned it revealed who he was, who Adam was, how they could love each other through ministering and being ministered unto and how the one could complete the other reciprocally. Baier's carers failed to learn these aspects.

Nouwen discloses how he also learnt 'The path of peace' through nursing Adam. He states, "There was a mutuality of love not based on shared knowledge or shared feelings, but on shared humanity" [1995:14]. Caring for others is seen to have such value, a value Watson [1979] validated as 'the moral ideal of nursing'. In her theory of nursing she identified human caring-in-nursing such as Nouwen portrayed: human care and caring requiring personal, social, moral, and spiritual enagagement of the carer and a commitment to oneself and other humans [1979:29]. The spiritual dimension Montgomery identifies and the ethical attention of Bowden are seen in his narrative.

4.2.5. Stan van Hooft

van Hooft [1995] wrote a philosophical essay on caring. This essay is useful in determining whether deep caring, as he calls our capacity to care, is in fact innate or not. It seeks to answer whether the meaning of caring is learned, the result of transcendent reflection [an ideal having a spiritual dimension] or a meaning enabling us to become complete beings.

If meaning is only made as we learn to care then caring is dynamic especially in terms of defining ourselves.

He approaches the concept 'caring' by phenomenological descriptive analysis: giving critical attention to his own and others' concrete experiences, specifically in regard to caring. His experience was concretized in teaching first year nurses. van Hooft accepts the insights of others, including classical writers, as guides to understanding particular concepts. He uses these guides to validate subjective interpretation of a concept other human beings share. He sees persons as bringing their own presuppositions, experiences, feelings, mind-set, and perceptions with them. He feels this 'baggage' where "a human being is constantly oriented towards the future and acting from out of its past" [van Hooft, 1996:84] affects a person's caring processes.

van Hooft shows caring about others, caring communication, even what he calls 'prereflexive ethics' comes from being a human being. As human beings we function on "at least four levels of formation and interaction which must be, in the mature person, integrated so as to constitute the wholeness of that person" [1995:48]. These levels he gives as: biological, perceptual and reactive, evaluative and proactive, and spiritual levels. Their application was made earlier under Gaut when discussing Sue Baier.

Nurses engage in behaviours, mental and physical activities, states and dispositions that have a mental basis. Like Bruner, van Hooft feels these behaviours, states and dispositions have meanings constructed through the culture of nursing. This culture and its language structure nurses' thinking about nursing. These meanings form but should not determine what we are as humans, nor what we are as nurses. For example, when a nurse does not care well in a behavioural sense, when s/he is not present to persons in the fullest possible way, this lessens human potentiality and is a result of a lack of courage, failure to understand the situation and the appropriate action necessary [van Hooft 1995:38]. Her failures are not determined by her culture.

Being a human being is realised in the way we do things as well as what we do. He says, "We understand ourselves when we understand what we do, feel and say as an expression of the kind of being we enjoy: namely, being as caring" and further on, "One invests oneself in what one cares about" [1995:8].

As has been mentioned he posits four levels of functioning that determine what being human means. The biological level constitutes the human being as a dynamic organism with a genetic make-up, metabolism and a specific relationship to the environment. The perceptive/reactive level enables us to cognitively orient ourselves through learned patterns of cognition, behavioural and affective responses. The evaluative/proactive defines us as reflective and active beings. In his opinion when one is mature and integrated, jointly these levels constitute the basis of our attitudes and communication and so forms the wholeness of a person. Integration of the four levels occurs at the spiritual level. The person for whom I care, at this fourth level, can be a completion of my personal identity because it is through persons that persons are defined. In this, his philosophy runs parallel to that of Thomists.

van Hooft attempts to plumb the depth of these meanings through his analysis of caring. His insights are useful for the philosophical contribution made not just to caring as such but, to caring in an ethical context. Ethics is seen as an expression of our deep caring. It is a profound thought that out of what we are, described by the way of life [nursing] we are committed to, our more focused and specific caring arises. He cautions that if we fail to confirm our attentions genuinely, or confine them only to the first three levels then we constitute ourselves as diminshed beings: we fail to give life meaning and others are constituted as reduced objects to be cared for.

van Hooft's work demonstrates that nursing in a behavioural sense [merely meeting needs in a routinized manner] is not a mental process unless it involves volition. When nursing is routine it is object-directed and its activity is determined not by oneself but by others. Nursing caringly becomes akin to desire and belief: it consists of affective and cognitive domains. This enables me to make sense of the idea that nursing must be embedded in mental activity. There are two directions for these mental activities: one is our selfhood. When activities are authentic, they express deep caring for our own selfhood. The other direction is caring for others. Our volition, attention and communication comes about solely through desire guided by an inchoate deep caring. Learning routines or role modelling others can lead to action-guiding norms at a perceptive-reactive level. However, personal meaning making only takes place at the evaluative-proactive level. This latter level indicates responsibility and being responsible in itself defines our being.

Communication expresses our being in relation to others. Where there is not this open communication, such as Nouwen described, there is self-withdrawal. Active, affective and purposeful engagement with others sets the agenda for communication. Reflecting upon, and knowing whom and what we care for is one of a multitude of means for discovering who we are and what our beliefs are. Through communication, we establish community, but this does not become our satisfaction, that only occurs at the spiritual level. At this level, we ground our faith, affirm our lives, unify meaning, and create our aspirations. In this, we realize our spirituality.

4.2.6. Peta Bowden

Bowden is also a philosopher. Her background has been given. She gives further examples of accumulating understandings and ethical possibilities from the paper she originally entitled "Caring attention: accumulating understandings" [1998]. She changed it to 'Ethical attention'[14]. This article investigates a perceptive-theoretical dimension of caring- attention: a cognitive disposition that her referees highlighted as an ethical dimension, hence the change of title.

Bowden found empiricists, acting on observational experiment rather than theory, gave words like caring-attention a neutral non-ethical meaning. Language philosophers have analyzed, according to Bowden, caring-attention under a multitude of classifications: as an act, operation, a process, a mental state, an experience, or a skill. Whatever classification,

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[14] Bowden P L [1997b] Personal correspondence: Sept. 1998

many [like Gaut] fail to catch the subleties, complexities and anxieties affecting role-players when analyzing the subject [1998].

'Caring-attention' is taken in this thesis as an additional necessary and sufficient criterion for caring: an added layer of understanding drawing out the affective domain. Caring attention is seen by Bowden as

1. Getting the 'feel of a situation'.
2. A cautious moving towards persons in thoughts, emotions, and imaginings.
3. Multiple ways of seeing and the need for contextual readjustments.
4. A waiting patiently in sensitive 'openness' until gradually the light dawns [1998:59].

The 'openness' Bowden discusses (from Simone Weil's writings) allows answers to come directly to a mind unencumbered by conditioning attachments. A mind profoundly open and receptive [1998:60]. These four points and the 'openness' contrast with Diana's [discussed in next chapter] mind where she tries to force, or will herself, to attend caringly. Had Diana been operating at van Hooft's four levels, or shown more maturity, knowledge and perceptiveness she may have been open to the patient during the physical 'doing' thereby allowing the patient to reveal her felt vulnerability through some means of communication.

Bowden [1998] feels that caring-attention is not demonstrated by classing it as an act, operation, a process, mental state, an experience, or a skill. The characterisitics of caring-attention are wrapped in what she feels can only be "moral feelings or impressions both of which can be ambiguous or vague" [1998:59]. Yet, I feel authentic carers experience these characteristics when they seek to care with ethical-attention to a person. This should be the meaning of Gaut's 'attention or concern'.

Bowden is not calling for an ethical theory. Instead, arising from the "difficulties, intricacies and vulnerabilities" she seeks to describe a quality of attentiveness enabling the sorting through of relationships with people and the situatedness of their lives [1998:60]. This 'sorting through' involves a type of 'self-effacement', or as Susan□ puts it: 'not putting yourself onto people'. Caring attention is aimed at removing "attachments to persons ... that we form for our own sakes rather than from any sense of those person's ... own intrinsic worth" [1998:61].

In total contrast Barker and Reynolds, mentioned at the beginning of this chapter, criticized Watson's caring ideology: of caring being a science. They felt Watson was writing of caring as some kind of magic. They claim caring is actually harmful to the cared-for because of selfish emotional reasons on the part of the carer. Caring, as Watson described it, they feel, is far removed from the traditional conceptualizing of interpersonal processes and is unlikely to be even therapeutic unless there is a cognitive-behavioural ability to develop such relationships [1994:17/18]. It is hoped the accumulated layers of understanding about caring contained herein, will go some way to refute the idea of caring being magic, harmful or merely cognitive-behaviour.

4.3. Reasons for choice of authors

The authors chosen and discussed refute this critique: from Benner's domains and nurses' accumulated experiences we could obtain a science of caring [though Purkis (1994) may dispute this on the grounds of an inadequate treatment of the power inherent in nurses' language]. Montgomery delineates a therapeutic communicative relationship. The other authors reveal that through caring we become more, not less, of a person. Our inchoate capacity to care leads us to discover more about ourselves, particularly our spiritual level.

It was said these theorists were put in a distinct order. This order demonstrates the layers of understanding of caring. As they are accumulated, the concept 'caring' becomes progressively deeper and more meaningful. This is not a criticism. These different authors arrive at their understandings of the concept care/caring having different beliefs and perspectives. These include particular research methods, lived experiences and reflections. The deeper the involvement, Montgomery admits, the deeper they draw from their own experiences and reflections, the deeper their analysis and conceptualization of these terms.

Gaut limited her questioning to how scholarly literature compared with 'normal' usage of the term 'caring'. She was asking within this parameter 'what do they mean' when they use the term. She sought evidence along these lines, but she studied care/caring before the ethic of care industry gave new meaning as to how caring was understood. Her study resulted in a conceptual and active meaning for nurses. This meaning has been applied to determine whether her 'necessary and sufficient conditions' were in fact enough to explain the topic and were found wanting. To enrich the topic we need the layers of understanding accrued from the other theorists.

Benner obtained her 'feel' for caring through the multitude of interviews she and her colleagues recorded and interpreted. Their judgements were used to evaluate expert nursing and quality caring. When a narrative was given, good or bad examples were evaluated accordingly. From this plenitude of material, their understandings and their own experiences, they could make lists like that of the 'helping domain' when discussing caring. As a result, a perspective of what constitutes caring is given by Benner. She and her colleagues are informed by and informing, shaped by and shaping, the 'primacy of care' within an ethic of care. They give nursing a meaning of caring firmly embedded in ethics.

Montgomery enters the debate from her personal dissatisfaction with traditional nursing. Entering research and interviewing a general range of care-givers results in identifying predispositional qualities, seeing caring practice as healing through communication and the transcendental aspect of caring relationships. What has not been mentioned is her data was obtained by using a naturalistic grounded theory approach. She became involved by immersing herself in the experiences of her 35 interviewees chosen as exemplars of caring. From what she writes, and her style of writing, they seem to have called forth a like caring spirit within her.

Writing from the perspective of his 'hands-on' caring of the severely handicapped Adam, Nouwen reveals a practical application of van Hooft's philosophical cogitations. He shows how caring calls forth a community, a family and a particular individual. His meditative thoughts are profound. He experienced deep calling to deep. He grew as he 'pulled from abundance' and learned the deep meaning of caring through his lived experience of caring-for Adam.

van Hooft was not merely interested in clarifying concepts but in value questions, about what was good in the practice of caring and what it is to be human. His concern is for a solution to the crisis he sees in morality. This he addresses in his sensitive essay on caring. His understandings come from his own and others' experiences and thinking that are structured by shared culture and language. He discusses deep caring as self-project and caring-about-others. He wants us to understand ethics as an expression and feeling of this deep caring so we can be led to a new view of the meaning of traditional morality and of our freedom as ethical agents.

Within the context of reflecting upon teaching philosophy: our being in the world, professionalism and commitment to first-year student nurses, Van Hooft uses a particular ontological and language method [the use of verbs]. He handles human caring as inchoate, as a guiding principle, an ethic, and a condition of being human. He weaves the theory, like Gilligan and Noddings, into moral development, and, like Nouwen into the very fabric of life.

4.4. Conclusion

It was said that Barker and Reynolds could not fathom the scientific about the term caring. If I care according to my accumulated understandingss of the given authors, especially with the ethical attentiveness that will be discussed, I believe I cannot ask for anything more scientific. If by being scientific means having one definition for all caring, they were right for one was not available, nor ever should be. These collective views are necessary to juxtapose interviewees' examples and criss-cross them with theorists to find similarities and dissimilarities, to determine their language and meaning and to show how their meanings compare with these authors. In this, there is a scientific approach to developing understanding.

In summary, there is not one single meaning of care/caring but 'accumulated understandings' from different perspectives. Bowden felt nurses were in danger of impoverishing their own ethic. Her concern about the rectitude of nursing and its ethics led her to give a framework for obtaining a 'survey' of examples to accumulate further understandings. This will be used in the next chapter.

The next chapter enters fully into the research process. It engages with nurses' narratives. This is done firstly by writing a subjective lived experience, then by introducing interviewees and obtaining their narratives to understand their meanings, attitudes and practices towards care/caring. Interspersed with the interview excerpts are interpretive comments to highlight specific points. Once the discourses have been engaged with in this manner, then what they are saying about care: practitioners' attitudes and beliefs towards their practice, their ways of understanding care are explored.

> To care means first of all to empty our own cup and to allow the other to come close to us ... to take away the many barriers which prevent us from entering into communion with the other. When we dare to care, then we discover that nothing human is foreign to us ... Through participation we can open our hearts to each other and form a new community.
>
> Henri J M Nouwen [cited by Coulson,1979:81]

CHAPTER FIVE: The discourses

5.1. Introduction

This chapter takes interviewees' discourses and derives from their use of language their meaning of caring-in-nursing. By evaluating the insights of research participants with those of theorists, it is hoped to substantiate their meanings.

The chapter is in four sections: a subjective account of my own experience of care-in-nursing□, the narratives of the first group, Bekkare's narrative within a particular cultural setting [used as a paradigm case] and lastly, the main body of participants. Each section has a preamble, introduces participants, followed by the narratives. Those from the same type of unit are given together to give a picture of the socio-cultural context of these units. In some respects, there is a veiling of participants to maintain confidentiality but as much background as possible is given.

Section I:

5.2. A subjective account[15]

Toner [1968] approaches definitions of love through a descriptive analysis of his own experience knowing there would be 'something common' in his experience with that of other persons. Having given a subjective analysis, Toner goes deeper he gives all the elements seen as aspects of the concept 'love' to find the central notion of love. Finding these elements was only possible, he felt, by critical attention to one's own concrete experience of loving. What I am attempting to do in this section [and later under other 'elements'] is similar to Toner's approach: I am trying to find through this and interviewees' narratives the central notion of care. I relate this narrative to search for the family resemblances in this experience when compared with that of other persons. It was not written lightly. It was written before attempting any analysis in order to understand care and what it meant to be a person. These two elements fuse. I realise it forms part of my value-commitment [Lather in Street, 1992 discussed. earlier].

5.2.1. Introduction

Needing to write phenomenologically upon memories of caring and being cared-for I 'empty my cup' as it were. The result has similarities with the narrative 'Dana' given by Benner [1991:14]. The memories captured are typical of experiences of nurses who trained in the 1950/60's. It reveals attitudes and actions expressive of the ethos of nursing at that time. Caring, although not the word used, was deeply inherent in the concept and context of our

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[15] Already and subsequently referred to as Diana for convenience.

nursing. Although the official ethos was militaristic and authoritarian, some nurses often found that human 'engagement' of which Watson, Benner, Montgomery and Noddings write. These individuals 'gave themselves permission to care' [Jean: a research participant].

The narrative reveals how personal growth occurred through nursing as well as a developing spiritual dimension. It shows no one can enter into the emotional, or psychological realm of another unless one's own person has been discovered. It shows mutuality, that of reciprocal giving, unfolding as I gave of myself in caring for particular patients. Another's inner life became a life for me. I became more of a person through another person who had already 'become'. The silence inherent in the narrative must be listened to. Some words are not written but, they are there: silent and deep flowing from one person to the other.

5.2.2. Early nursing days

As a student, it was taken-for-granted nurses would regard patients as human beings. Psychology was not taught. Aspects like self-acceptance, self-respect, self-awareness and self-actualization had not come to classrooms. A nurse could not talk to patients person to person. It was not allowed. If we did talk for what appeared to be too long, a sister's voice asked what we were doing, or did we not have better things to do? Yes, 'better things' were the words used. This implied cleaning the sluice room, dusting the ward, tidying cupboards, cleaning trolleys: wheels and all.

Patients were attended to physically. Often not referred to by name unless one deliberately chose to do so. They were diagnoses in bed such and such. Our handling of patients was body-centred, routine and task-centred: washes, bedpans, observations, drips, dressings ... One met bodily needs. Interpersonal skills were not taught. Communicating with patients having social problems or concerns was Sister's job, contrary to Nightingale's advice to nurses: "Always sit down when a sick person is talking to you, show no sign of hurry, give complete attention and full consideration if advice is wanted..." [1952:8]. But, we did talk. We communicated sympathy [empathy had not been 'invented'], expertise, confidence, hope and healing over a dressing, or even during a bowel evacuation, or skin preparation prior to operation. But, we were not allowed to sit.

We learned and portrayed an increasing sensitivity because patients' illnesses taught things not in textbooks. Patients taught us about pain, sadness and grief, comforting, joy and relief. We learned to minister to people's physical and emotional needs: verbalized or not. The physical is emphasised because when I first began nursing I did not know how to converse deeply with people. What could I talk about? I learned to listen. I asked questions and listened to the answers. I would use these and test them out in conversation with others. My repertoire of conversation topics, and my ability to understand what someone felt, grew. I learned from others' experiences.

5.2.3. A test on life's experience

Whether others are tested on how they learn to become more of a person I don't know but the following is a test that has stayed with me: one showing how little I knew about the real world. How little I was prepared to face emotional or spiritual pain, or even my own mortality. How little nursing had prepared me for dealing with dying. It was a test situation I would repeatedly undergo in subsequent years. It reminded me of the painful process of becoming a nurse.

One evening, as a fourth year student awaiting registration, I admitted a mother in her late twenties. She had Botulism. I will call her Mrs Parke. On admission she could move her upper limbs, breathe, and speak, though it was an effort. When I left her, nothing moved: not her limbs, nor tongue; only her eyes. Throughout the night I did not know what to say to her. I thought of her youth, her children, and her dying. What could I, a twenty year old single nurse say? I who took my aliveness and health for granted.

Intentionally I kept busy in a legitimately busy medical ward. We had acutely sick patients, some terminal, like Mrs Britt, a lady with cirrhosis of the liver. She was, what some called 'a classic text-book case-study' of her condition. She was jaundiced, and scratched, despite medication. Her limbs were covered with peticheae. She knew she was dying. We talked about death, not that night, but on others. We talked a lot after this incident. She would be awake and although everything possible was tried to help her sleep it was to no avail. There was a mutual comfortableness with her. I began to see her version of reality. She preferred to have someone to talk to. At least that is what she said, when I suggested I should go for her sake. I learned things about life and death. She was prepared for the latter. Not that she sat and taught like some Buddha, but what she did say I pondered upon, and through reflection I learned. I am writing about the time when patients stayed in hospital for months and nurses did six months night duty at a stretch: twelve nights on and three off.

That night a lady on the 'verandah' had a blood transfusion reaction. On a round, after all were settled, I sensed something wrong. The patient was having rigors. She was frightened and unable to move to ring for a nurse. She had had penicillin some days previously and developed an allergic reaction. Her skin formed blisters as big as half tennis balls almost full skin thickness. Dealing with this crisis kept me busy. After that things calmed down. Yet, I was unable to speak to Mrs Parke, the lady with Botulism. The reality was I avoided her. I had neither been taught, through previous socialisation, nor nursing, how one communicated with a person who was progrssively becoming more paralysed.

It seemed unfair. To whom did one bring this rebuttal of unfairness? These thoughts, and questions, were present but there was only emptiness to draw upon. What did I know about how it felt to be dying? Did she know? Had 'they' been honest with her? Doctors did not always feel patients should know what was happening. Doctors were paternalistic: that word was learned later. Patient advocacy was unheard of.

This thinking took place whilst ministering to other patients. I was not aware one could just 'be there' for a person by sitting silently; doing nothing, just being there; what today is called the 'therapeutic use of the self'. I realise now that this dying process was an immense struggle of vulnerability: helplessness, powerlessness, and utter dependency.

My questioning went deep: what does one say of comfort, of spiritual use to such a person? The spiritual was another aspect not taught. Was 'comfort' appropriate at this time? Was it I who wanted comforting? How did one feel not being able to say what one wanted? Is one finer tuned mentally; is one more sensitive if one has no physical feeling? Did she stop being a person once she lost these abilities?

To this day, I regret my inability to render this person anything more than routine basic nursing care. We nursed her to our fullest ability: pressure care, a bed-bath, warm linen [warm sheets and bunny blankets in the winter because I had been taught to put them into warmers in the kitchen]. Mouth, teeth and hair care were given. No-one could have been given nursing care more tenderly, more competently. Vital signs and observations were meticulouly done. However, no one did anything about the readings. The doctor merely stood about looking grave, and giving orders. My team and I gave of our utmost, but we knew nothing about the psyche -not one lecture - or sociology; certainly, no ethics, and the doctor gave no enlightenment.

Some nurses would call her a 'good' patient - she demanded nothing. How could she when she could neither move nor speak? We had been told the paralysis would strike her respiratory muscles. What we had been taught was the physical the emotional and spiritual came from learning to 'read' patients and understanding that their backgrounds influenced their health. The World Health Organization [1947] defined health as not merely the absence of disease but those social, emotional, psychological that we saw from experience to be necessary. Why were we not taught this?

Section II: The first group

Research participants were not pre-selected. They were interviewed because they were conveniently 'there' and willing. Referral sources had been asked permission but no selection by 'gate-keepers' of those 'seen to be care-givers' took place. Discussion about these interviewees takes place after all the discourses. Iinterpretation of the narratives is given and linked with other aspects of care/caring.

5.3. Personal introductions

5.3.1. May

Introduction

I was observing, listening and reflecting in the Oncology unit of a State hospital. I had talked to one RN on the ward about this research hoping for an interview. She asked the topic and said, "We're too busy to care in here". There was a particular ethos in these wards, much like Street's [1992] medical dominance. One example illustrates:

It was Christmas time and busy. Some patients had asked nurses if they could go home. Only when a female Registrar announced loudly from the Nurse's station, "The breasts can go home" was action towards this end taken. The ethos was of an aggressive medical attempt to cure patients; many were desperately ill. Some were dying. Some had been 'dumped' [in the sense that Wright [1981] uses the term: chapter 2]. Relatives did not want the heaviness of impending death hanging over Christmas festivities. Many were thus denied that spiritual 'wholeness of somebody who belongs somewhere' [Wright's interviewee].

This ethos, combined with the difficulty of interviewing RNs, affected me. I needed to discuss the ward with someone. The Sisters in the ward were unavailable. Were these wards always medically dominated; were nurses always waiting to be 'ordered to care' as Reverby

[1987] felt? Observation showed that nurses were without authority to control institutionalized or bureaucratic activities. It was expected duties would be performed according to orders and not as autonomous self-directed agents.

In uniform at the Nurses' Station I reflected on this. A Chaplain approached asking about a patient. Seeing her name-badge I knew she would be aware of not just this ward, but the hospital. It had been recommended that I talk to her so I asked for an interview. This was granted immediately.

May's discourse

I walked out of the unit with questions, and the words "the breasts can go home" ringing in my ears. I asked May what caring meant to her. Implicit in her reply was the view that care had negative overtones. She discussed why positive care was absent from wards. The main reason for this lack of care, she felt, was nursing's quest for professionalism. I found this statement puzzling, not realising May would speak from a nursing perspective. "Are you a nurse?" I asked. Receiving affirmation, I learned she had nursed for most of her career. She left a State hospital to run a nursing home for the elderly. I felt that as a nurse and a chaplain, she would clarify the concept 'caring' and give it meaning. My mind-set was of someone who would objectively give meaning to the ethos of that oncology ward.

In her nursing home she had increasingly became aware of a spiritual dimension and this led to an interest in chaplaincy work. She said,

> "[T]here was much more behind the eyes of the people that we were looking after than plain nursing".

She realised,

> "we had to adjust the bare reasons for living, their patterns of living, and what purpose [the elderly] could find in their present state: continuous, glorious old age. And, what was happening to their families, roles, their relationships and situations: father and wife. At least take care. All of that had to be addressed if we were going to have a nursing home where that was what caring was about".

May was discussing elements of the spiritual - an emphasis she wanted for her nursing home. There was more to these elderly people than the physical. Nouwen's book emphasizes befriending death. There could be purpose to living because a person "dies well through being cared-for well". May's nursing enabled these patients to befriend their death. She "cared well" by allowing others to die well according to Nouwen. May felt relationships with others were important for elderly persons' continuation as persons. She prepared others for death by establishing togetherness.

But, she remembered, that if she sat on a bed talking to a patient that was 'wasting time'. As the matron of her old age home she could now decide:

> "if my staff want to sit on the bed talking to the person I call that nursing"

She felt professionalism was over-emphasised:

"I think we need both. And I think care is an attitude of a vocational aspect".

May discussed that she felt nurses were saying they did not see nursing as a vocation but a profession. She felt nursing, which she saw as a vocation,

> "had thrown the baby out with the bathwater".

My mind was asking, "What has this statement to do with caring? In answer to this unspoken question May stated:

> "if you take the vocational out of professional nursing you take care out. If you focus on one's own skill in nursing and you take out one's attitude to caring and love then you are going to lose caring".

May used the word 'if' twice showing if someone took the vocational out; if someone focused only on skill in nursing [said with the idea of fixating upon these skills in the sense of nursing expertly but without displaying care] then a non-caring disposition would be produced.

Listening to May I would have to say she saw nursing as a vocation and a profession but without stress on professionalism. The danger, as she perceived it, was an imbalance between professionalism and caring. This imbalance would put an emphasis on rules, policies or imputed standards of care and not on the person-to-person [intrinsic] aspect of care.

May believed a felt calling was the reason many took up nursing:

> "I felt for them sometimes. They came wanting to change the world. They came with a vocation needing to be developed and they would not give up. It was vocational work".

Her narrative shows her using the terms nursing and caring interchangeably. She reveals too, as Frieda does that caring can create negative images. This implies an inherent standard of what 'good' care means. When she discussed the lack of care she discussed shortcomings in that standard. Care was more than an attitude, it was a desire to do to someone something beneficial, and ideally done for the person's sake.

> "But in these days many nurses are battered. They are trying to care but because they themselves were not cared about they internalize socially and they are struggling to survive. Nurses used to be respected. Now they are not. You were seen as someone who was willing to work long hours, willing to give of yourself. Attitudes to nurses have changed. Things were changing socially. If you are not cared for you will not be caring".

This discourse concurs with Noddings [1984] that if a person is not cared for s/he will not be caring. But these attitudes could be the result of 'dumping'. The aftermath of years of 'negation of self, denial of personness, and the destruction' that came from the Apartheid era of which Wright [1981] wrote, "[W]here potential had been destroyed, where people had been meek, submissive and not their true selves". Now they had changed but these changes were still becoming socially acceptable.

Replying to my question as to what had changed May felt:

> "Nurses then had integrity. Patients trusted them. Nurses are not trusted as they used to be. Now they strike, ... they lose all dignity ... They have lost all respect. So it is a vicious circle. If you are not trusted you are not trust-worthy. You are not respected. You were seen as someone who was doing something worthy. Now you are not. There is a roughness, not care".

May comments on the hindrances to caring amongst Black nurses. They come from so far, they have to get up early, run their families, see that husbands get to work, children to school, all before 7 a.m. when they themselves must be at work. Then it is all reversed as they go home after 7 p.m. and have to cook and get children bathed and to bed, and then prepare for the next day. It is hard on them. On top, many have their own family problems to cope with".

This daily agenda is what Wright [1981] explained as the meaning of the word 'survival' for the Black population.

I asked May how she understood the terms 'person' and 'health':

> "To me healing of the body isn't sufficient, to me the body is the flesh in its health and inner state. If you just heal me, the outward flesh of an inner injury it will either recur again or appear in some other sign because ultimately the whole person has got to be healed. And if a nurse was involved at that particular time in that particular way it might be that caring is then surely given. As in the example of an alcoholic person. It would be more than the body that would need healing. Hopefully the nurse would identify the person's mental state ..."

May stressed healing the whole person. It could

> "occur at night when people could not sleep, when there was fear, or unspoken things, and there was a need that could be filled by someone caring. Being there and talking of spiritual matters. Not evangelising, but meeting the person where they were. And that's caring. Caring really is getting alongside the person with healing".

She said these days nurses made so much noise. She described how she visited wards at night and found nurses listening to the radio or some form of music. This non-caring attitude was dominant and concerned May deeply.

5.3.2. Sister W

Introduction

This nurse, though known to be strict, had senior students wanting to work with her because of her method of teaching ward administration. Working with these students I found myself echoing their opinion because she had a wealth of experience about nursing. She agreed to being interviewed but at her home after her retirement. I can put first name pseudonyms to all research participants, except this sister. Perhaps it is because of her exceptional professionalism - a professionalism that combined with the vocational in the way May had wanted. This lady is Afrikaans. Expressing the meaning of concepts in English was not easy for her. I had given her a copy of the questions previously. She wrote the answers prior to the interview. I told her she could use Afrikaans as I could translate. She uses both languages in the interview.

Sister W's discourse

Care, to Sr W, was being calm in the midst of crisis when something wrong was occurring to a patient, or, in the presence of others' panic, being reassuring and gentle.

There was a religious and spiritual dimension in her caring. She mentioned the comfort of prayer and of having been cared for herself by a nurse who was a Christian. She stated the sick must be nursed as one would have nursed Jesus Christ if He had been sick. Praying for a patient was caring.

To Sr W basic nursing care was caring the right way: with knowledge, skill and particular attention to detail. It included physical aspects as well as respecting a person's dignity. It was being observant of physical needs and meeting them without being told. It was developing a good relationship between nurse and patient. A relationship where the patient could

> "freely tell a nurse how he felt, what he was worried about and things like that ... being friendly to the patient. If you are not friendly the patient will not feel free to talk to you. If you are friendly ... you start talking ... then the patient says 'OK I can talk to this person she will listen to me'. You must be able to listen to your

> patients. That is also very important. And to keep quiet when you think they need quiet".

She felt a caring attitude or caring skills were not intrinsic to nurses.

> "Perhaps", she queried, "because they were not taught enough, or they were not taught the basics, whatever, it was not applied when they came to the wards".

Fulfillment in caring was nursing someone from the day of admission to the day of their discharge. This continuity of care she found rewarding. So too when nursing someone expected to die, especially if that individual was a child. The reward lay in using one's caring knowledge and expertise so that the individual was restored to health.

In the first twenty years of her nursing career, up to 1970, Sr W felt she had obtained job satisfaction. Thereafter she felt, like Montgomery, that nursing had become scientific. In asking what changes she would make to nursing her reply was,

> "Bring nursing back to earth, do not get scientific. All a really sick patient expects from a caring nurse was to feel safe in the environment; well cared for; and that relatives be fully informed of the whole situation".

She obtained her satisfaction, after 1970, in training students on the ward. Seeing them grow from being first year students to knowledgeable fourth year nurses. This growth would come about through basic nursing care. They would also learn discipline. By this she meant if one was not disciplined one could not be organised.

> "One cannot work or learn in an disorganised place where everything is in disarray ... Discipline and organisation go together." [translated]

It was this organized approach that most students liked and wanted to learn, though some bucked at the discipline. On the positive side she found students wanted to know: patients' diagnoses ... treatment ... medications. They wanted to expand their knowledge. They requested to go on a ward round and would ask questions that helped them understand what the diagnoses involved.

> "You must have time to answer their questions".

The reality was that nurses in general, and these students in particular, were concerned that if they missed their transport getting home became problematic. This revealed a negative side but one that was reality:

> "They are anxious because they might be late for the train or transport problems, or things like that".

Discussing ward management Sr W. felt:

> "The sister in charge of the ward was in control of the work of the ward, not in the way that you are in control and what you say is final. You must have everybody else's say. You must take everybody into consideration in your ward. The acting sisters, the clerk, and the floor [cleaner] because the ward is a team and they are part of the team pulling towards one objective: seeing to nursing care. Adherance to routine gave patients the feeling nurses cared".

Patients had returned saying: 'Thank you, you people are still caring'".

5.3.3. The breakfast group

Introduction

During the research journey a meeting was arranged with a hospital Chaplain, hospice Doctor, hospital Social Worker, the Mother of a newly qualified nurse, and myself. This group usually met for other reasons but, with my research explained to them, they were willing to be interviewed during breakfast [hence the name]. The interview, though on a small scale, reveals a mother's and health care professionals' perceptions of nursing and caring. They give insight into what patients look for not just in nurses but in the hospital environment. This interview validates what the first three nurses say. It gives a multi-disciplinary and public perception of caring in nursing.

The persons interviewed had worked with nurses, or were aware of the role of nurses. The doctor [HD], although retired, was doing sessions at a hospice. He had been a medical superintendent of a 400-bedded hospital, and in an administrative-planning position of a larger academic hospital. The social worker [SW] was involved in teaching social workers at a University and in particular guiding students in research projects. The chaplain [HC not May] had wide teaching experience (teacher training, counselling skills, teaching listening skills, and moral development courses). There was the mother of a nurse [MN].

The Discourse

The preamble was the idea: everybody cares; to care was a natural virtue. I was playing 'devil's advocate'. At this stage I was not fully committed to the idea that caring was a natural capacity within each one of us; or that everybody cared. My own experiences raised questions within me: if this capacity to care was inherent within everyone, [a notion new to me], why did we not see it expressed everywhere? Why were so many non-caring stories told? It took time to assimilate, to realize one was talking about the ideal. What was being said by those who wrote in this vein was that we are made with a capacity to care: like our capacity to learn any language but, it may not develop if not nurtured.

What needed to be looked at, at some stage, was why caring was diminished or lost in some individuals. Having read Noddings [1984/8] and hearing May give examples of diminished dispositions for caring, I realized the need to reflect on reasons for negative caring. Like Montgomery I saw nurses as caregivers theoretically; but, from looking at actual practice my attitude towards the way nursing was performed by some was becoming sceptical. I saw and felt, as a result of my own hospitalization experiences during this research journey, that caring, for some, had become technical, depersonalized, automated and rule-following. Were all who nursed caregivers? Would Montgomery's predispositional qualities stand if I used them to scrutinize all nurses? As Interviewee Cindy says,

> "Some nurses just want you to tell them what to do, and they do it, without caring".

At this stage, close on feeling ashamed of my profession, I wanted to know what other health care professionals were thinking about nursing. This interview was exploratory, one that, like those above, gave direction.

I commenced by asking what the doctor thought about doctors nursing. He said I was questioning the converted, the average hospice doctor did not see his role rigidly defined or separate from that of a nurse. The whole team concept, he felt,

> "Was on the basis one did what one was trained for, what one's role was defined as, but one overlapped into the fields of other people and found a way of doing that without causing offence. The ordinary hospice doctor would, as he had, give a patient a bed-pan if that was the patient's need then and no-one else was around to meet the need".

Tasks each team member did tended to be fluid. Some were defined others not. He felt there was no demarcation line in a hospice: "this is your job and this is mine, or, this is your problem and this is mine". A problem was sensitively shared. Legitimate tasks and needs of other professionals were not infringed. Each team member became involved in counselling in a hospice. Neither doctors nor nurses took over the whole social worker role. I asked him to go back to his ordinary hospital days and answer the question. He replied,

> "There, the work tended to be in rigidly defined roles from both the doctors' and nurses' points of view. There was a jealously guarded role pattern, which did not, in my opinion, work in the best interests of the patient".

He felt whichever health care professional was working with a patient, that person should

> "have the patient's best interests at heart: to do, or be, for the patient, for the patient's sake alone".

He sometimes felt the patient was between doctor and nurse.

> "Professionalism, and striving after academic excellence, made the patient merely an end-point of the whole activity and resulted in not seeing the patient as a whole person to be cherished".

He felt this was a fact of life. I picked up his use of the word 'cherish'. His view was

> "Health care professionals should be professionally competent. That was the least the patient required. But the job was not being done properly if the health care professional was doing the job coldly. It had to be done with the heart as well as the head".

Semantically he did not want to use words like caring or nurturance. To him it was a matter of feeling rather than thought.

The social worker entered the discussion. She was interested in the word 'cherish' in the context: a 'whole person to be cherished' as part of the activity of caring, not just as an end-point. The discussion moved to caring for patients as persons. The mother of the nurse [MN] declared not everybody cared for people this way. Where she had been a patient the atmosphere contributed towards the way one experienced caring, she felt. The social worker [SW] said she consciously chose to have her operation at a certain hospital because of its atmosphere. She chose the venue then looked for a surgeon who worked there because "There is real care for people as people". It had 'soul' compared to hospitals she described as being like rabbit warrens. Part of this 'soul' was being cared for as a person by a caring competent person.

The SW acknowledged she was saying this in the context of herself: her kind of personality and knowing her kind of needs. She knew she responded to warmness, kindness and gentleness - personality traits that made her choose a place that suited her, where her need of caring and nurturing would be met.

These latter two concepts had not the same meaning for the SW but were closely related, she felt. Nurturing was an important word for her. It came from her background of having lacked nurturing. She was still looking for that which she never received as a child. Nurturing was a personal need.

These were profound thoughts: caring not occurring in a vacuum. Here was someone spelling out the kind of ambience necessary for her, that she chose. When I reflected on patients in general, Bekkare's patients, or the patients 'dumped', I realized they have to take what they get in their attempts to survive.

SW showed how important it was for a nurse to assess her own caring and patients' personal needs if she was to really care for this person. She felt 'categorically' some people needed this caring less than others. The reason being some people had had their nurturing needs met whereas SW had not.

Discussion then centred on the size of hospitals. SW had found the hospital she trained in was:

> "a very uncaring hospital: ... big ... overwhelming ... terribly frightening for a young student".

The chaplain [HC] asked if what SW felt would be the same kind of fear young nursing students would feel when working there. SW related how a young social-work student had exactly these feelings when in a large hospital and had focused her research on these feelings.

I started a conversation on professionalism, picking up on what HD had said. His words had given me the feeling that professionalism, in his opinion, was antithetical to caring. His view seemed to be on a line with May's,

HD put professionalism in the context of preserving distance between the patient and a health care professional, this was like

> "functioning without your emotions leading you astray".

He had been taught not to get too involved with patients, but, professionalism had now gone too far. It was necessary, but there had to be a balancing act. [A point interviewee Frieda makes]. On one hand, not to be in distress, burst into torrents of tears and be too jittery to minister to the patient. On the other hand, a patient could not be treated adequately if nurses did not

> "to some extent get emotionally involved in the patient's pain and their suffering".

If a person was treated on a mechanical level, he felt, they were not treating the whole person. A carer's involvement could, in his opinion,

> " ... materially affect the level of drug you give by the patient's feeling of acceptance and love. Patients could have emotional difficulties, problems at home and come into the hospice suffering a great deal of pain. But when in the hospice immediately surrounded by this atmosphere of caring, where everybody is interested in them ... the pain diminishes and you do not have to increase the drugs at all. After one day as an in-patient, the pain is gone. People need to feel they are accepted, that they are special. The obverse was doctors and nurses, especially in big institutions, who are so busy with gaining technical competence that caring goes by the board, with some exceptions. The emphasis is not on treating the whole person: their emotional needs as well as their physical needs. Caring should mean total professional competence and confidence."

HC felt student nurses came into nursing

> "starry-eyed because they're going to do a wonderful thing for humanity and then their tutors do not from the word go start teaching that nurses have to care and they don't demonstrate it, nor are they role models for it [tutors or ward sisters]."

HC asked:

"Nurses come with a calling, don't they?

MN felt, basing this on discussions with her daughter, that for some it was a vocation, but many went into nursing for the money, or a secure government job, or the status. She said,

> "the caring attitude was not instilled or modeled. For those for whom it is a vocation feel hurt because they feel that just because nursing is seen as a vocation they are not given what they need. That is, many are expected to live below the bread-line kind of thing."

HC considered whether nurses themselves were viewed as persons: that they received very little in the way of praise or affirmation. Burnout and felt stress had become a feature often because of the lack of interaction between members of staff. Students were not treated with the dignity they needed, this was a big source of stress. HD said how important it was to affirm people as people. He gave concrete examples.

Attention became focused on non-care. The HC asked:

"How can you address that sort of thing in a big hospital?"

Various answers were given. There was the view that this was why people were getting out of nursing especially since being offered a voluntary severance package. HC persisted with:

> "Is there nothing that somebody from top management can do if they are concerned about care?"

HD replied that his contention was no hospital should be bigger than 5-700 beds maximum. That

"the bigger the institution the quicker you lost the intimacy, all that loving tender care".

He told stories of matrons he knew who had shown the type of nursing care he defined as intimate and tender-loving. The group felt that these were examples of the kind of person he and those matrons were.

HC added:

> "They were real persons, and being real determined caring. When student nurses were in their first year, having their first lecture they listened to this person talk about real people, real personhood, and about caring people, and that these were the people one wanted."

The doctor wanted to know:

> "But who is the person giving this lecture now? Senior nurses whose reason for existing has been to accumulate diplomas and who had little nursing knowledge left and who was cold and distant in her relationships with people".

The group concluded this kind of role model was not needed.

Discussion of this text will take place later.

5.4. Summary

What, it can be asked, are the features of caring in these narratives that gave direction for the main research? At this stage a definition of caring, and a method that would reveal what caring in nursing looked like, felt like, or even sounded like, was still being sought. I had not reached the stage of applying Bowden's 'survey' idea.

1. There was a spiritual dimension within caring, one that applied to the elderly and to nurses in their attitude towards death and dying. If there was a solidarity, a togetherness with persons, if they cared well they could enable another to die well, to befriend death. And this comes up again as discovered in Ruth's narrative in the discussion under 'the spiritual'. This is why the spiritual is treated as absolutely integral to the concept of care.

2. That professionalism could act against being caring. A person could focus so much upon professionalism [as shown in the discourses of Diana, May, and others] that the whole person to be cared for was forgotten. Such professionalism could become unethical but the idea of nursing being a vocation was still alive.

3. An atmosphere where there was 'soul' could contibute much to being feeling cared-for. A frightening ethos could affect patients and staff. The idea that a person could choose a distinct place to be cared for was still feasible. But, when confronted with patients who could not choose, [like those in Bekkare's hospital, and worse, those 'dumped' or feeling abandoned], then one could say that a hospital with such a 'soul-less' atmosphere has become sick [Beales, 1978].

4. That listening attentively and with a sense of giving time was beneficial to patients and could run parallel with discipline, routine and organization given the right caring ethos. Total competence and confidence included emotional needs: surrounding patients with an atmosphere of caring interest and making them feel special and accepted. The antithesis was patients and nurses 'battered' by life's stresses. They needed to be affirmed, to grow as persons through particular persons who could foster personhood. A nurse could learn from both patients and role-modeling staff that how she cared defined her as a person.

It was not that I was very unaware of these understandings but their application, and the context in which they were given had a startling effect that of a symbolic growth experience [Frick, 1987]. Previously I had failed to understand how not feeling accepted could materially affect the amount of drug administered. I had never engaged with caring to this extent: this depth before. The 'accumulated understandings' created an 'openness' through which gradually 'a light dawned'. I was 'seeing' in a new way. I had omitted the ethical in the sense of giving the type of deep creative caring as contained in the previous chapters. These were the first narratives and they gave direction to this research. They explored 'possibilities' of caring in nursing, and ultimately unique family resemblances between participants' use of the terms nursing and caring, and that of theorists, and later interviewees.

The next section introduces Bekkare.

"Where there is ultimate concern there
is the passionate desire to
actualize the content of one's concern"
Paul Tillich [from Stenberg, 1979]

Section III: Bekkare:

5.5. Introduction

This chapter introduces Bekkare who is a Shangaan: one of the Eastern Transvaal African tribes. She can be seen against the historical backdrop that Wright's interviewees describe [chapter two].

She had a memory of being her father's "beloved child" which is relevant according to Noddings in terms of memories of being cared-for. Bekkare had been nursing for more than a decade. Her being an interviewee was again more by chance than design. I met her whilst she was engaged in a post-basic Oncology nursing course. She was on the ward, available and willing to participate. Her interview is used as a case to reveal an ideal in caring. Why this narrative has been chosen as a paradigm is explained.

5.6. A paradigm case

The value of this example is to show meanings of caring, to reveal the possibilities of care of an ethical nature. As such, it might be criticized. On the surface, the caring may seem to be merely 'basic'. Some might even say caring is non-existent or that the focus is superficial and on her fellow nurses. That is to miss the cultural richness. Meleis [1997] feels a paradigm embraces "an entire repertoire of beliefs, values, laws, principles, theory methodologies, [and] ways of application ... It includes ... questionable areas ... and some puzzle solutions that could act as examples to help solve ... problems in the discipline." [pp. 72 citing Kuhn].

To appreciate this narrative as a paradigm I can say, with Carr and Kermis [1983] that it generates a particular interpretation of 'reality' ensuring that theoretical knowledge produced will be consistent with the view of reality the paradigm supports. In a new South Africa: with a 'rainbow nation', we need to understand the reality of the areas from which many of our patients come. This narrative with its interpretations goes a long way to portray such reality.

There is also the possibility of an ethic of care if I take the narrative with the interpretations of the authors who have helped me to understand Bekkare's 'sayings'. Some points are confirmed in Shutte's book: Ubuntu - an ethic for a new South Africa [in print]. He and I came to this African ethic along separate but parallel pathways. The paths meet with ubuntu [to be explained] particularly in the context of health care. He has been theorizing whereas in this narrative Bekkare's experiences and their interpretation portray the outworking of his reasoning in a particular clinical setting.

This narrative portrays an intrinsic attitude of a person 'making a difference', or 'being there' for someone. Attitudes reveal a person's habitual way of regarding or valuing someone or something; it is consequently, an affect showing itself in "activity imbued with ethical meaning". The story is given in detail because as Peta Bowden wrote:

1. It "conveys so much of the texture and personality of her person, and that seems crucial when you want to talk about the way affect imbues activity with ethical meaning".
2. It has the "potential of showing us what it is to care ethically, what sorts of things motivate someone to care in the way she does and what sorts of expectations/rewards she has and needs, to keep her caring fulsome" [Bowden[16]]. .

The 'affect' Bowden writes of is referred to by Tillich [at the head of this section]. He writes of 'ultimate concern' leading to 'passionate desire' to actualize the content of that concern".

There is in this narrative a depth of caring having significance in its portrayal of values in a particular context. These values, as will be shown, portray facets of humaneness that should be universal. They become contextual: the particular experience of a particular individual. They reveal the notion of that 'ethical self' given by Noddings. The story is told by a person who, having furthered her nursing studies anticipates going back to the rural setting in which this narrative is told. I make some attempt to be attentive to the social conditions of city and village and of the impact of culture in these settings.

For a city perspective of genderized nursing one can use Rispel & Schneider [1988] or Marks [1994]. The first felt nurses were being dominated and oppressed by the medical regime; the second writes how apartheid divided the nursing profession. From a nursing point of view, little has been written on either the impact of gender or social conditions amongst Blacks in villages and townships.

I draw on the work of Jabavu [1960], an Eastern Cape Xhosa, and other authors able to interpret the African ethical and cultural aspects discussed by Bekkare and so give better meaning to her narrative. Quotes are interspersed within Bekkare's narrative. One final word of explanation is the way Bekkare discusses her story in the present tense. As Holdstock [1987] explains, "[African] case histories are not told in terms of developmental stages, ... but rather according to some other set of priorities, that reach freely backward and forward in time and are told as if they are happening in the present" [pp. 247]. Hodgson [1980] observing this phenomenon writes: "[Their] traditional view of time is non-linear: a long past, a present but virtually no future". Time "does not project forward to a distant and transcendent future; it projects back upon itself to the present in cyclical fashion, to the all-important now" [1980:45].

5.7. Bekkare

Bekkare's story is derived from two transcripts. In one, she describes care as "another type of love". There are elements in her representation of care revealing a striving for an intimate nursing engagement [with those terminally ill persons suffering from cervical cancer] not for her sake but for the patients' own sake. This mutualism is in stark contrast to that being given by other nurses from this institution, as will be seen from the context and content. This relationship shows ubuntu being exercised [discussed later].

In discussing 'What Africa can teach us" Holdstock mentions holism, spirituality, ubuntu, communalism and emotionality [pp. 226-236]. These concepts also flow from

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[16] Bowden P L [1997b] Personal communication, March 2, 1998.

Shutte's Philosophy for Africa [1993b]. These are important when validating the interpretation given to the narrative content.

5.7.1. Valuing the person

Bekkare opened this discussion about care by saying,

"While you are giving this care to this person you must take the person as he is. You must not compare and say so and so is better... Care must be individualized according to this person's culture, and their culture must be resepected..."

There are many ideas enveloped in these words. One of which is her use of the term 'person'. 'Person' has been used by other research participants. For this reason the concept of person is developed further in chapter six. But 'person' in African usage, especially in its proverbial context, will be highlighted throughout this discussion.

Another concept is that of individualizing care. Hospitals will have African patients from many cultures in one ward. She feels it is important not to compare one person's progress with that of another. And this must be done within the culture of that person. This cultural aspect means that if a patient wanted to be discharged to think about whether to have an operation this should be allowed. They go home "to slaughter a goat and to see the tradional healer". The decision is that of the extended family and the community. A decision is not taken by the patient alone. During this time family and community [strangers included] come together: talk, discuss and eat. The traditional healers, she felt, should be involved in the care

"otherwise we are going nowhere [culturally]".

She summarized this by saying,

> "My care is going to be personalized according to the culture of [that] person, and, not forgetting this person who is giving care".

The words: 'personalized', and 'this person giving care' must be explained. In African culture "group identity is ... given preference above personal identity" [Malan, 1990:42]. Bekkare is aware patient and nurse can have their different cultures. What was on her mind as she continued was that:

"These cancer patients have never been attended to for their own thing".

The context in which she makes this statement implies they are not being cared for 'for their own sake' because they have cancer. [Cancer is a taboo condition as she states later]. Nor are they cared for as the terminally ill persons they had become because their cancer had been neglected [according to Western practices] both by themselves, through their particular health-seeking behaviour, and by the folk medicine failing to identify and treat these cancers.

5.7.2. Traditions

This way of neglecting a person is in contrast to what, ideally in the traditional sense should occur, except perhaps, that there could be another set of values or traditions for those felt to be dying, which will be discussed as the story unfolds. Jabavu writes,

> "Store is set on the value of the individual in the sense of belonging to the culture of his/her people; of showing respect, dignity and feeling for this other person" [pp. 55].

Bekkare in explaining 'culture' [where culture cannot be separated from caring] said,

> "Culture [in the African sense] is the way we talk with people, dress, and eat".

Jabavu explains the phrase: 'the way we talk with' as meaning,

> "[B]eing allowed to speak without interruption, comment, comparisons; witholding surprise or pain. Uttering only that which encourages the speaker to continue".

Note the word 'comparison' used earlier. Jabavu shows that:

> "It is in talking that one explains artistically, poetically, properly, beautifully, in detail. This is kindness, feeling: humanity is there [ubuntu obabulapho] - it is something one can hear, if not understand" [pp. 193].

The use of 'talk' here, and in many other places in this work, conveys the idea of a sense of presence, finding a 'voice', even of 'a knowledge' of oneself. The word "Ubuntu" is expressly referred to in the South African Constitution:

> "[T]here is a need for understanding but not for vengeance, a need for reparation but not for retaliation, a need for ubuntu but not for victimisation ...".

Botha [1996] explains, Ubuntu is an indigenous Southern African concept and refers to a practical humanist disposition towards the world; and compassion, tolerance and fairness. The concept was applied and defined in the Constitution:

> "Generally, ubuntu translates as 'humaneness'. In its most fundamental sense, it translates as 'personhood' and 'morality' ... While it envelops the key values of group solidarity, compassion, respect, human dignity, conformity to basic norms and collective unity, in its fundamental sense it denotes humanity and morality, its spirit emphasises respect for human dignity, marking a shift from confrontation to conciliation". [S V Makwanyane. 1997].

Bekkare's story shows concern for those of her people who are terminally ill with cancer. This concern is part of the ethical 'ubuntu' but in the context of cancer and the cultural taboos associated with it her story is outside the cultural norm. Although she is one of many nurses, her concern reveals an ethical aspect to caring.

Shangaan people, according to Bekkare, are commonly known for their respect, kindness, concern, and sympathy to others, more so than some other ethnic groups. I believe this was what I felt during the interview. Her concern showed in action through a voiced commitment and vision. This commitment was to study further in order to help her community overcome its ignorance towards cancer. Her vision was to teach relatives and patients "preventive aspects of cancer, especially cancer of the cervix".

I use the word commitment because she emphasizes the words "I want to..." so strongly. She wanted

> "to be able to teach awareness and such things at schools, in the working environment and churches" [as a community nurse].

One has to try to experience the ward she described to understand her feelings about care and her memories of caring. It was a 90-bedded ward where patients with ectopic pregnancies, abortions, and other acute gynaecological condions. Into this terminal patients who had cervical cancers were dumped. Only three RNs, "too stressed to give care", worked there with other nursing and non-nursing staff. There was no special ward for oncology, or terminally ill persons.

Bekkare reflected that before the course, she had been unable to explain to herself, let alone to patients, what would happen when they transferred from her hospital to a hospital 400 kilometers away where there was an oncology ward with radiotherapy and treatment facilities.

Another factor to this ignorance, as Bekkare confessed it, was her own unawareness, and that of other nursing staff, of the importance of having Papanicolaou cancer tests [PAP smears] done. Bekkare did not want to waste a single minute in making those at home, hospital and in the community aware of the need for this test.

On one hand, was ignorance and this base hospital "not [being] a good place for the terminally ill". The alternative centred in what Bekkare felt this transfer would mean to them. They would have "no explanation as to what was happening to them". She did not know enough. "No-one knew what they would undergo once they were at [the receiving hospital]". On the other hand was the expense: "It is a lot of money that is wasted on the way". [Patients had to pay for their transport and subsistence]. "The environment [culture] would be different". [Out of one country and into South Africa; and, traditional African country peoples have their own health-seeking traditions]. The majority of these patients were already terminal: weak, helpless and vulnerable, she said.

The feeling was of stepping back into history before Cicely Saunders' hospice era before the Western world accepted death, dying and bereavement in a more normalized way.

5.7.3. Terminal care

Bekkare specified what she felt the terminally ill patients needed, stressing these ideas came from her experience. She wanted these patients

> "in one place so that they can get enough care. At least they can have a separate ward ...", and " ... I am afraid they do not get enough care".

They needed 'total care'. Someone to sit next to them, to listen and to talk to them and their relatives. Someone to give them time, to answer their questions; to

> "bring them even that glass of water that they asked for and the nurses were too busy to give".

Being caught in the enthusiasm of what could happen at a hospice, Bekkare wanted them to have such palliative care and support. She wanted to live longer so she could be of help and implement what she had seen [including home visiting and day care]. Bekkare translated her care as being able to negate the "bad things" that were occurring:

1. "The cancer patients do not get the regular pain treatment". Nurses are not giving the morphine at regular intervals because the nurses feel patients will become addicted.
2. "No-one knew [when] they passed their stools", or, that morphine had the side effect of constipating patients.
3. "No-one took care [of these cancer patients] because they were too busy with other cases, especially theatre cases: ectopics, laparotomies, incomplete abortions".

This lack of attention from staff was partly due to the busyness of the ward. Routine nursing care needs for the terminally ill were neglected. However the Westernized concept of a lack of care could be taken as a cultural 'kindness'. Zulus perhaps would have a racial memory of 'sending' their elderly/ dying persons 'home' - "ukugodusa" - a type of euthanasia of the elderly or terminally ill where they either walked out of their home and into the bush voluntarily, or were forced to go [Samuelson, 1974]. This probably would not be a 'good death' except for the fact that Africans are stoical by cultural preference

Malan in discussing the aged in parts of South Africa gives evidence to the reality of this neglect leading to disrespect and the "hastening of death" when a person could no longer "play a functional role" [1990:27]. Fourth year Xhosa student nurses working in township clinics have said RNs pay more attention to the acutely ill than those dying. The terminally ill are regarded as 'wasting' time or filling a bed that could be occupied by someone who would live after treatment.

5.7.4. Family expectations

Bekkare explained it was not custom nor practice for African relatives to nurse their 'beloved' in hospital. She said,

> "When it comes to being involved in the care of a beloved one in the hospital set-up ... they, [the relatives], expect the nurses to do everything for the patient. This is part of African tradition. They will help with food that the patient is known to like but not with everyday lay-person type care. And, if the person is terminally ill the relatives think that the hospital is the place for these people. The expectation is that when the patient is discharged they will be better and not be returned home deteriorating".

Relatives expected hospitals to cure, not to send a patient home to be cared-for. She graphically painted the picture of busy nurses running up and down between two busy wards: rushing, pushing the dressing trolley, "taking patients to that other side". And the relatives?

> "They are standing looking at us. They take it we are just walking up and down. We are not doing anything. They want to ask us something: "O.K., I am coming now', and this one [nurse] passes by: 'O.K. I am coming now'. But theatre is calling you. A pre-medication must be given to the patient. Who is really going to sit down and talk to them because they need someone to tell them something, whatever it is that they need".

What was driving Bekkare to be concerned in the way she was telling? "Why?" I asked, "were you interested in patients with cervical cancer; was it because you had a relative die of cancer?" No! These were not the reasons, nor was it from the observations she had just discussed. I asked no more questions and said simply: "Tell me".

She went back in memory to when she was a student on a female medical ward [in this hospital outside her tribal area and South Africa]. They had admitted a patient with cancer of the cervix. She recalled with poignancy, her emotion. No-one was willing to bath this patient because of the smell surrounding her: She said,

> "Ehh, it was really smelly!"

Bekkare asked this patient if she could bath her. The patient replied in her African way,

> "Yes, I can be very happy".

She was bathed that day, and the next. But that next day Bekkare asked a colleague to help. The colleague refused saying: " ... but you go there". And Bekkare did though the smell still clung to the screen curtains. She reflected,

> "So I asked myself, but no-one wants to go next to this person. It means that if somebody has got cancer it is the way you are supposed to be treated. No-one wants to come next to you because you are smelling. But maybe one day it is going to be

> me or maybe it is going to be my mother and then I won't like that thing to happen to me. So I started to develop [pause] another type of love, I don't know, from that thing. Then I continued like that. If you talk of empathy in particular I'll go and think about that experience and I will definitely go to that person".

Was it Bekkare's particular Shangaan culture shaping such behaviour? I was curious about this in terms of Nodding's 'motivational disposition' and Bowden's idea of rewards motivating a nurse to be ethical, giving individuals the care that ideally should be part of the ethic mentioned but which could be extrinsic. Did she care because of that intrinsic capacity that Shutte [1982], van Hooft [1995] and Noddings [1984] describe? Being curious about this act of caring [or, 'another type of love'], I asked pointedly: "Why did you go past the smell and get to the lady"? She replied,

> "I don't know what it is about me. But I did not really mind about this smell. I wanted this person to have a peace of mind like anybody else. If I mind about the smell and I don't stay with this person what about this person who must stay with the smell and everything ? What had this person done? That was really unfair to me".

"I wanted this person to have [a] peace of mind". Would that all nurses had this as their motivation for caring. What she was doing was not only caring, but putting a particular type of justice and an ethic of care into practice through her concern for this person's peace of mind. This conveyed compassion, and showed an essential component: that of justice, concern and presence [Jobson, 1996]. This caring-concern rose above odious smells and others' non-caring attitudes it was that the patient be treated fairly..

Bekkare's reward was that after bathing this lady with Savlon water there was no smell. Another reward was the comments of the nurses to this effect. But the most satisfying was that they came:

> "next to this [patient] and said, "Heh, heh, How are you today after the bath?"

They related to her. Bekkare had been worried about these persons being treated with loss of respect and no show of empathy, or love. She was unhappy at what she perceived to be lack of caring amonst her own kind: Shangaans and others.

I asked, "You are condemning your own people, your own nurses for the lack of care. Is this true?" Her reply was: she could not

> "just run away from that and say it does not happen".

She saw the reason for this lack of care being linked to African culture regarding chronic conditions [like cancer]. To the African chronic conditions have meaning. The condition is seen to have deep significance. The person wants to know:

"Have I offended an ancestor? or "Who has done this to me?"
Only after they have asked the traditional healer, or Sangoma,

> "Why do I have this thing?"

and the Sangoma has told the person s/he has

> "done this and this to their ancestor[s] and a goat is slaughtered and [African] beer drunken"

Then only if all fails and the condition remains will the traditional African "seek help from the Western doctor". But, she added,

> "It was not as simple as a, b, c; or as I am explaining it to you"

She affirmed that African nurses would spend more time with patients "who are acutely ill than that one who is terminally ill".

Perhaps this shows more concern with cure than care. Perhaps in this context it is to do with the perceived role and function of the ill person. If it is felt a person no longer has a role to play in the community's life, or can no longer perform communal functions, pitiless neglect may eliminate those who no longer achieve [Malan, 1990: 27].

Bekkare also put this attitude of not caring by the nurses down to ignorance and identified herself with this unawareness.

> "I also was ignorant. I did not know anything about cancer [or cancer nursing]. So I must just start within the hospital to create the awareness bit by bit".

Her concern moved her to want to

> "gain the confidence of the people whom I am working with".

She felt a fear of cancer amongst the community:

> "[A fear] of the cancer thing ... of the tumour thing makes it very, very hard to convince them".

And too they would talk about it as 'Bekkare's thing'. She role-played [a typical African style] their words and attitude for me:

> "She comes with this thing from [the training hospital] and then she thinks she is going to convince us" [her emphasis].

Her caring showed in concern and commitment not just to her colleagues, but to her community. There is conflict here: perhaps in her culture an ethical dilemma. On one hand the community asks to be allowed to be themselves [Vorster, 1996:13]. Hodgson mentions there is an "innate conservatism among African people" a bias against innovation [pp. 21]. This point is confirmed by Gelfand [1958/75] and Rack [1982] because African background is not only collective but largely matriarchal, and compliant. On the other hand, criticism could be levelled at her individualism and innovation as something negative and anti-social by her people. She could be perceived as flowing against collectivism. But, Vorster feels Africans have healthy self-concepts, their own values, and, an appreciation for traditions [normally within collectivity]. This seems to be true of Bekkare.

5.8. Discussion

Why did I choose Bekkare as a paradigm case? There are many reasons, but chiefly this narrative illustrates an African portrayal of care and an ethic of care within that culture. Many nurses are African. Their prior experiences, knowledge, and culture affect how they experience and interpret nursing. Their interpretations affect their construction of knowledge and define their meaning of caring. An understanding of the many African concepts that flow from this narrative enable others to understand aspects of care and culture unknown to some at the moment.

Bekkare's narrative reveals not only an attitude of 'ultimate concern' but 'the passionate desire' that is an intrinsic part of caring. The person and her discourse cannot be separated: nor the emotions engendered. I had the feeling when I interviewed and observed her that there was no duality between public or private meaning as far as caring-for was concerned. This narrative not only says something of the 'deep care' van Hooft [1995] describes, it shows it. It portrays an ethic of care: a system of values and beliefs towards persons upheld in a particular context.

Some might say this paradigm case is so completely different from Western culture in South Africa especially in the rural context in which it is set as to be valueless. Others might say the caring portrayed is too negative. Others that it is plainly a portrayal of neglect and non-care. I disagree on all points. Firstly, the differences in caring are in degree only. Secondly, it focuses on the narrator not her colleagues. Thirdly, the ethical possibilities of Bekkare's practice could be taken for granted, glossed over, or ignored; another aspect that Wittgenstein was aware of. He felt we could miss important aspects of these concepts for these very reasons. What is portrayed by this narrative is an ethic of everyday life - a communal life. A judgement can be made whether this is instrumental nursing: something to be done to someone; or, non-care towards patients with cervical cancer. The judgement would then be as to whether the ethics in the story are good or bad. [These 'ethical possibilities' are discussed in chapter nine].

Another reason for using this narrative as a paradigm is that it allows for comparison. Bekkare's narrative acts as a bridge between State hospital and non-State Hospice world-views. Being on an Oncology course put her in these two worlds. There is the State and non-State hospital where she trained; and, the rural State hospital as against an Academic State[17]-run hospital. To look at the one from the view of the other is important in the context of care and in line with the methodology of this thesis. It goes back to what the Breakfast group were saying about large or busy hospitals. Caring is said to only take place when the 'atmosphere' is conducive, yet we find Bekkare attempting to swim against such a tide.

Bekkare's interview can leave the reader appalled. Where is the care here, could be asked? Terminally ill cancer patients in a 90-bedded ward are abandoned. We could question whether this treatment of the dying was cultural. But we have to look deeper.

If we recall Western civilization's social history, especially its history of modern hospices, then we realise afresh that in the 1980's death was still being treated as a taboo subject. Clergy, according to Father Ryan, were "as afraid of death as doctors" [Oliver, 1992:65]. Death was perceived as an affront to scientific progress. Pain and suffering were to be obliterated [Chase, 1986; Kubler-Ross, 1969]. Many had been opposed to hospices because money could be better spent on the living: for example, invested in cancer research. Surely ,this is the same as that of Bekkare's culture.

What Bekkare described in an African rural setting in 1996/7 had happened in Western cities in the 1980's when the pioneers of hospices were championing against neglectful treatment of the dying. Oliver lists many of the arguments [and misunderstandings] given by Australian medical personnel, and others, in their attempts to oppose the hospice I visited.

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[17] The general populace of patients in South Africa are nursed in State or public hospitals

Where there is a difference in African culture is the wholly understandable but naive perception that people go to hospital to get better. An African family does not expect a relative to be sent home dying, or having to be nursed. An ethnic memory may be involved in the idea of not looking after the dying. Certainly there is the socio-economic element in the idea of not receiving back a dying person. There is frank poverty in the many communities visited by nurses like Prudence [mentioned previously]. In Africa Wright's 'survival mind-set' persists because over many years there has been financial hardship, and violence of an unprecedented nature, both leading to debilitating social conditions such as Wright [1981] discovered.

5.8.1. Points of clarification

Two points should be clarified. Firstly, was Bekkare showing caring such that can be used as a paradigm case? Secondly, what did Bowden mean when she wrote this narrative had the "potential of showing us what it is to care ethically"?

The first I will answer by referring again to Gaut's criteria. Bekkare showed an awareness of the need to care, and concern for, not just cervical cancer patients, but staff and community. Her cultural ethic [ubuntu] ensured a respect for persons. The African proverb enables her to care not for her own sake but for the sake of the other with 'another type of love'. Bekkare's knowledge was sufficient to know this patient's health: wholeness, and spiritual wellbeing, would improve through these ministrations. Her attentiveness demonstrated intent to show caring. By means of healing communication [in this case the care and effort put into bathing the patient] the patient benefitted, which Bekkare knew would happen. The staff validated the positive change for them and the patient. Thus, one can conclude that she meets these conditions, but given her type of concern, attentiveness and love, she goes beyond them. She shows caring as compassion.

The second question is answered somewhat by the first answer. As Bowden writes, [1997:1] "Caring expresses ethically significant ways in which we matter to each other..." Bekkare, and other research participants, revealed such caring attentiveness: an ethical attentiveness. Bekkare's narrative, her deep concern, the possibilities she wants to explore, all have ethical ramifications. Her contextual values, beliefs and the attitude displayed reveal that process of 'responses and adjustments' to ideals and persons that is ethical. [More will be said about the ethical in chapter nine].

5.8.2. Reflection

After interviewing Bekkare I was left wondering what would happen. Her status could be an advantage or disadvantage depending on how her community views the nursing profession [if May's view of the public perception of nursing is taken into consideration]. Bekkare is up against ignorance, cultural mores, racial memories; economic cut-backs and a busy hospital. To this end I will apply another of Jabavu's proverbs [1960:205] where I take Bekkare's 'children' to be her terminally ill patients

> "To bring forth children is to increase your own capacity - ukuzala kukuzolula - to do, learn, weigh up, experience through what happens to, or is done by, your children".

The next section will continue to reflect upon the discourses, those given by research participants in hospices, and, oncology/haematology units: both State and private.

I continue with the interviews in Section Four. These are interviewees from persons working in both State and Private units.

> What we see, and like to see, is cure and change. But what we do not see and do not want to see is care, the participation in the pain, the solidarity in suffering, the sharing in the experience of brokenness. And still, cure without care is dehumanizing as a gift given with a cold heart.
>
> Henri J M Nouwen [1994]

Section IV: The caring world of other interviewees

5.9. Introduction

This chapter contains the main body of interviewees' discourses. The research participants are grouped according to the work-place in which they practice. Caring in these different contexts gives rise to similarities and d'ifferences. I will firstly, discuss the context in which participants worked and then introduce them according to their work-place.

5.10. Hospice context of caring

Hospices have a limited number of RNs so for confidentiality reasons more than one was visited [five in all and not all in South Africa]. All the RNs approached were more than ready to make time for being interviewed. Having interviewed in one hospice, the need to make comparisons with others was important. The comments in this section are generalized to discourage identification of a particular place.

The operational differences in these hospices lay in public perception, management, size [the number of patients accommodated], staffing levels [including skill-mix] and their funding. Where there was no State funding, and salaries came out of public monies, I found there was anxiety and unsettledness amongst the staff. Bekkare's concern with her 'little pay' [previous section] was not peculiar to her - perhaps her reaction was - but the lack of financial security touched other lives. This affected the quality of caring being given: not so much on a personal level, though that took its toll, but on a contextual level.

Let me try to explain this statement. Hospice RNs desired to give care of the utmost quality. That was their motivation for being in a hospice. Those interviewed had a range of 7-38 years nursing experience [on average almost 22 years]. Their hospice experience ranged from one year [Brenda] to fifteen years [Susan]. Apart from Brenda, because of her newness, having observed many, one could say they were hospice nursing 'experts' from a palliative, emotional and spiritual aspect. There were few exceptions. Most were quick to discuss patient's needs in terms of emotional or spiritual pain; or the advantages of an inter-disciplinary team over that of a multi-disciplinary one. I obtained a picture of commitment despite the circumstances prevailing in some of the hospices and financial constraints becoming overwhelming when there was dependence upon voluntary funding.

Most portrayed that 'passionate desire' for patient care referred to previously [Tillich]. Most chose to work in a hospice in order to render the type of care they felt no longer existed in State hospitals. However, management styles, the shortage of resources: staff, drugs and equipment [due to financial constraints]; and the pressure of legitimate administrative aspects [non-nursing tasks included] took their toll on the quality of care given. To care 'passionately' one had to personally be able to overcome these constraints. Such caring is not budgeted for. As some indicated, "It takes courage to care".

Then when one comes across hospices that appear to lack for nothing; where the atmosphere is of a peaceful holiday resort rather than a 'house of death', then one wonders why all hospices do not exude this feeling. This, after all, was what Cicely Saunders had advocated [Chase, 1986:4]. The problem was not just the way the place was managed financially or administratively [though these contributed] but had wider cultural and societal overtones played a part.

The financial status of a hospice is an important consideration. Although in some countries they are supplemented through Government funding, other countries are not. Relying on public goodwill does not give financial security to staff. Some hospice nurses knew their hospice could not guarantee salaries for more than three to six months. Having a steady salary such as one obtains in a government hospital would be important to those being breadwinners for their families.

Public perception is important. If a hospice is perceived as 'a living place' it stands in great contrast to being seen as a 'a death house' [one manager's perception of the community's attitude]. Where the emphasis was more on palliative care than caring for the dying, this perplexed not only the public but staff in the State hospital: they could not understand why a hospice would not accept its terminally ill patients. But, funding accounted for the problem. And Susan implied: it was getting to the stage where she wanted a hospice only for those dying, not where aggressive treatment was being given.

Where a private hospital ran an Oncology/Haematology unit, one concern was affordability for patients. Bone-marrow treatment could cost half a million Rand. When RNs perceived treatment would need to be prolonged or was ineffective they were deeply affected because a primary nursing approach was used and it facilitated strong attachment to patients as will be seen.

Management style and approaches are important. There were strong feelings when staff were not involved in the decision-making process, where management adopted a 'top-down' approach, rationale for staff cut-backs was not adequately explained, when innovations were introduced and nursing staff had to take additional courses [e.g. training for computers] that they felt "had nothing to do with direct nursing".

Skill-mix was important, and the fact that staffing levels were affected by shift work. Non-nursing tasks beseiged RNs in one hospice: from being asked "where the compost was" to spending hours looking for 'lost' property. As in State hospitals, it was Auxiliary Nurses doing hands-on care whilst RNs did 'office work' [planning; attending courses/meetings; hand-overs; public relations work; ward management: drugs, reports, statistics, stock ordering,] or dealt with relatives, friends and other visitors. One patient, a RN whom I knew, commented [without prompting] on how office work kept Sisters too occupied. Sometimes interruptions were so continuous that patients were not seen at all by RNs during the day shift unless there was something specific to be done to a patient [e.g. a dressing/injection]. The telephone had been a problem. It constantly called day/night staff away from patients. The problem was solved when cordless 'phones were donated.

Transport costs being expensive, nurses did not want to work short hours, only twelve-hour shifts. In one hospice, this affected RN continuity of care to the extent that doctors were handing over to them because only medical staff had seen patients over a whole weekend.

It would be an improvement for a dying person to have a hospital volunteer rather than be left alone to die as was sometimes occurring. Volunteers in hospices were trained to cope with many functions for the dying depending upon their personal feelings towards death and dying. They were supportive just being there for a patient. The non-availability of volunteers reflected socio-economic and cultural circumstances. Socio-economic because the number of volunteers was dropping. Many women could not afford to be out of paid work. Where there is a population of unemployed persons then the concept of voluntary work is anathema [to Trade Unions]. The perception being if a job of work is to be done that job should earn a monetary reward. Culturally, as I learned in Australia, Japanese do voluntary work because it is seen not only as a status symbol, a desire to contribute to the community, but in a religious context, as earning favour towards the next world.

5.11. Vera

Introduction

Having seen Vera at work I had no doubts as to her caring abilities. Although quiet by nature, she was described to me as a "strong person to whom other staff listen, really listen". Her difficulty in expressing herself by no means diminished the reality of what caring meant to her, nor her expertise but it made the interview 'heavy' for which I blamed myself. Yet, after transcribing her interview I realized the depth of what she had said.

Discourse

Vera took my question: "Describe memories of being cared for" as meaning being cared for as a patient. Her response was that she had never been in hospital as a patient, never had a serious illness. She focused on the parental care she had received when sick as a child. This was 'being comforted', 'talked to' [presence], 'kept company'

"you weren't alone ... there was always somebody there, telling stories and boosting your spirits".

Vera's own concept of caring centred on

"getting down to the bedside, and attending to a person's needs".

This care was practical: "basic caring for people". There was action. As a student she had seen hospice nursing as love and care. Now she saw caring as

"making sure a person's needs are attended to, nurturing, looking after, ... making as comfortable as possible at that time depending upon their needs".

This implied vigilance so the person did not have periods of discomfort. By comfort was meant the physical for she mentioned other dimensions of comfort: psychological, emotional and spiritual aspects. She reveals a conscious intentional desire: a belief in and commitment to care.

In her 'best memory of care giving' she related how she 'stood beside' the wife of a dying patient, 'being there' for her. In this picture one could feel her identifying with the hurt of the wife. She says:

"Not saying very much but giving support. Not necessarily doing anything just being there ... he was dying ... she was hurting".

This 'being there' had emotional dimensions for the wife. She returned to the hospice to thank Vera for:

"just standing there and giving her support meant the world to her".

Describing care Vera said it was:

"A feeling towards your fellow-man; not just attending to the physical needs, its support .. love ... compassion ... respecting others' dignity and rights. It is caring for them as a human being".

Vera qualified this statement by saying care could be given at different levels. This is in line with van Hooft's philosophical essay on care [1995]. For Vera these levels depended not only upon physical, emotional, and spiritual aspects but on whether the person being cared for was a relative or someone in another relation to one [e.g. friend]. For each of these persons Vera believed a different level of the emotion 'care' was invoked. This was borne out later by Susan and Kay when they discussed caring for a relative. Bowden [1997] also discusses levels of caring: that of friendship, mothering, nursing and citizenship - all at different emotional levels.

This shows the term 'levels' having three different groupings of meaning.

1. Applied in the context of persons having emotional, physical and spiritual needs.
2. Nursing different kinds of people: 'strangers' or relatives; and,
3. At different levels of our being which van Hooft described.

5.12. Frieda

Introduction

Frieda filled in the schedule before the interview but I had had no opportunity to read it before meeting her. This interview, though previously arranged, was problematic. It took place in the office because she was the only RN on duty, the other having gone to lunch, and the third off sick. This was my second interview for the research and it seemed a bad interview. The ambience affected me [lack of privacy and my hearing aid magnified extraneous sounds in the office]. I felt I reacted negatively and this would be read from me and affect the interview. However, when we chatted afterwards and met on subsequent occasions there were no problems. I felt unable to obtain positive perceptions of being cared-for or care-giving. This statement says more about me than the interviewee.

For months, I pondered about this interview and its content. Was my dilemma because her version of care did not seem to fit into the shape I was getting of caring? I only formulated the definition of care some while after this interview. One question was "Should I include this interview?" Another was, "How was she using the terms care and caring?" My answers came from the method I used. If I was searching for family resemblances of care, I had to take this interview 'warts and all' and show it for its dissimilarities and/or similarities. Eventually it dawned on me that the script, written before the interview, actually validated that Frieda's exasperation was not of my making.

Discourse.

Different levels of caring are evident in Frieda's narrative. I begin with her answer to the second question: "Describe your best memory of care giving". Frieda, to my amazement, stated:

> "I do not have a best memory of care giving ... "

After her twenty years' experience of nursing, I found this statement difficult to digest. I need to digress for a while to explain this. Of particular significance to this interview is Nancy Drew's article [1989]. She reveals how a researcher's perspective influences research, particularly their emotional responses to its purpose; the interviewee's person and their discourse. Like Drew, I felt asking staff for their time, when they were obviously busy, "seemed intrusive". When I encountered persons who gave what seemed to be negative interviews I had questioned my adequacy as an interviewer [1989:432]. I learned Drew felt the same. She was left feeling awkward and self-conscious. A sense of doubt about the credibility of her project encroached; her response was to feel she had obtained nothing [1989:433] from that person.

Comparing Frieda's written answers to that of the interview transcript, I realized her understanding of the question: "Describe memories you have of being cared for or care giving" were being seen in an alternative sense. I supposed she had an image of what caring should have been for her. However, although she had been a patient yet she could not recall a positive memory of being given care. She said:

> "I do not have a best memory of care-giving as my only hospital experience was when I had ... and they were not good experiences"

Admittedly, the interview question did not ask for good or bad care examples. Neither did it specify whether it was one's experience of being nursed. To this end, the question was ambiguous. The intention had been to relate the question to one's memory of either being cared-for or of one's own care-giving. I assumed it would be taken positively and not contrarily. The non-English-speaking persons interviewed had reacted to the questions positively. Noddings [1984] believed one could not give care to others if one had not been cared for oneself. As I had Frieda's written response I opened the interview saying that it had been suggested: "A person could not give care to others if she had not been cared-for herself". Frieda "totally disputed" this fact on the basis of her own hospital experiences,

> "My experience of care was terrible ... "

I found myself lost in contradiction as to Frieda's perception of care especially as these events had not happened recently. For Frieda the term 'being cared for' had neither a neither positive nor negative value, that is, her use of the term could mean either good or bad care was given. Her personal experience of care was extraordinary. She wrote and repeated verbally that

> "After [an operation] I was dumped in a private ward at 6 p.m. At 4 a.m. the night Sister woke me by turning the main light on and checking drips and catheter ... I was left and the first time I saw a nurse was at 4 p.m. Nobody had come to help me or even checked..."

She felt the staffs' attitude that of "writing her off". She was not just saying she herself was caring notwithstanding the fact that she had not been cared for. There was more to it than this. Mentally I was asking whether she was handling a very different kaleidoscope? Was her perception of care shaped by the treatment received on these occasions and as a post-basic student [given later]? Frieda was saying she could care adequately to a standard she had set herself, one intrinsic to her, quite apart from not having memories of being cared for.

Frieda had been aware when she was a patient that one was very vulnerable. But, there is in Frieda's narrative a description of caring that opens up areas of vulnerability for patients. This is that sense of no one understanding what one is suffering; that sense of being a burden because of relentless pain suffered that cannot be shared. She said,

> "I find head and neck [cancer] patients very difficult to nurse".
> [There were two of them on the ward at this time].

> "... I feel that they really suffer and you have to try and help them and empathize with them but you can't take their suffering onto your shoulders because if you do then you don't cope yourself".

Frieda wanted to cope. She did not want to become "stressed out" by head and neck cancer patients' suffering and fears. They become scared of choking to death, of being alone and much more. But, comparing this attitude with Susan's: where she shared in patient's suffering, understood that another's pain "... shouts at you" [patient and nurse], then I see how individualized caring can be. The same idea of sharing in pain is true of Nouwen's thought: "What we do not see and do not want to see is care, the participation in the pain, the solidarity in suffering, the sharing in the experience of brokenness" [1994]. Wilkinson [1998], discussing emotions in the context of care feels that when such emotions are experienced they become compounds of feelings, beliefs and desires, and not only complex cognitive states. These interviewees and Nouwen cogently express the complexity of emotions associated with caring for persons in pain.

I see dissimilarities in this caring narrative; degrees of dissimilarities of the type that contribute to Morse's 'confusion' about the use of the term care in nursing [1990/1]. Even as Frieda spoke my mind was on the term 'sympathy'. Its literal Greek meaning being: 'to suffer with', that is, 'to walk alongside someone, not supporting them as with a crutch rather to be willing to feel with and suffer with a person as Nouwen [1994/5] describes.

If I think how persons, in particular Africans, want to know the meaning of their suffering, and de Jong [1987] emphasizing that a health service should function to give that meaning to suffering, then I fail to understand Frieda's 'caring' but understand it I must.

On the positive side Frieda wanted to:

> " ...do my job properly ... be a good carer ... communicate with the patient ... being with that person and walking with them ... try to support them"

I asked her to explain: 'walking with them'. She said:

> "Walking beside them; you can't take their pain, you can't make it any easier for them, but if you walk beside them and try and support them that's basically all you can do... "

Again, that paradox. The paradox lay in the negatives: 'you can't take their pain', 'you can't make it any easier for them'. I was thinking "What did a hospice stand for if staff could neither 'take their pain' nor 'make it easier for them'? But, there is a cost to taking other's pain as the following newsletter published in a London hospice shows. "The cost of caring" [St. Christopher's hospice, 1984]. The article was a conversation between 'Janet' and 'Lucy' overheard in a corridor. Janet describes the 'negative side' of hospice work. Although recognizing the need to keep a balance with her 'outside life' her attempts at doing so failed. She saw herself becoming 'Edgy'. She was all absorbed in the process of others' dying, death, witnessing emotional pain and helping them to express it positively. This resulted in her defenses being down, becoming raw and vulnerable to the avalanche of needs from patients, and colleagues. Each time she witnessed the process a bit more stayed with her. Ultimately she felt 'punch drunk', 'like a sodden sponge full of other people's pain'.

Lucy asked if by this Janet meant she was heading for a breakdown. Janet replies in the negative. She had become chronically sad. At the Christmas social, she had felt this sadness tangible in those still working there. Janet counseled Lucy to consider doing something other than hospice work 'while she was still young'.

This newsletter gave me a new 'layer of understanding': the different perceptions of the causes of burnout. One could make two columns and compare her idea about burnout with those of Drew [1986], Benner [1984], Montgomery [1993], and Maslach [1983]. The first identifying those that believe that burn-out is caused by nursing particular types of persons; the second identifying those feeling that burn-out can be overcome by 'drawing from abundance' [Montgomery, 1991]. Later in the interview Frieda said:

> "What I am trying to say is you have got to know when you have to switch off and you have to have balance in your life ... that's basically my coping mechanism".

Drew found that when persons had been ignored [as Frieda had been in her hospital experience] negative consequences in subsequent interpersonal relationships occurred [1986:40]. I asked Frieda what she would include if she was teaching a nurse to care. [I was still trying to understand her concept of caring]. She felt this person must

> "want to care. You cannot care if you don't want to care. ... And you must be interested in that person as an individual, not just as another patient in bed. Your heart must be in it".

I hinted, in the light of her already having spoken of 'balance' in her life, that what she said might cause stress. Her reply was,

> "Not if you have got balance in your life. You have to have a balance. You have got to have outside interests. You can't hone in completely on this otherwise you would burn yourself out".

Unlike Montgomery's interviewees, there is a fear of over-involvement, a need to protect the self from becoming stressed and exhausted. She had learned to hold back, distance herself, or in Wright's [1981] terminology 'set boundaries' in her relationships with patients. Her coping mechanism was 'balancing' her outside life with her nursing. To prevent 'burnout' Frieda hands patients over to colleagues so that their talents and her own facilitated holistic care. This is an interesting angle on the concept of holistic care. Frieda showed commitment to teamwork, her colleagues and that holistic care was a team effort.

There are good but puzzling aspects about this interview. When one takes a concept like caring and analyses it, it is not just to get a description of what the word itself means. Nor, in the case of this particular research, is it how the RNs define the word. There is more to it than that. I must hear how this word is used in Frieda's narrative. I must know what the concept means in her life. This analysis of how a research participant uses the word, not just in what she says but in what she reveals in these 'sayings' is her particular way of showing her understanding, beliefs and desires.

Frieda's statement of care is significant in this light: her care embraces a perception of a different degree of care. She is virtually saying: "And they didn't care for me: about who I was, what I thought or felt". Words Sue Baier [1985] used when she felt neglected.

Nurses who had shown Frieda no care were negligent because they had a duty to give care. Their 'care' differs from Irurita's [1993] 'rough- or hard-hand care' because instead of abusing power or discounting requests [as Irurita found] they were negligent by totally ignoring Frieda. Had she been forgotten because she was in a private room?

For Frieda this poverty of care was the type of care she felt she received twice. She calls it care. I could call it non-care rather than use the moral idea of 'bad' care, or even the ethical concept 'exclusion' [Drew, 1986]. Was her experience of non-existent caring where she learned her meaning of 'care'. There are three possibilities:

1. Gendlin [1962] emphasizes subjective experiencing creates meaning. Could Frieda quantify the value of caring in the light of nothing positive being said, done to, or, for her? Was her lived experience not Drew's exclusion? This means: "patients were ignored as persons and not accorded the social recognition they would have been given in different circumstances" [1986:39]. Drew cites Van den Berg [1955] as the only one who interprets exclusion as depersonalization. The opposite of exclusion is, for Drew, 'confirmation' [1986:40]. 'Confirmation' equates with affirmation.

What connection [similarities/dissimilarities] is there in Frieda's 'story' with that of others? Is there family resemblance? Does this show a 'falsity' in her use of the concept? On the contrary, her use of the word surely shows that the idea of 'deep caring as being inchoate' or a capacity is relevant [van Hooft, 1996:84] and where having a 'memory of being cared-for' is deeply rooted [Noddings, 1984]. Frieda had totally disputed the idea that one cannot care for another if one has not been cared for oneself. The capacity to care was there but overwhelmed by her need to 'balance' her involvement. As the newsletter and Lesley[18] suggested, some nurses become hurt and withdraw from caring because they are no longer able to care due to emotional/spiritual pain.

2. Bowden confirms that caring can have negative connotations. She writes:

> "The tendency to see perspectives and concerns arising from ... other practices of caring simply in a positive light glosses the dark side of these practices: the frustrating, demeaning and isolating dimensions of their routines. 'Care' has a lengthy history in the [English-speaking] West as a burden, a bed of trouble, anxiety, suffering and pain; care ethicists ignore this history, and the dismal actuality of many contemporary practices of caring, at great risk" [1997:9].

3. Ayer [quoted by Bambrough, 1968] discussing Wittgenstein's game analogy, states that his argument brings out the point that the resemblance between the things to which the same word applies may be of different degrees, one looser and less straightforward in some cases than in others. Bambrough disagrees. His feeling is that Wittgenstein's argument points out that all games are in fact games [1968:193]. I think both points are valid. Frieda gives a loose meaning to the term caring, one implying that she has a standard of care in mind. This is contingent with the idea that all games are games: one can say all care is care. But, some care is given ethically as an expression of that deep capacity. Some care, according to Watson's concept of care being connected with morality, can be a-moral, without any intention of good.

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[18] Lesley is an interviewee who will be discussed later

Therefore, with Frieda's use of the word care, I can say, given Bowden's analysis, it is still a type of care. There is, Bambrough argues [and I use care where he uses game], 'an objective justification' that care is care and there is 'no element that is common' to all care [1968:199]. He concludes there is no single answer: "The resemblance is unintelligible except as resemblance in a respect" [in quality or property]. In talking of "properties and qualities", one can "do nothing but point to the resemblances between" the concept [1968:204, his italics].

Even with rough or bad care there is some degree of care being given. What is missing is relationship: the ethical aspect that either diminishes the care-giver or the cared-for, or, it enables one to grow as a person. Relationship is the element the majority of research participants emphasized. Frieda's positive perspective of the concept came from her work experience. Care was doing her job properly and being a good carer. This gives care an ethical meaning. Caring for her meant, and I repeat:

"Being with a person ... walking with them. Not taking their pain. You can't making it easier for them but walking besides them trying to help and support".

Basically, this was all Frieda could do: have her heart in it, be interested and present to the person, not just as another patient, but as an individual. Her volition motivated her to communicate care in her attempts at supporting and helping her patients. Perhaps Frieda had not made her perception of being cared-for public. She entertained a perception of caring that was her own. This is said because when I asked what she would include in teaching caring to students, she immediately gave another negative view involving a post-basic nurse educator. Perhaps some nurses do have a negative taken-for-granted meaning of caring?

What Frieda described in her first illustration was negligence or exclusion on the part of the staff. The next was of a nurse educator who believed in Freire's [1968] "banking method" of teaching: depositing content into students' minds. They are examined as to how much they can draw from these repositories. In tests this nurse educator expected everything to be "given back parrot fashion and sequentially". Having been given nought for a question Frieda confronted the nurse educator, whose remark was, "Half the class failed. I couldn't care". There is this negative dimension again this time in relation to 'disconfirmation' or non-affirmation of a person [Drew, 1986:40]. What this nurse educator is actually saying is: I am not concerned; I am not willing to affirm you. There is no relationship between us that enables me to change my original attitude towards you. It may diminish me as a person but I am not taking that into consideration. I do not care.

Frieda and this nurse eeducator are, whether they are aware of it or not role models of caring. Both have their own meaning of care from presuppositions and taken-for-granted meanings, or, the 'nonsense' that Wittgenstein writes of - those private meanings [Quinton, 1964:6]. It begs the question of whether a private usage of the term care is the taken-for-granted meaning: a negative value; and, whether one should work at a more 'public' open, positive meaning for the sake of patients, students and other care-givers.

5.13. Paula [Appendix IV is given as an example of data collected]

Introduction

Paula struck me as a deeply thoughtful person really wanting to spend 'quality time' with patients. She gave me the impression that she was talking to me as she would have talked with her patients. Paula's characteristic was wanting to make time to be with, and for, patients. She sought for quietness, and obtained it in the hospice garden, which patients could freely enjoy and was why Paula loved being on duty over weekends. Being with Paula made such calmness noticeable and a pleasure not only to me but, as I had noticed, to her patients. The stillness of the place and Paula's presence had this calming effect like the calmness Sr W felt was needed in a ward. Paula struck me as being reflective and this was, she confirmed, because she drew on her life experiences, her spirituality, and her sense of being. She called herself a 'nurturing type'; one who gave to her fellow man. The interview took place in the garden and we were disturbed at the end which is why the interview ended abruptly

Discourse

I felt if she were to assess and prioritize my needs as a newly admitted cancer patient I would feel comfortable with her, and she would be listening and interested in my 'story'. And if I, or any of my friends, became anxious or upset she would be there for me or mine with this calming effect. She gave that impression. She exuded a professional-personal involvement: enough to understand my pain whether spiritual, emotional or physical.

Caring meant being professional about her role yet fluid enough to be there ready to counsel especially spiritually if that was what was necessary at the time. She would assess the situation. She was knowledgeable about symptoms and their control which would give the confidence imperative to quality hospice caring. Paula's use of the term 'spiritual' was fairly common in hospices. It is a realm that the uni-disciplinary team is particularly aware of. Spirituality will be discussed later because it seemed to become an integral element of caring.

She had memories of caring of the 'hands-off' type: helping someone to gain independence. She said she had learned patience and professionalism through nursing a patient who had been at this hospice for two years. Paula showed love and caring for her in spite of, or because of,

> "the gruelling demands she made".

Through this

> "very incredibly stretching experience' she was taught 'a great deal about suffering and caring".

She was 'motivated to make a difference' to patients. Paula became aware that people 'grow' spiritually through caring and unconditional love. This contrasts with Frieda's statement: 'not taking their pain'; but confirms Nouwen's 'emptying our own cup and allowing the other to come close to us...' Both had learned about suffering through caring for their patients.

Paula had a standard of care that she called 'optimal care'. It implied having empathy and understanding for patients, spending time talking to them. It encompassed doing basic care: nails, hair, so as to listen to her patients. It meant being gentle with patients and going at a slower pace. This kind of caring was special [for both herself and her patients]. She was willing to learn from patients and others. She was not saying that she knew 'it all' after many years of hospice experience. The opposite of caring for her was having no time, and being rushed. She described rough handling as being 'practically quite harsh' and 'ungentle'.

She was aware the caring being given at this hospice was below the standard set previously. She felt it to be at the level of a State Hospital where one never felt one had 'finished off the day properly'. She had deep concerns, even fears, about caring because of the way she felt the hospice to be going due to financial constraints. This would mean that:

> "The hospice would lose some of this very special care in the process".

She was unsure as to how things could be changed. She understood the staffing level from the financial point of view but felt that they could not

> "possibly continue the kind of care they used to give"

They used to have, in the past, a high RN to patient ratio. She enumerated changes that could be made and that would stop time wasting doing non-nursing work.

The sad aspect about Paula's discourse was the effect the financial constraints were having on patient care. Questions could be asked about why a Government does not subsidize hospices caring for the terminally ill. Why are the finances of hospices left to the Public's generosity? Is it the old psychological-cultural problem of not wanting to be involved with the dying, that the living were more important? Care had not degenerated to that of Bekkare's ward of 90, however the RNs who remained after budget cuts were so busy with non-nursing tasks that it was left to Auxiliary Nurses to do basic hands-on care, except, as Paula shows, for the week-ends when disruptions were fewer.

5.14. Lesley

Introduction

My introduction to Lesley's caring was her hospitality. From the outset, Lesley made me feel welcome. She consistently acted this way towards me, and others. She was near to retiring age, had a wealth of experience as a nurse, and had had cancer herself. She was quite open about this experience. This sensitized her to patients especially those diagnosed as having the same type of cancer. She was open, chatty, expansive, and helpful. She laughs a lot, and appears very generous of spirit, reflective and openly spiritual.

During many visits, Lesley told me about the ethos of the ward, how they were organized, off-duties, forms/records, and some of the many problems. This included not only the shortage of nursing and voluntary staff, but how colleagues became hurt and withdrew from caring because they were "no longer capable" [of caring] due to this pain. The interview took place a short while after accompanying her on a medicine round one evening.

Discourse

I had worked with Lesley before I interviewed her. I had observed her ward on several occasions. The shortage of staff was obvious in this unit. Lesley was working on her own with too many terminally ill patients at times. It came as no surprise that there were crises. We had two on the evening medicine round when I accompanied her. Lesley wanted to give more attentive caring at these crisis points but conscious of time passing, people needing medicine, the legal aspect of charting them, other patients, and record keeping in preparation for the evening hand-over, detracted her attention. Patients in dire need had to be left alone, died alone in one instance. The two Auxiliaries were working with ill patients on the other 'side'. The ward was full. Money was tight; there were no other RNs to call upon.

Lesley was sensitive to patient's needs in a particular way: trying constantly to assess their anxiety, comfort and spiritual needs. Caring, was to Lesley, "looking after the patient totally". She related doing a full wash on a Matron when still a student nurse and what "a spiritual experience" it had been for all involved. She acknowledged the fact that with the dying patient

> "really you have only got this one time with them. You haven't got lots of time".

The words were true because the patient died between attending to the next patient and returning to assess him.

Lesley felt, "Caring is the same as nursing" then pointing to a non-nurse friend said:

> "Look at what a complete carer she is ... it's a complete sort of love, ... it is grace: a gift. It's a gift that you impart to others, and others impart to you. It's all part of the whole thing. It is difficult to describe. It is natural: the basics are there, but it has to be developed... Then you get this lovely wholistic care, sheltered: all the concentration on the sick patient. The whole multi-disciplinary team all caring".

This was true during the day, but not as true in the evenings when the rest of the multi-disciplinary team was off-duty.

5.15. Brenda

Introduction

Brenda had not worked in a hospice for long. However, she was already commended by her 'gatekeeper' as a person who cared. She had a particular fun-loving gay type of personality. She included her family in her discourse on caring.

Discourse

Brenda's picture of caring was refreshing. Caring was

> "Thinking about people from every angle. It was not just going into caring-type-mode where you became all concerned but [where] you treat [the patient] with respect". "If you pick them up you do it with care".

This meant respecting a person's privacy and dignity. It was important when working with patients to show these aspects. People were to be accepted for what they were, [e.g. patients with AIDS], without criticism, without putting labels on them. One did not become judgemental.

Brenda's emphasis on caring was remembering. She felt,

> "You must be disciplined to remember those [personal] things about the person: their names, relatives, incidences, places". She says, "You remember that they are sick, you are well, stronger, more robust" [than them]. [Therefore] "you work at their pace not yours".

In this statement is the idea of nurturing the weak and vulnerable. Brenda's 'remembering' is one of her values She went so far as to say,

> "Even if you forget pretend to remember; don't lie but pretend to remember. What's important to them must be important to me".

Brenda had been chosen as a research participant for me. Before I left I asked the 'gatekeeper' why she had chosen Brenda. The immediate response was, "Because she cares so much for people".

5.16. Susan

The 'gatekeeper', Mary.

I begin by introducing Susan's 'gate-keeper' because she shared that at this hospice they had improved on staff selection. I feel this is important because it says much about the characteristics of care-givers. The terminology may be different. It represents clinical practice language but the points show 'family resemblances' with Montgomery's 'predispositional qualities'. It was not personality they looked for. Many nurses wanted to work in a hospice to find what Mary called 'the essence of nursing again'. She, and other managers, realized they were looking for a 'being-person': one who listened; who was comfortable with silence and loss. This silence was of the utmost importance, she felt. Silence had taught Nouwen the depth of caring. Mary looked for those who had had losses in their own life-experiences. Not necessarily, loss by death, certainly not a recently bereaved person, but one who understood such loss, had faced up to loss. These persons had learned from experience and "come up the other side". They had grown and gained strength. They were aware of those strengths and weaknesses and most importantly, they were person-people.

Introduction to Susan

Susan met these criteria. Her patients benefited from her caring though many of them would not improve in their physical condition, they would have improved their health [where health implies the more-being and growth of another]. She met Mary's perception of the essence of care. This was in her communication transaction: being perceptive-, brave-, and comfortable- enough to share of life experiences in mutuality with another. A mutuality along the lines of Noddings thought: "enhancing the ethical ideal of the cared-for" [1984:113] because Susan felt caring was two-way; both persons "got something out of it"; "something got added" to the person, "something came back to the person" who cared. It showed compassion when you learned to cry and no longer saw crying as a failure to be professional.

Susan had known hospice work from its inception. She felt there should be a new type of hospice just for those dying [i.e. not for palliative care].

Susan's present personal 'curriculum' was enabling her to 'empty her cup': become even stronger mentally and emotionally. Her closest relative had cancer. She felt "she knew everything there was to know to practice nursing in her hospice". She was used to "giving a high standard of care".

Discourse

For Susan a hospice was

> "the kind of nursing that you dream about. You have the patient to support and you're there to do what the patient wants. Totally and completely, and that's the way it should be".

Susan displayed a concern for people. People mattered to her. When asked about memories of being caring herself she immediately mentioned her sister. She saw this sibling as her biggest care. She felt,

> "You know everything, you know how to practice, but it's hard, harder with the family"

What made it harder was that she wished she had the cancer and not her sister. Her reasoning was she felt herself to be the stronger mentally and emotionally. She had

> "walked down the path with hundreds of people, but to walk down it personally is another thing". She had not learned anything more from it, but "I'm putting everything I know into more practise. I just know what to do, but it's hard, very hard".

Caring meant everything to Susan. She defined it as

> 'being there, and being aware of people's needs; their needs, not yours. Theirs". [Her emphasis]. You've just got to be a presence, and let them know that you do care for anything they want. It doesn't matter [what]. You're not here to judge anybody".

The patient should know that a nurse was not there to judge.

> "It was caring for the mind, body, physical - where the symptom control is at. Caring for the family, where they were [emotionally]. It was being concerned about everything that is going on, at all levels. Being aware all the time if things are changing. And you must not care from your (stressed) point of view, you must care from their point of view".

I asked her to explain this. She said,

> "You mustn't put your own thoughts and feelings and everything onto them. You must be where they are. Be where they are thinking. Don't intrude. Be there, but don't intrude. These [dying] people are only with us for a short time. They've come into our lives only for a short time. They've had a life they are going into another life. We are only part of it for a short time and we can't change anything. You mustn't even try. You try to think how they feel".

Thinking about Nouwen's 'emptying our own cup', 'taking away the many barriers which prevent us from entering into communication' one can interpret Susan's discourse more fully. Susan had, like Nouwen, learned to care, dared to care, through experiencing and reflecting upon the meaning of her own spiritual pain. To explain.

> "... to care for people you've got to make sure they're pain free ... that they are properly controlled; pain free as much as you can. You can't really care for them properly if they've got pain and nausea; where pain takes over your whole being and you can think of nothing else. Pain shouts at you; it makes you vulnerable. Caring boils down to what you want for yourself. How would you care for yourself?"

This understanding of pain was said as if she had walked with people in pain, as if she knew the reality of it. Certainly one did not get the feeling of avoidance, or distancing. In this vein she remembered nursing an old lady in rather a routine manner. Then she asked herself

> "Imagine if this was your mother; how do you want to treat her?"

This goal became her ideal eight hours a day.

> "Caring is a conscious willingness to meet their needs at any level, anybody. Not to be cheerie, not to put yourself onto them. If they don't want to smile that is it. You're there, but not there for yourself". She ended: "I know what it is to do but not to put it in words".

She felt nursing had become more professional, more scientific even in its approach to the dying. The patient became more comfortable and symptoms were being treated better. Yet, she felt that the death and dying process had become less important which she did not feel was good. Her care was of the compassionate type something she learned from her father.

> "Staff don't understand how important it is to die, nor empathize with it like they used to".

For all this, she felt the hospice was giving a higher standard of care than anywhere else was. But, the focus was on palliative care and not on the dying. One would need to "start another hospice just for the dying", where the staff would be educated about the importance of being in the room with the patient while they were dying. They would be taught to lay out a person properly for relatives' sakes.

Time and staff were both in short supply. She reminisced about when they were able to spend a whole afternoon, even a whole day, with a dying patient seeing them through to the end. This had all changed.

She volunteered her opinion about the term burnout.

> "I don't know what it is. It is just a word. A selfish attitude. Their needs are more important than the patients. Why are you thinking about yourself? It is a question of not switching off, their concern, their tiredness".

Susan was a 'gatekeeper's' choice. She was chosen, "because she cares". She felt she had always been that kind of person. Her father had been a big influence upon her being caring. She saw him as a very compassionate man.

5.17. Haematology/oncology units

Introduction to all participants

Going to these wards was, in the first instance, unintentional. It came about because staff in the oncology unit of the State hospital could not give me time for interviews. This became a problem because of my own limited time. The fact that interviews had to be done when I was off duty inhibited potential interviewees. They wanted to get off duty especially after a 12-hour shift. It was when a 'gatekeeper' asked me how I was getting on that I shared this problem and she suggested going to the haematology wards. As a result, I went to more than one hospital. I learned from them about haematology as they taught me about caring. There was not the atmosphere of anxiety [about money] that was prevalent at some of the hospices visited.

The next kaleidoscopic care patterns are from four RNs working with patients who have a similar kind of 'lethal illness', leukaemia. Two are in a state institution, two in a private hospital.

Their narratives made me realize the intense nursing happening in leukaemic units. Leukaemic patients suffer not only from their condition but from an invasive battery of bone-marrow and blood-tests; drugs, and their unpleasant effects and the 'see-saw' of remission. Some of them, as Amanda emphasized, go through the developmental crises of adolescence concurrently. To learn that adolescents were in isolated units not being able to communicate face-to-face with peers was an overwhelming emotional upheaval for me.

I use the term nursing in a generic sense: perhaps in these units this was 'intense caring'. At the time of these interviews I was partially satisfied with the definition of caring I had formulated, but during these interviews I put it aside. I needed to be open to evaluating the type, quality or, nature of the caring taking place in these units from different perspectives. This was possible because it was before I fully developed the research strategy eventually used. I was attempting to judge caring through others' understandings of the concept.

The style is slightly different in this section as I discuss the person they are in their discourses: again, this is for reasons of confidentiality.

5.17.1. Amanda [in a paediatric unit]

Amanda talks specifically of continuous and intense caring as "being totally there for a person". Her attitude towards caring is that of giving of her presence in relationship, and treating the patient wholistically. Her "type of nursing" takes the form of explaining carefully about procedures, reassuring the person, staying with them as necessary, making time to sit with and talk to them. Giving of her presence to them in brushing their hair, and checking their teeth. In her words she does "basic nursing" of the type she "performed in her first month of training as a student nurse: "weighing patients, checking intake and output charts, how much they ate, and so on". She empathizes with a child who is treated "as just another child" and [who is] told [roughly] "eat your food and go to bed" which was why she says, recognition of patients as persons "is meaningful. It is very important to me". She draws this from childhood memories. Thus she is attentive and sensitive to childrens' needs.

What unfolds in her narrative is how she takes families and relatives and relates to them in a positive, purposeful manner that gives meaning to both parties. She relates to the physical, psychological, social and spiritual aspects of her patients and their families. As she put it: "The whole family is affected by this illness". When she described wholistic care it was not just a cliche. The reality for her was what some call intersubjectivity and others empathy:

> "Meet[ing] the patient and going though all that feeling that the patient goes through, and denial. Everything that the patient feels".

She applied her knowledge to individuals as separate unique beings. Throughout she affirms her patients as persons. Her objective is to make these little people "feel wanted and valued". Within this idea of caring communication are the concepts confirmation and empathy. Montgomery unfolds her perception of these concepts. Confirmation, she felt, is one part of caring, empathy another. She uses a Buberian description of confirmation, "The measurement of humaneness of a society... The basis of man's life with man is twofold, and it is one, the wish of every man to be confirmed as what he is, even as what he can become, by men; and the innate capacity in man to confirm his fellow men in this way ... Actual humanity exists only where this capacity unfolds" [1993:20].

These aspects are noticeable in the remaining interviews too.

5.17.2. Henrietta

This was a home interview and it seemed timeless, it was so quiet and easy to interview. Henrietta uses picturesque words to get her understanding of caring across. Care meant love, attention, being bold. Care was a two-way relationship though she, unlike others, felt that "a nurse could not expect caring back".

Yet she spells out the kind of reciprocity patients could give. She says:

> "The patient is not better for me but it's uncanny what they will do for you, and what you [the patient] care about. It matters what I do for you".

She felt there were different levels of caring. As she put it, caring for a new mother as a community nurse and caring for a mother in a hospital bed [with leukaemia] were different. One would not touch the former as one would the latter, nor show the same type of care and empathy. One could only care about someone in a certain way or not at all. It was based on their needs. Care was something one did, it was action not just a feeling. As a child visiting a mission station she had been awed by this type of caring.

> "[P]eople [were] doing these loving things to these dirty people who couldn't even ... communicate well, who had nothing. Here was this group of people ... feeding, touching, binding up wounds, praying ... They were loving it, proud of it".

Caring was accepting, and seeing the value of, the person. Persons would receive attention and acknowledgment that they were part of the situation. She seems to turn the kaleidoscope and explain the picture reflected:

> [The person] "was not just a figure standing in the middle of a tapestry. All the background was being filled in too".

She gathered facts about the patient, but not only facts.

> "It was the things which to me were telling me what was happening to this person, and those things around their lives .. things that were important in their lives and made them ... respond because they realised that I was more interested in them than in a body with a disease".

Graphically she continued, patients realised there was someone interested in the little pictures in their lives because

> "I think that the little pictures are as important as the big, bright, bold ones because it is often those little ones that make us".

Care was something "tangible with hands, feet and words".

Care-giving was not only about physical things, nor

> "did it stop at the bottom of the patient's bed".

Giving this tangible care one would "go into the patient's home".

Meaning that when patients were allowed home for a week-end and their IV line blocked one went to the home and unblocked it [rather than instruct them to return to hospital]. One spent time and became part of the family. This was important and something was missing when family involvement was absent.

> Henrietta's caring extended to staff and students. I had seen some bright scholars in another hospital. Thinking of these, I asked Henrietta if she had any idea of the questions this kind of student would ask on her ward [a Spradley-type cultural question]. She wanted them to get away from
>
> "What is wrong with this patient?; What can they, the students, do for them if they are going to die?"
>
> Instead she wanted them to ask,
>
> "How is this patient getting better?"
>
> There is a reflective brilliance about this question not to do with cure but the concept of care. She wanted students to focus on imparting health, to get away from disease processes
>
> "... I want them to see that the patient ... can be physically ill but can be healthy emotionally, or intellectually, spiritually, in any sphere. The patient's physical component may be a little component of an [otherwise] very healthy person".

On checking the transcript with Henrietta she emphasized that it was nurses who cared for patients in the most intimate of ways. These ways of necessity, had to relieve 'bad things that happened to them' because every physical aspect of a patient is exposed to nurses in a manner that no other health care professional has to deal with. But this aspect of vulnerability will be discussed later.

5.17.3. Kay

When asked for a memory of care-giving, Kay said she did not feel she could give just one example. She mentioned a relative in late stage renal failure. Kay had to decide whether to donate her kidney and this was on her mind during the time I saw her for these interviews/observation periods. It led her to discussing the spiritual. She emphatically distinguised spirituality from religion or faith. The spiritual, for Kay, had to be drawn from elsewhere other than religion. Though she knew that at a time like this religion could give her comfort, she deliberately denied herself this religious comfort.

Regarding caring Kay said,

> "[I]f I say that I care about a patient I am saying that the patient is important to me. She explained it as, "When the person is important to me it matters to me what happens to that person and how that person feels. It is significant to me. Care builds up a personal relationship and sometimes you take it home. Its more than professional. Its got to do with bonding".

She felt that it was better to become too attached than detached. Some people cut themselves off from a patient. She felt, one needed an attachment, some kind of interaction between one personality and another. But, she thought, there was a fine line between attachment and detachment. It depended on how one was cared for oneself. A distancing-type of relationship is discussed by Flaskerud et.al. [cited by Montgomery, 1993:24] as typical empathetic behaviour by nurses. This behavioural message, they felt, came through nurse education. Nurse education's message about empathy enabled nurses to be close to patients but not too close. Where this so-called appropriate 'distance' was, was not defined, they felt.

Kay's patients could stay for three months and a nurse could be allocated a patient for that length of time and could become quite attached. She thought caring could be equated with love but this word was not to be used lightly. It depended on how love was defined. She admitted to becoming over-attached because the unit worked a system of patient- rather than task-allocation. She had nursed a child who had died a few months earlier. This had had an emotional effect on her.

> "After [the death] I think I was doing a job rather than caring too much".

Which reveals that she did not see caring as a job normally. But during this [painful] time she could not connect emotionally:

> "every patient doesn't matter to me when I'm in this emotional state".

Someone could comment on the patient's feelings but she found that in her grief-stricken state she did not want to pick that up.

For Kay caring was not something primarily physical. As she said,

"We act for them, do everything for them" when they were in their very ill phase.

> "You do everything for them, nothing is left undone".

5.17.4. Cindy

Cindy had never felt not cared for. She linked this statement with "I have always felt nurtured". Care was something reciprocal to Cindy: how the patient felt mattered to both parties. How she, as a nurse felt, mattered too.

Cindy felt caring was not something she thought about, or was conscious of, she just did it. She had learned what one did for people in order to care for them and she did it unconsciously as far as she was concerned. In asking Cindy to think about her own care-giving, what she actually felt about it, she thought one needed to be a patient. Then one thought about one's needs.

> "You have to put yourself in their position, you have to put yourself where they are, think in terms of what they might need".

This statement revealed Cindy's reflection. She wanted to give time to her patients.

> "They need a lot of time given to them. [Haematology patients] are alone so much they need extra time to be spent with them".

She enjoyed the reciprocity terminal illness brought. Her meaning was she could make people feel that they mattered. The interaction in this situation was

> "almost a spiritual thing".

Acknowledging this spiritual dimension to caring she said,

> "We all have a spiritual need.. whatever way it is expressed ... I don't think we can exist without it.

I asked about bonding. Cindy's quick reply was

> "unless you bond with them I don't think you can do the job properly. You shut yourself off; or you distance yourself. "Then", she said, "you get nothing from the patient, you don't get as you should".

This was what Cindy meant by reciprocation in oncology. She could not care in an oncology situation without bonding". Her reasoning was

> "you go through the processes that you need to and it gives you all the feelings imaginable: positive, negative, irritated, you know. It's part of it [bonding]".

Caring was not a question of "hands" [more staff] to Cindy.

> "Extra hands were not necessarily what was needed. You need to want to take the extra time".

Caring was a question of "personality type" and volition. There was no difference for her between nursing and caring.

> "If you do nursing you're doing caring".

She admitted some nurses were not always caring,

> "They come to work because its work. [They] do what they do because someone tells them to".

Against this attitude was that of the child-patient who was present with us during this whole interview. This seven year old had had a blastoma of her eye removed. She was used by Cindy as an illustration of caring. She explained how this child, far from home and parents, sensed when staff were busy or troubled; when she had to keep out of the way, but she gave herself to the staff. She made everybody smile. Cindy summed it up saying,

> "She's a caring person".

This picture of a child caring shows caring is a natural, in-born capacity; but one, that needs developing. It also shows how one person can be defined by another, in this case as 'a caring person'.

5.18. Conclusion

According to Bowden [1997:13] Wittgenstein's clarity of understanding concerning a concept is obtained by "a discerning juxtaposition of different 'objects of comparison'. These enable appropriate connections to be made.

> This becomes true of the concept caring because 'certain dimensions' have become focused. They emanate from these discourses and from the theorists. Having obtained the data: through interviews and observation, the discourses need to be put together for the purpose of comparison and evaluation. This will be done in the following chapter by continuing to juxtaposition aspects of the interviewees' discourses in a discerning manner. The approach will be discussed therein.

> "Caring in nursing is concerned with relieving the vulnerability of people's life experiences, as well as the promotion of health and wholeness. Thus nurses work is with concepts such as hope, compassion and empathy to moderate reductionist approaches which produce averages and idealistic norms. Caring is the moral and scientific basis of nursing. Caring is not, therefore, a series of predetermined, isolated actions, but manifests as patterns of interaction not regulated by rules. Caring defies quantification...". Farmer, 1992:537.

CHAPTER SIX: Dimensions of care

6.1. Introduction.

This chapter reveals elements surrounding the concept of care. These elements are taken from participants' discourses and are juxtaposed with authors' writings. The elements to be discussed are 'vulnerability', 'persons', 'health' and 'spiritual'. The concept 'person' is central to compassionate-care and is considered within a health-care perspective. Then because caring has been discussed as relieving a persons' vulnerability [Farmer, May [1969, Gadow, 1988] this too must be explicated along with 'health' and the 'spiritual'.

6.2. Vulnerability in nursing

Farmer's [1992] quotation: "Caring in nursing is concerned with relieving the vulnerability of people's life experiences ... ", links nursing inextricably to caring. Farmer's concern highlights Gadow's definition that caring is a "commitment to alleviating another's vulnerability" [1988:6/7]. We need to understand how caring can alleviate vulnerability. But, what is the vulnerability that must be alleviated? Noddings [1984], writing of caring in the context of both moral development and ethics, felt that if caring is to be moral, one must feel a sort of pain in response to the pain of others. This 'pain' would not only be of the physical variety but emotional and spiritual as well. Noddings' perception of caring in this vein reveals itself as compassion inherent in caring. It also gives a wide perspective to vulnerability.

Gadow [1988] identifies with the perceptions of patients: she sees vulnerability as the exercise of the power one person [e.g. a nurse or Zimbardo's 'guards'] can have over another [a patient or Zimbardo's 'prisoners']. Gadow's perception includes even where that power serves a benevolent purpose like a care-giver relieving pain. Her point is, the patient in pain is vulnerable until the pain is relieved. Relief is under a nurse's control [1988:7]. The caring manner in which she relieves pain determines how this vulnerability that the patient feels is relieved.

The meaning of a concept like vulnerability can be taken-for-granted and this is important to realize. The taken-for-granted must be exposed. Feeling compassion for the vulnerable: those troubled or suffering is a domain not often shared or discussed. I can be exposed to others' vulnerability: their powerlessness or helplessness yet not 'see' nor comprehend the meaning it has for that patient. Unless vulnerability is experienced or reflected upon and a shared meaning with the one suffering found, I am not in a position to affirm or disaffirm what others say about it; nor able to relieve it intelligently.

6.2.1. Approaches to subject

This subject can be approached from different angles: from the perception of what authors write about patients or the lived experiences of interviewees, or one's own personal experiences. If research is to be caring in itself I believe the researcher should be able to describe such a concept as a lived experience in order to understand and share its meaning and language.

Research participants' use of the word came from their felt experiences, not from theories. For example, Amanda said she felt vulnerable everytime she was in hospital. For her feelings of vulnerability were present during each maternity experience. This was validated by Frieda's experience as a maternity patient. Amanda's awareness of the possiblity of vulnerability gives her a heightened awareness of the need for her patients to feel safe and protected: to be cared for.

Henrietta, though not actually using the word vulnerability expresses the idea. She said, "Only when bad things happen is one cared for". She is describing vulnerability as susceptibility to physical and/or emotional hurt, harm or injury; being defenceless or weak in respect of being open to verbal, or other, assault; a person having diminished control over his/her life and the integrity of that person being at risk.

Thinking of persons, their spirituality, the relational aspects bound up in the word with its idea of wanting the growth of another, then the fragility of persons, their dependency, emerges when 'bad things happen'. Life experiences touch and expose that personhood [Farmer, 1992]. For this reason Stoics aspire to an incapability of feeling. They do not want someone else to affect their feelings for that would give that person power. They do not want to become vulnerable in this way.

Henrietta ensured patients were made to feel accepted no matter if they had had a diarrhoea episode in bed and felt embarrassed about it. She cared for them: worked at making them feel accepted for the person they were. She let patients know she was there for them. Her patients were valuable for themselves regardless of condition. Her caring caused her to create bonds, through compassion for their suffering. Her actions arose from her choice: a choice that gave her freedom to be caring.

Kay gives another angle: of State patients, who came from long distances without family or community, trusting nurses with their vulnerability because, unlike private patients, they did not have anyone as a support system, and bonded with nurses. For Kay vulnerability meant "exposing oneself, putting oneself on the line". She juxtaposed it with trusting: that someone would provide protection when one was in the haematology unit and became so ill. This trust operated when one revealed confidences and one's property and name was treated with respect. Non-caring meant enhancing feelings of vulnerability: the patient was not seen to be important. Kay was adamant that nurses who lacked knowledge and skills and who paid little attention, made patients feel vulnerable. Without realizing, she felt, they were not taking responsibility for the fact that it was significant to patients when lines got blocked, or air got into J-lines, or the abrupt way they talked to patients.

Cindy blatantly said nurses were not good carers. They could give care but were not good at making one feel that one mattered or what one felt mattered. This, she felt, was how making one feel vulnerable started. Suffering caused vulnerability.

Richard Zaner [1982], a patient with chronic renal disease, describes the nature of vulnerability in the context of his suffering. He explains vulnerability as an attack on personhood: where the boundary of the body and the person is transgressed by others. It leads to a perception of fragmentation that is deepened by the world of institutional health care. A person's private world becomes public through impersonal organizational routines. Ordinary relations with others are distorted. Zaner is saying that if he places himself in the hands of others he could be deprived of that crucial sense of self or integrity: deprived of what he values most about himself [Bowden 1997:113].

According to de Jong [1987], a medical anthropologist, a health service functions to explain the cause of a person's suffering. What has to be faced in this discussion is that health care professionals cause patients' suffering by intentionally or unintentionally making them vulnerable. As one reads Sue Baier's [1985] narrative one sees health care professionals doing just this.

Stenberg [1979] uses her perception of that vulnerability confronting patients undergoing surgery as being constructive towards a covenantal ethic. She sees compliance to surgical treatment as "an act of faith": where a patient seldom fully understands the necessity for each act of care. Although patients put their lives into the hands of strangers in acts of submission of the will and body seen nowhere else in human endeavour there is radical invasion of privacy: mental, physical and emotional such as Zaner and Baier describe [op. cit.]. The patient submits voluntarily to this and to varying degrees of fear ranging from slight to life threatening. There is control of life style by one person over another; even bodily functions are in the hands of others. These disruptions of personhood are present in all phases of health care from comatose individuals to well persons in ambulatory settings. Caring practice needs to minimize the impact of this reality [1979:21]. An ethic unfolds in the fidelity of promises made and truth telling. The skill is to care with compassion whilst safeguarding personhood and preserving self [keeping one's own and others integrity]. This frees patients from fear, pain, and the possibility of abandonment. Such safeguarding provides hope.

The third perception of this concept vulnerability is my own. I underwent a lived experience that validated what others said about the concept. The frightening aspect of this experience is that it took place with student nurses who had failed an Objective Structured Clinical Examination [OSCE] and when they should have been showing ultimate caring in order to pass their examination. I role-played the part of 'patient' in getting a weak patient out of bed. During the procedure, I was made to feel fear, dehumanization and the sensation of being out of control. The reality was having to be dependent on others whose knowledge and skills were seen and felt to be wanting, of realizing that I, 'the patient' mattered little to these nurses. This is said not because of their past failure but because of their approach to the task.

Their handling was the antithesis of Bowden's caring-attention or those of Montgomery's predispositional qualities of a care-giver, or even those of a lay-person.

Reflecting on this experience I concluded that persons who make another vulnerable are not aware of, nor willing to perceive, a patient's need for protection; either because of thoughtlessness, a lack of feeling, knowledge, or indifference to these needs. They are not 'seeing'. As Bowden [1998, citing Murdoch] reveals this 'looking' and 'seeing' is linked with attitudes and feelings. Murdoch felt these to be moral attributes, her premise being, that one could only make a choice within the world one could see and she gives a moral sense to the term "see". Therefore not "seeing" a patient's vulnerability or potential vulnerability is the result of a lack of skill, moral vision, imagination and effort. One cannot be skilled at what one cannot 'see'. No effort is made to become aware of, or attuned to, the patient as a person because of some other agenda. The nurse's own emotional needs [whether nervousness, shyness or anger] are put above the common courtesies of kindness, gentleness, everyday communication, competence and patient instruction; put above treating the other humanely. This makes a patient feel unvalued, belittled and dehumanized. Caring-attention should be an ongoing process that unobtrusively strengthens 'structures of values' around us [Murdoch, cited by Bowden, 1998:64]. These enable us to 'see' rather than fall into an attitude of indifference.

Where inattention exists, a nurse is unable to 'see' that caring practices and attentiveness promote a person's health. There is no valuing of the personness of another for their own sake. A person acting in this manner is able to humiliate or disempower another by making this person feel vulnerable: treated without dignity or respect. The carer is more willing to obey orders implicitly than to consider the person from an ethical stance. For example, if the doctor's order is for the patient to be out of bed, regardless of what the patient says about their state of being, the order is obeyed. There is more concern about doing the procedure than listening to, or relating with, the patient as a person. The person is excluded from a mutuality of relationship: not seen as someone to be talked to, or instructed, but as an object upon whom things are done. Such a nurse is willing to deprive patients of their sense of self, integrity, self-esteem and value. As Drew [1986] writes, such a nurse disconfirms an individual. There is an unwillingness to enable the patient to be autonomous or independent: to make choices or decisions for themselves, and to be able to act upon them.

6.2.2. Conclusion

In concluding this section on vulnerability one can show that this OSCE did not measure the affective domain: whether the nurse 'sees' or 'looks at' the patient with caring-attention, whether they are acting ethically or with compassion. When these reflections were expressed to the examiners, they replied there was no place on the tick-sheet for such evaluation. Our emotions are cognitively related to the way in which we perceive a situation. A nurse should act because the patient matters, that is, the patient and his/her needs should be of concern to the nurse. Motivating attention to these needs is a basic application of the moral principle of respect for persons and their ability to choose and be involved in their care. It demonstrates the 'how' of showing dignity and respect to persons' autonomy.

We seem not to notice that the capacity to care in many nurses needs to be awakened. Street [1990b], writing about students, states students enter class with a history of being subjected to controlling practices. These practices not only shape the way they think and act voluntarily but shape their involuntary thoughts and actions. If students and others are 'disconfirmed' or themselves made vulnerable through nursing, this needs to be addressed. If caring is perceived to be the alleviation of such vulnerability, it should include alleviating the vulnerability of potential care-givers, as the breakfast group suggested, by affirming them. By their attitudes, nurses define what they are as persons in relation to their being caring. It is through caring and therefore by alleviating vulnerability, that we can learn from one another how to be human.

6.3. What it is to be a person.

At the outset let me say that although various headings are used the point being discussed does not always end before the next heading. Headings act more like snowballs, enlarging and gathering other material as they achieve momentum.

Research participants used the term 'person' often. The sense in which they used it needs to be explicated to obtain their understanding. Two other reasons for discussing 'what it is to be a person' exist. Firstly, Leonard [1989] rightly takes the view that methodology should not be considered until the researcher has understood the nature of human beings and this understanding undergirds this section. Philosophical assumptions need to be consistent with the researcher's view of what it means to be a person [Benner 1994:44]. Secondly, the practice of ethics in health care must start with a practice-based understanding of 'what it is to be a person' [Benner & Wrubel, 1989]. This is taken to mean that the relationships formed, in health care contexts [between patients (or clients) and health care professionals in general, nurses in particular] should call forth this understanding.

6.3.1. Research participants use of the term 'person'.

Interviewees' perceptions of what a person is and how the process of developing as a person occurs will be discussed in order to understand the capacities that are intrinsic to being a person and to understand what is involved in being committed to a 'whole person' [a phrase used often by interviewees] 'with healing', 'affirmation' or 'conscious willingness'.

Authors already mentioned have given us the concept of caring being 'other-person' oriented, that there should be a mutuality between persons, that persons have experiences, reveal attitudes and that one can be defined as a person through other persons and one's actions. There is concern expressed by participants that persons be treated wholistically, that they have peace of mind, that they are not judged and that they be taken as they are. Most of the participants used the term person rather than patient which in itself shows a particular respectful attitude. Others show that patients should be considered, and be cared for, as real persons to be cherished. It is shown that persons can be vulnerable, neglected, depesonalized and diminished. In other words the term 'person' is used in a variety of contexts and ways which begin to give a picture of "What it is to be a person". But this picture needs to be explicated further. We need to understand not only what it is to be a person but how persons develop as persons.

Amanda specifically used the word 'person' when talking of herself and those in her care. She was at pains to explain that in her interpersonal relations she wanted people to treat and respect her as a person who had dignity and value. She showed self-awareness: of herself as a person of worth. This knowledge, generated by her mother, she wanted others to develop. This is what makes Amanda's and Kay's points so valid. They wanted to care for others as they had been cared for and as they cared for themselves. Their image of themselves was positive therefore; they could care for others positively.

I am going to enlarge on the theme of developing as a person through the idea that the person who is fully developed, fully a person, as I believe Amanda is, is a resource for health: her own and others. The person who is becoming fully developed is seen as caring transcendently for others because of their growth in self-awareness and self-realization. Ideally, persons care because they want growth in themselves, and in others. However, to make this more meaningful and less solipsistic persons should care for persons because they want their health. There is circularity in this: a person's growth is health; health is growth in wholeness and well being [or, as May put it 'getting alongside a person with healing']. Persons learn what they are as persons through other persons: this should be healing. It can be destructive. Affirmative self-knowledge leads to the healthy acknowledgment of other aspects of self. Over and above this, a person becomes aware, through a certain kind of other-dependence [whether they are sick or well], that they can grow as persons [become self-actualized]. Other-centeredness enables self-transcendence and self-giving. The activity of compassionate-caring by research participants leads to this 'more-being'. These aspects must now be discussed.

6.3.2. Personhood

In philosophy, the technical term used to describe 'person' conveys the meaning that a person is free, rational, self-realizing, self-aware, and self-transcendent [or spiritual]. These are the common denominators that make one a person. They are common to all human beings. The ultimate goal of personal growth for persons is the creation of a community of persons ideally having self-knowledge and genuine love for others [Nouwen, 1994]. A community in which one is enabled to constitute and participate through that self-knowledge and self-affirmation. Such personal development becomes other-centred: self-transcending and self-donating. This relational, community dimension is distinguishable in African wholism. Among indigenous peoples of Africa this concept of person is as natural to them as breathing. They see man not merely as an individual or social being but as a vital force in close and continuous contact with other forces. Man influences these forces but they constantly influence him. The backdrop for this wholism is, for the African, the ethic of 'ubuntu'. Ideally, it leads man to embrace man trustingly and completely, it imbues a person with significance and meaning and these elements enable growth as a person (Shutte, 1993b).

6.3.3. What is involved in being a person

This ideal acts as a measure. Could I say of myself that I embraced others trustingly and completely, did I feel imbued with significance and meaning? To get to the stage of realising my personal potentiality: my self-transcendency and self-donating attributes was a painful journey. The following is an attempt to describe 'the meanings and essences of the experience' [Moustakas, 1994]. Although it can be said in all senses of the word that one is a person from one's beginning, one can, in many senses think, and subsequently, behave as a 'diminished' person [Noddings, 1984]. It is needful to explore how personhood can be diminished in the way Noddings, and Drew discuss [1986].

This diminishment is in the sense of not growing as a person initially because of knowing nothing about being self-realising, of being a free, self-determining spirit through others. It had never occurred to me to question who I was. I was consciously affirmed by few. Nevertheless, affirmation did happen in nursing: sometimes through patients, sometimes by Senior RNs. I rarely affirmed myself. What I was totally unaware of was the spirit within: that self-transcendence capacity, my personal spirituality. I was unaware and ignorant of the internal relationship I could have with myself. Each human being begins life as a person who has all the essential elements of personhood but growth can cease. Another way of putting this is to say that in such a person there is little health. The word 'health' implies the meaning of a personal sense of wholeness and 'more-being' [Paterson and Zderad, 1976]. Although a person can be physically and mentally sound, emotionally and spiritually s/he can be missing out in terms of this wholeness and well being through neglect of their conscious personhood. Where someone cares little for herself has a bad self-image or is self-negating then that person becomes growth retarded: not physically but emotionally, spiritually and perhaps morally. I say perhaps because as with caring I believe morality is also a capacity deep within.

6.3.4. The centre of persons

If I, as a person, am unaware of my capacity as a person, and specifically as a caring person, I would have to have some kind of awakening as to my need for health and growth. The word 'conversion' is useful because of its meaning 'to turn, to change direction'. I would have to turn from seeing myself in negatives to seeing myself in positives. I have to see that there is something intrinsically valuable about myself.

Shutte [1993a/b] discusses his conception of humanity, centering on human beings being persons, using the African proverb: umuntu ngumuntu ngabantu: persons depend on persons to be persons. He discusses the point that only another person can reflect the person back to itself as a "being with a self". In Bowden's language, the attentiveness of one person towards another "reflects back on oneself in enriched possibilities for self-knowledge ... [and] ethical attentiveness to oneself, with its limits and prejudices, facilitates revised and augmented possibilities for attention to others" [1998:72]. What is needed for this development is the presence of one person [A] conscious of the other person [B] actually directing the consciousness of [A] towards [A]. It is through [B] having a particular relation with [A] that the personhood of [A] is affirmed.

No matter how negative a person may feel, no matter what has been taken away emotionally, even physically, the real personness of a person can never be destroyed. A person cannot self-destruct this personness: the body, even the mind, yes; but the spirit, no. When this process of valuing self occurs, meaningful caring for self and others evolves. As Nouwen states, caring overcomes the 'temptation of self-rejection' [1994:73]. Such caring produces unconditional love of self and others. Even if one is discussing, for example, the most self-destructing, or the most self-actualized individual, either person is a person who still acts upon himself. Both people can determine what sort of persons s/he is becoming through judging their lives and making rational choices for themselves. Through the community of other persons, and one's responses to them, a person is defined the way he is. Ideally, it is in the process of being made a person, of being affirmed, by others that we become whole and enjoy well being.

If a nurse values herself, she is affirming herself and in the process of learning to care for herself, she learns a healthy self-love. To love herself in this way is to be comfortable living with oneself and to be able to say: "I am glad that [I] exist" [Pieper, 1972], in other words, glad that I am the person I am. John Powell [1972], a psychologist dealing with self-awareness, personal growth and interpersonal communication asked "Why am I afraid to tell you who I am?" His answer, in the context of self-knowledge, was about personal disclosure: "If I tell you who I am, and you don't like who I am, it is all I have". Although a person may have been previously rejected by others [for whatever reason], once she values herself, once she as a person utilizes her self-knowledge, she learns self-acceptance and self-determination. There is a positive relationship with oneself. The person self-affirms, has respect for, and enjoys her own company unconditionally because the knowledge of herself is dignifying. She defines who she is in positive terms.

At the centre of my personhood then is what I make of myself. I have freedom to determine whether I enable myself to become negatively or positively 'made'. I have the freedom and capacity to change myself at this very centre. What I make of myself at this centre, determines the way I relate to others. That is, what I create of myself is what I share with another. It is my increasing contact with other persons, reflection upon those interactions and myself as a person that can reverse a 'non-healthy' attitude towards myself to one of more health: wholeness and healing. As I develop as a person through affirmation and knowledge there may be conflict in that innermost being of myself, my soul. The conflict is between desire [what one would like to do] and knowledge, [what one ought to do]. Growth as a person is the resolution of this conflict through self-knowledge. Becoming more of a person is the process of developing self-knowledge and this increases my personal [and professional] freedom. These aspects of myself become inter-related and in so doing unravel further elements of myself. They encourage me to realize what is valued, believed and desired [they constitute my volitional-, cognitional-, and emotional-self]. Real volition or knowledge is the resolve to freely decide in favour of actions based on some motive such as wanting to care and be compassionate. The desire can also be willing one's own or another's growth as a person.

This type of volitional willingness was expressed by May and Susan. The latter felt caring to be a 'conscious willingness'. Such compassionate caring contributed to their growth their understanding of pain and suffering.

To put this more specifically in the context of nursing and what the interviewees implied, viewing persons, as remote objective beings 'out there' would not contribute anything to another. There has to be 'meeting', presencing, reciprocation and mutuality. People must 'matter' to a nurse in a particular way. S/he must be willing to 'make a difference'. There has to be the alleviation of vulnerability, affirmation and reciprocal respecting and valuing. These are aspects of caring-for. No longer does the nurse think or act as a separate, closed individual for herself. There is an openness to others, an 'entering into' [or union] with another. This results in movement from self-centredness to self-transcendence [Montgomery, 1991]. It is the nurse's contribution to a spiritual dimension, an inner life, that yearns for some sort of spiritual fulfillment. As Montgomery [1991] puts it, "[C]aring, inspired by spiritual transcendence, provides the care-giver with a sense of personal fulfillment and emotional satisfaction" [pp.93].

This reciprocal relationship between self and others is self-giving, and self-receiving, other-giving and other-receiving. It must be a consciously chosen pathway to others. A person can affirm others, respect them, recognize their value but for reciprocation to occur there must be mutuality: mutual affirmation, mutual respect, and mutual recognition. It is not there automatically especially in nursing circles, it has to be worked at. There has to be a positive relationship between one person and another: human beings who realize themselves in dependence on others. Another way of putting this is to use the African expression: "Umuntu ngumuntu ngabantu" that persons depend upon persons to be a person. The idea that a nurse depends upon other nurses not only to develop as a person but to be a particular kind of nurse is valid. However, the same idea can become a threat for some nurses and especially those only beginning to find themselves as persons: students. There is a sense of vulnerability in this relationship that defines one as a person. There can be total dependence upon how [A] perceives or defines [B]. The danger is that [B's] perception of herself is [A's] definition and not her own.

6.3.5. A person defined by persons

If I, as a nurse educator, define a student as the person the student is in reality I treat the student as able to exercise, develop and fulfill the natural capacities that define her not by her role as a student nurse but as a person who is a self-aware, self-knowledgeable, free, self-affirming, transcendent being. Even if the student is unaware of these latent capacities in herself they exist within her. If there is reciprocation, one person to another in a particular growth relationship they will be quickened and we will 'meet'. The student will view me in the same light and value me for the person I am: this too is mutuality. I relate to the student in terms of the natural capacities that the student possesses as a self-realizing being. This was what I was trying to do with Rachel [see chapter one]. How person [A] treats any person is determined by the extent [A] has developed her own personhood.

In its proper formulation, the principle is that persons depend on strictly personal relationships with persons to develop as persons. Only those relationships that are affirming and enriching actually develop one as a person. Though this may seem paradoxical, such relationships produce the freedom to develop as persons. The process is accumulative: partly because of mutuality of trust: the other's process of growth in self-knowledge and self-affirmation, and partly because the other has become other-centred in this process like Montgomery's predispositional qualities required.

Any other kind of relationship with persons takes away personal freedom or destroys integrity [as when one is made to feel vulnerable]. Autocratic, controlling relationships, [such as Revans, Kramer and Menzies discovered] belittle, dehumanise and depersonalise. Relationships that inhibit one's growth lead to disintegration or diminishing of the self. Self-knowledge and self-affirmation together are the result of a progressive increase in personal integration [consolidation of one's personhood] and therefore of an increase in personal self-realisation or freedom. This freedom within oneself is important in nursing. It is while exercising one's free will, in making the choice to care for a person as a person in their own right, that true freedom is found. This is being free to fulfill the role of doing as one wants to for, and on behalf of, that patient. A caring nurse gives him/herself permission to care ethically. It is a want, not a desire, a volitional want-to-care-for, or be compassionate towards, from the point of willing that care to another for no other reason than one accepts this other for themselves. This is not because of any role played, 'quality of life' displayed, any attraction or to please, or to satisfy one's own desire, but simply because one wants to. One's very presence bespeaks their character of being a person in the technical sense simply because the naked person is there: naked in the sense of being stripped of class, wealth or health and being accepted in and of themselves [as Hennrietta implied].

A person [student or patient] is not depersonalized nor dehumanized when their personhood is conceptualized in this way rather it affirms the person and their character. It is saying: "I am glad you are what you are - the person you are". This does not mean being glad the person is, for example, a rapist, gangster, or thief, nor that s/he has a multiple personality disorder, mental handicap, or whatever. It means I am glad this is a person, that I am affirming their personhood with its potential, its dignity and its inner life force. Nouwen's relation with Adam was an illustration of this. To recap: Yancy [1995] had perceived Adam as a useless person who should have been aborted. Nouwen, amazed to be asked the benefits he had gained from hours spent caring for Adam, lists for Yancy amongst others: a fulfilling inner peace and the lesson that "what makes us human is not our mind but our heart, not our ability to think but our ability to love" [1995:19]. This affirmation of a person is not simple it has to be worked-at.

6.3.6. Towards an African[19] ethic embedded in 'persons'

The 'motivational disposition' [Noddings, 1988] Bekkare displayed could have been a combination of 'ubuntu' and the African proverb:

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[19] The word 'African' in this section is not limited to Black persons. 'African' is taken as embracing all nurses working in Africa.

"Munhu i munhu hi vanwana vanhu" [Shangaan] It translates as:
"A person is a person through other persons".

This is the most usual rendition [Shutte, 1993b, Malan, 1990]. Goduka [1996] in discussing the ubuntu world-view gives the Xhosa version of the above proverb: "Umuntu ngumntu ngabantu". She mentions the latter to emphasize that "African ethos is based on collectivism" rather than individualism [1996:30]. This collectivism is not European communism or socialism, but more a community-based society, one where people are ideally united among themselves even to the very core of their being.

Malan quotes van Rooy to emphasize this collectivism. Van Rooy writes, "[T]he focus of importance is upon the group rather than upon the individual. This group means the family, including ancestral spirits. Many striking proverbs and sayings emphasize this. He gives, 'a person is a person through another person' ... "meaning that man by himself is helpless and has little value". He adds others: "A person is born for another"; "You can't tread open a path by yourself"; "One finger cannot take samp [a thick porridge] from the pot". "These sayings", he writes, "serve to illustrate the fact that the individual looks at his personal value as an integrated part of totality" [Malan, 1990:42].

Goduka draws this out through a common variant interpretation of the proverb:

"I am because we are. We are because I am" [1996:34].

Goduka's variant interpretation is the African view of community. The 'I am' is a single person. In African culture, each single person or individual is related to the community as a person is related to his/her own self. The individual member of the community sees their community as an extension of this self. The person [the 'I am'] exists because of the community. Each individual shares a common identity with the larger group. This gives wholeness and belongingness. The larger group [the 'we are'] comprises individuals. Black individuals could possibly rise above adverse situations but the group could not. The group mind-set was survival: basic things came first [Wright 1981:62]. This indicates not just groupthink but the kind of collectivity that is the norm in African culture. The proverb, as Goduka explains it, personalizes this 'we are because I am'. At the same time it draws out the usual rendition of the proverb: a person is a person through other persons.

6.3.7. Summary

As a fully fulfilled, free, transcendent nurse, [to keep this in the nursing world] there should be a 'health resource' - an inner sustaining joy within a person. This acts as a resource to me and to others in the process of care-giving. This is essential for the health and growth of the other. What has to come first in any human interaction is persons relating to persons in terms of self-knowledge and self-affirmation, self-transcendence and self-donation. As a nurse, I can continue personal development through caring for another's health. A nurse should not stop, nor forget about, developing as a person because s/he is a nurse. Nor can the individual nurse forget that this is the patient's primary project. One's growth should not stop because a person is a patient, nor can the nurse treat him/her as "just another patient". The patient must matter, must be of significant importance to the nurse. The nurse has a role, through caring, to help herself and the patient to grow as a person and be there for their health.

This notion of caring-in-nursing is about affirming patients through the attention given to them. Genuine affirmation equates to caring. In other words, a nurse who cares is a model for promoting health: wholeness and well-being through a particular kind of caring. 'Caring' and the idea of 'health' are to be explored further.

6.4. Understanding caring

The findings of Gaut [1983], as discussed earlier, are applied:

i) attention to or concern for;
ii) responsibility for or providing for,
iii) regard, fondness, or attachment.

This framework is used because it is felt that these connotations of caring, if acted upon in their fullness, would alleviate the vulnerability that persons can experience. Developing the concept 'caring' its relationship with 'vulnerability' and 'person' becomes stronger. Gaut [1983] understood caring in a normative sense though she did not relate it to vulnerability or to personhood. Within this normative sense of caring she also discovered others' meanings showing the richness of understandings that can be obtained through the concepts care/caring.

6.4.1. Attention to or concern for

The discussion about vulnerability entered into the arena of 'attention' and 'concern', and so it must if caring is to alleviate vulnerability. Linking attention or concern with vulnerability is the question of an ability to 'see': to pay moral attention to those being cared-for.

The terms 'attention' and 'concern', in Gaut's usage, lack the feeling Rollo May [1969] imputed: 'a relationship of concern', or 'worth seeing'. Gaut's use was not of the kind that would counteract vulnerability because of the lack of relationship in 'concern': when the other's existence matters, a relationship of commitment and a willingness to take another's suffering. In Gaut's interpretation, the term seems not to be imbued with as deep a meaning or activity as that of caring- [or ethical-] attention where the meaning is deeply contextual, affective and volitional. An attempt is made to explain this difference in depth.

Concern, as a synonym of caring, is felt by Benner and Wrubel [1989] to define a person: that things, ideals and persons matter in this world. Maintaining ties, engaging with concern in this way, gives reasons for being in the world, getting involved with people, guarding and protecting those things we care about. Yet each person describes this in his/her own terms: with a meaning that grasps the intent and content of the concern or care, directly for the situated self.

One hears a Kay and a Susan paying attention to their patients because "I am saying that people are important", "people matter"; a Bekkare being concerned because she had noticed no-one washing patients with cervical cancer. Her 'seeing' leads to action: she wants to do something to alleviate this person's discomfort. In each case, there was self-disclosure, an awareness of self, who one was. Susan saying "people matter to me" defines her attitude as caring. So does Bekkare asking: "what if this was me"?

Attentive nurses became aware of, sensitive toward, unspoken need. This allows the world in which their nursing is situated to reveal itself, to 'talk' to them. The expert nurse in wards of a "Nightingale-type" could stand, look, and feel what was happening without anything being said. Experience talked through the silence. The RN became aware of things that ought not to be. The 'looking' and 'feeling' is an active intellectual skill. Through watching, focused ethical attention, I learned to understand the ways in which the interviewees were socially or culturally constituted, whether they shaped meaning for themselves.

May described looking "behind the eyes of the people". they were caring for. This metaphysical ethical dimension concerns the concept 'person', that 'ethical attention' which Bowden citing Weil shares: "looking until the light dawns" [1998]. Such attention is ethical because it is a particular comportment: a mind open and receptive, motivated by a conscious willingness to presence oneself in giving support, love and compassion. These are qualities of the care-giver and are revealed by giving respect, dignity, patients their rights and a sense of personness. Physically, Vera's concept of caring centred in attending to a person's unspoken needs. There is action through attitude. Caring meant being able to comfort, communicate with, 'keep company'. Emotionally there was love, nurturing and identifying with hurt: not having to say much, nor necessarily doing anything, just being there. Spiritually, caring was this feeling towards one's fellow man.

Henrietta had been awed by this type of caring that overcame passive preoccupation with self: attachments to persons or objects formed for the nurses' sakes. Instead, she saw nurses centred on persons' superior intrinsic worth.

> "[P]eople [were] doing these loving things to these dirty people who couldn't even ... communicate well, who had nothing. Here was this group of people ... feeding, touching, binding up wounds, praying ... They were loving it, proud of it".

Caring was accepting and seeing the value of these persons. As Weil [in Bowden, 1998] puts it: it is a looking until the 'I' disappears. Henrietta's patients would receive attention and acknowledgment that they were part of the situation. She seems to turn a kaleidoscope and explain the picture reflected:

> [The person] "was not just a figure standing in the middle of a tapestry. All the background was being filled in too".

Caring, to Henrietta, was tangible, attention, being bold, having pride and empathy and love. There was the element of Weil's 'sacredness' about such total caring. It was holistic, concrete and as Susan had discovered, it was entirely other-centred and not a 'tool' to impose one's own point of view. It was accepting patients for what they were, affirming them as persons of value.

As Henrietta and the Breakfast group revealed, their notion of caring-in-nursing[20] was about affirming patients through the attention given to them. This affirmation was consenting that there was not just a desire to care but a firm volitional wanting to care, a must,

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[20] This subjective experience of caring-in-nursing also demonstrates developing as a person.

but not in the sense of duty or ought. Consent gave to caring-attention its ethical quality: it was human being-caring [as a verb].

Nouwen concurs: For him living and caring were yoked. Caring consisted of being present existentially, and giving "loving attention to another person" [1994:71]. In this ideal type of caring he, and others, were helping persons to overcome not only the 'temptation of self-rejection' [1994:73] but feelings of diminishment, dependency and vulnerability.

These are the virtues of attention or concern. They are grist for nursing's ethical concepts. Nursing is caring attention; caring attention alleviates vulnerability through ethical caring.

6.4.2. Responsibility for or providing for another.

Such responsibility is demonstrated by May. Not May alone, but she epitomizes responsibility for me: something that grows and develops from inside a person. It is learned first from having self-respect and a sense of dignity and grows out of an increasing self-understanding. Such 'self' learning comes before one can fully respect the rights and differences of others and it comes through interdependence [Axline, 1964:58]. May became the free and responsible agent Montgomery and van Hooft discuss. Her connection to her patients was from her wanting to respond to their needs in a responsible caring manner. It was a motivational attitude; a focused commitment: caring about others, nursing with particular values in mind. [May used nursing and caring interchangeably: the terminology did not matter]. What was of the utmost importance was her ideal, to adjust responsibly to that unspoken need in the eyes of her elderly, to enter a responsive spiritual relationship, where she met the person at their deepest level of need: the elderly person 'behind those eyes'. She noticed these things because they related to her felt responsibility. She had wanted her nursing to provide for others in this way but had been told that that was not nursing. In her own home for the elderly, she could call this ideal caring, nursing.

There was commitment to persons: purposeful, situational relationships that conjoined the elderly with family, friends and others. Her concern revealed a perceptual understanding of the need to provide for her elderly those reciprocal relationships with other persons that would keep them functioning as persons. This concern, this responsibility, defined May. She had found meaning, met her aspirations and realized her own spirituality.

May had profound insight into the practical realm of nursing. She meets Benner's criteria particularly those of the helping/healing domain. May believed there was more to looking after persons than 'plain nursing'. By this she meant what van Hooft [1995] explains as acting from our fourth level of existence, a spiritual level, where, in nursing these elderly persons, she was acting out her highest ideals.

May's evaluated lack of caring, the roughness, was occurring partly because the public's attitude to nurses had changed; partly because many nurses had 'lost' that inherent capacity to care, to self-donate. Instead of feeling responsible for others, many had abdicated this ethical aspect in caring. It had not been provided for them, it had not been nurtured: therefore they did not feel a responsibility to care perhaps also because they had not been cared for themselves. Nursing was merely a job enabling them to survive: this is how they defined themselves. Fortunately, this is not the end of the story. There are nurses who show another side. There is another kaleidoscopic view of caring: that of

6.4.3. Regard, fondness, or attachment.

Gaut does not go so far as to include the word 'love' in her equation of caring, but other nurses do: theorists and practitioners [Astrom et. al. 1993/5], Leininger [1981], Swanson, Watson to name a few]. Dunlop [1994] has been referred to: she believed caring was an emerging construct with an emerging usage involving a form of love [1994:28]. She goes further; she argues for the possibility that a central task nursing took upon itself was the 'translation of "love" from nurses' private sphere into a public domain [1994:30]. Seemingly we have failed to vivify this possibility.

Such deep attention whether private or public, is ethical because it is a particular comportment: a mind open and receptive, motivated by a conscious wanting to presence oneself in giving support, forming an attachment, developing bonds or rendering unconditional love, coupled with compassion. "Concepts [such as love and care are both moral and ethical and] like the people who use them, are complex, obscure and opaque" [Bowden, 1998]. This thesis has probed some of the private domains of interviewees to discover their meanings and such delving unearthed the complexity of caring.

This is a difficult area in nursing, especially where some feel that the professional thing to do is to keep a respectful emotional distance from the patient. However, as Montgomery [1993] discusses, no one has ever stated what that distance ought to be. There is a danger of losing the contextual humaneness and sensitivity of a phrase like "... [caring] was an act of love" [Swanson, 1986a:72] when describing the feeling and perception of the actions of nurses towards this research participant if nurses are compelled to keep their distance. Nurses who desire to use their freedom of wanting to care sometimes have to display a tough courage.

Henrietta had earlier said that caring meant loving, attending, being bold.

> "[P]eople [were] doing these loving things to these dirty people who couldn't even ... communicate well, who had nothing. Here was this group of people ... feeding, touching, binding up wounds, praying ... They were loving it, proud of it" [Henrietta].

This concerned action is towards the whole person, their dignity and humaneness, without working out an emotional distance:

> "... ultimately, the whole person has got to be healed... If you focus on one's own skill in nursing and you take out one's attitude to caring and love then you are going to lose caring"[May].

Caring was accepting and seeing the value of the person. Persons would receive attention and acknowledgment that they were part of the situation. Caring was acknowledging these feelings and being defined by them.

> I would say now that I loved that lady. She, and the others, were certainly important to me. To me she was a real person like the way Skin Horse described a real person in 'The Velveteen Rabbit' [Williams, 1922] [Diana]

These other patients are mentioned because I was sensitized to them. I loved this medical ward. I would have done anything for the patients. On the whole, the feelings, were reciprocated. The ladies liked it when I was there. They said their ward was calm, quiet, orderly, and restful to them when I was on duty [Diana].

This reciprocal feeling was why Paula "loved being on duty over weekends". It was why Bekkare could say:

> I started to develop [pause] another type of love, ... from that thing. Then I continued like that. If you talk of empathy in particular I'll go and think about that experience and I will definitely go to that person" [Bekkare].

If Bekkare is to carry out her 'individualized', 'personalized' role in terminal caring, then she will continue to practice 'another type of love': an emotional kind where the needs of nurse and patient centre in the need to love and be loved, to accept and be accepted for the unique person each is, to be listened to and be understood. These nurses seek to presence themselves; to be there for the person in a committed, concerned and connected manner.

This is also demonstrated by Vera: As a student, she remembered hospice nursing as love and care. Her own caring she saw as:

> "making sure a person's needs are attended to; nurturing, looking after, ... it is support .. love ... compassion ... respecting others' dignity and rights. It is caring for them as a human being" [Vera]

Kay thought caring could be equated with love but this word was not to be used lightly. It depended on how love was defined. She admitted to becoming over-attached because the unit had adopted a system of patient- rather than task-allocation. Her caring would be done with that depth of attention and looking that has already been commented upon. Paula showed this loving and caring in spite of, or because of

"the grueling demands she made". Through this "very incredibly stretching experience' she was taught 'a great deal about suffering and caring".

She was 'motivated to make a difference' to patients. Paula had become aware that people 'grow' spiritually through caring and unconditional love.

Lesley specifically felt caring to be equated with loving. Pointing to a non-nurse friend she said:

> "Look at what a complete carer she is ... it's a complete sort of love, ... it is grace: a gift. It's a gift that you impart to others, and others impart to you. It's all part of the whole thing. It is difficult to describe. It is natural: the basics are there, but it has to be developed... Then you get this lovely holistic care, sheltered..." [Lesley].

Here we have a picture of love in the form of self-donation, reciprocity. For Amanda the ultimate of such intersubjective caring was expressed in terms of bonding, or "latching-on", as she also described it: a two-way relationship communicating comfort, valuing and protection. She described what I think C. S. Lewis calls 'need'- and 'gift-love' [1960]. It is similar to Lesley's 'complete sort of love: a gift one imparts, grace'.

Laing, Montgomery wrote, equated confirmation [valuing, affirming another] with love: that "process through which individuals are recognized, acknowledged, and endorsed" [1993:20]. Citing Sieburg, she states that for an interaction to be called "confirming" there has to be: "The recognition of the other's existence as an acting agent; acknowledgement of the other's communication by responding to it relevantly; congruence with and acceptance of the other's self-experience; a willingness on the part of the speaker to become involved with the other person" [1993:20]. One cannot be fond of, have regard for, nor love another without engaged involvement. However, involvement has already been discussed so will not be discussed further.

6.5. Conclusion

This discussion sought to understand how research participants understood certain terms. Most have displayed a depth that has cognitive and emotional dimensions. To use van Hooft's ideas in conclusion they care not just at a perceptual and reactive, evaluative and proactive level they move to a spiritual level.

The perceptive/reactive level would enable them to cognitively orient themselves through learned patterns of cognition, behavioural and affective responses. The evaluative/proactive level defines them as reflective and active beings. Jointly these levels constitute, in his opinion, the basis of attitudes and communication when one is mature and integrated and so form the wholeness of a person. Integration of these four levels occurs at the spiritual level of a person.

The person for whom I care can, at this fourth level, be a completion of my personal identity because it is through persons, ideals and beliefs that persons are defined. What we know or love leads to desires, beliefs and choices. The spiritual is composed of such. Part II [next chapter] explores this as a dimension of caring, but firstly Part I: the dimension of health. This is felt to be important in the context of care/caring by asking what the goal of this attention, responsibility or attachment is? To answer this is to explore the concept of health.

"Only when bad things happen is one cared for"
- Henrietta, a research participant.

CHAPTER SEVEN: Added dimensions of care/caring

7. Part I: Health

7.1. Introduction

This chapter explores the concept of health from personal, theorists and practitioners' perspectives. In health care, each health care professional can have a different perception of the meaning of health. These different perceptions result not just in different roles and functions, but different goals for promoting, maintaining and repairing health. There can be a failure to analyze what health is or to limit its meaning to one's own professional perspective. Our ideas of the concept 'health' affects how people are treated, how we perceive what can be achieved [by patients alone or through the members of the multi-disciplinary team] and it will affect the way ethical decisions are made as well.

7.2. General perceptions of 'health'.

Others' uses of the term will be taken first. There is Frick's idea that personalities can become more integrated and 'healthy' through finding meaning to life's experiences, this meaning impacts on spirituality: an aspect of health if its holistic meaning is incorporated. Frick's meaning of 'integration' is like that discussed by van Hooft where the latter discusses different levels of caring [the biological, perceptual and reactive, evaluative and proactive] being integrated at a spiritual level. In other words our deepest caring and its meaning for oneself and others comes from being integrated as persons: this is health.

Zimbardo [in Maslach, 1983 see Chapter 2] mentioned that his experiment used normal 'healthy' individuals. Montgomery that every care-giver should have concern for what she saw as the human element of 'health care'. These uses enlarge the context of 'health care' and place it within a 'human' context. Benner [1984], Paterson and Zderad [1976] and Montgomery [1993] link the term 'health' with growth which could be perceived as adding yet another element to it but in reality links it with the integration discussed above.

My own statement about caring discussed the idea that caring action can lead one, motivate one, to act ethically towards the health of another in various ways but that there was the possibility of health being diminished or that impediments could obscure one's health. These 'impediments' could be social, environmental or personal. Whether there are impediments/diminishments or not health should be linked with 'wholeness' [Farmer, T:111]. That this 'wholeness' was something to be promoted was the intent of Paterson and Zderad in connection with their idea of more-being. 'Health' gives the idea of the possibility of facilitating the 'more-being' or development of a person wholistically.

The context in which 'health' is most frequently used in this thesis is contained within the phrases 'health-care' and the title 'health care professional'. This implies that there are people who have chosen to care for, and about, others' health status as professionals and they do it within a context of 'health care'. 'Health care professional' is a taken-for- granted term and seemingly not much discussed. What is assumed is that the phrase 'health care' and the title: 'health care professional' are well known. People using the term and those with the title are assumed to know what is meant. We can discuss health care professionals. Or, Praeger's statement: "Our experience in the world of health care, is the foundation for understanding the nature of nursing [or caring]; or what it means to be a nurse [or to care]". Or, Nightingale's notion that every person who became a nurse in her day must have had charge of someone's health, restored someone to health. In each instance, the term 'health' in its context should be explained.

Health as has been shown is not limited to a disease-centred view but incorporates growth and development such as leads a person to becoming fully fulfilled, free and spiritual [being able to transcend self]. For example, to take one type of health care professional, if a nurse values herself, and her health, she affirms herself and in the process of learning to care for herself she learns healthy self-love. To love myself in this way is health. I become comfortable living, and at peace with myself and am able to say not only that: I am glad that I exist, in other words, I am glad that I am the person I have become and that physically, emotionally, mentally and spiritually I feel in a homeostatic state. I feel a wholeness and well-being that incorporates feeling at peace with myself and others. As such, I become a 'health resource' of an inner sustaining joy. I act as a health resource to myself and to others in the process of care-giving. Being such a resource is essential for my own health and the growth of others. There is in these elements the sense of 'health' as dynamic having everything to do with growth, development, more-being, wholeness and integration. It gives the sense of being fully fulfilled, of being a source of, or resource for, inner sustaining joy. Such are the usages of 'health' mentioned in this thesis.

One can ask as a result of this 'survey' whether a dynamic state of health is purely an idealistic notion: one that is unobtainable or at best only transient? Would such an idealistic notion reduce health merely to a feeling, or to particular persons? Is the word 'health' or being 'healthy' being given too wide or too narrow a meaning?

To answer these questions 'health' is discussed in the context of caring. I can ask a health care professional: why are you caring for this patient? Will the answer be: "I care because I want their growth or their health to improve. Caring for a patient [as a health care professional: physiotherapist, nurse, doctor] leads me to want to 'get alongside a person with healing': to want their mental, emotional, physical or spiritual health.

There is another angle. This is the personal experience of health or non-health for particular persons. From a professional perspective, my view of health could be biased. Health could be seen only from the perspective of the healthy. Therefore, it is not sufficient to analyze health from a health professional's stance alone. Patient's, like Richard Zaner in particular, point out what it means to be dispossessed of health. Zaner gives his 'lived experience' of what it is like without health and is often quoted in this respect [Benner et.al. 1996, Bishop & Scudder 1987, Bowden 1997, Carper 1979, Gadow 1988, O'Malley undated]. This shows that there are more dimensions than a merely functional approach to health.

7.3. The unlimited boundaries of health.

The term 'health' should acknowledge persons as wholistic beings having physical, mental, emotional and spiritual dimensions. In concert with the conception of 'more-being' health, ideally, should know no boundaries. In general terms, to limit health is to limit one's potential to become fully fulfilled. More specifically limiting health could deny other aspects inherent in a person and the possibility of integrity: that element, as mentioned, that unites body, mind, spirit and emotions. To discover what health means at this deeply personal level I need to discuss health from a subjective angle. Health procedes from one's environment, lifestyle, the extent to which one becomes more of a person and integrated. Such integration sensitizes one spiritually to different human beings and can cause one to question not only the meaning of health but, its goals as one considers one person who has 'health' and another who is 'unhealthy'.

One can feel the shock of nurses who, in undergoing psychiatric and mental handicap courses, see grossly mentally and physically handicapped people, and ask outright: 'Are these people'? They are asking about the meaning of life: the goals of health. Trained nurses have wept at bed-sides, and one weeps with them, for those who died lingeringly and without recourse to spiritual counselling or even knowledgeable social support: the alcoholic person dying of cirrhosis, the patient with leukaemia dying from AIDS acquired from a blood transfusion. There are those who have nursed the grossly physically handicapped 'cyclops' [and felt the parents' confusion]. They have seen the grossness of elephantiasis, patients who are just bodies with no limbs. Felt the anguish of someone suffering from Hodgkins disease and just married, the mother who, for twenty years tried to fall pregnant only to find at 40 years of age the petrified remains of an almost term baby in the abdominal cavity [and health personnel thought she was psychotic!]. These conditions serve to personalize the concept 'health' and help us to have compassion towards those without it. Through our own mental health, we have an ability to respond to that which is within us: the spiritual, moral and ethical dimensions of human life. Health, in terms of the integration of mind, body, emotions and spirit, becomes a resource for compassionate-caring.

7.4. Particular perceptions of health from discourses.

A weakness in this research is that I did not initially perceive caring in the context of health. I obtained a picture of the nature of caring but not in the context of 'health'. In this research, compassionate-caring is shown in the context of alleviating vulnerability and towards the growth of persons but there is more. For this reason I believe I should have asked: Why are you caring for your patients, that is, to what end? I do not believe a health care professional should be caring without some goal in mind. To care because one wants another's health is such a goal. But, this goal is only valid if it takes into account the wholistic nature of health and that the possession of such health on the part of a health care professional acts as a resource to bring another healing.

Perceptions about 'health' also have multi-cultural variations. A mini-research, For example [Haegert, 1996] done with student nurses revealed many transcultural variations.

Bekkare's narrative also reveals such variation. Her narrative confirmed what Vorster [1996] stated, that Africans [like Bekkare] have healthy self-concepts, their own values and an appreciation of traditions. Bekkare's input regarding 'health' lay in her cultural perception. She was concerned for the health of her people: a concern not only with their physical well-being in connection with cancer, but a wider perspective. She saw health in educational and cultural terms. She wanted to improve her community's knowledge so that the cultural-spiritual issues surrounding cancer would not be taboo subjects. She also gave 'health' a complex spiritual dimension. She wanted to care for the community's health from a social, cultural and welfare point of view.

Within her health care context, Amanda was a health resource for the children who bonded with her. Although in her nurses' role she acted out of a legal duty to care on behalf of parents [locus in parentis], she went beyond this duty showing deliberate, evaluative choice and action. Through being self-aware and willing to self-donate she consciously bonded with children to enable them to grow in health. Why was she caring? It was for the children's wholistic health. She was willing for a child to be present to her in such a way that she could be present to the child. She could not have done this if she did not have a healthy self to express or to donate. She acted as a health resource. Through Amanda, the child learned that s/he was valued for her- or himself. This was particularly evident with smaller children.

Adolescents were still finding their own sense of identity. Part of this identity was their own body-ness, something being learned through kinaesthetic sensations. In Amanda's unit particularly, her patients became aware that others also gazed at their bodies: withdrew substances and pushed chemicals into them. The danger was of them becoming too body-centred or self-consumed. They were not mature enough to realize that they had other health needs, such as personal self-awareness and self-knowledge or that these could be gained from the mutuality of personal relationships and connections with others. Amanda tried to show this by being available for them. Many suffered not merely physical pain but that pain of utter loneliness when parents would not disclose nor discuss their illness with them. When they were more aware of and knew more about their illness than their parents. They often entered a private lonely world emotionally separated from others [Bluebond-Langner, 1978].

Amanda attempted to meet their non-physical health needs by her willingness to show caring through her bonding with these persons. She related to them through her work as a health care professional caring to make them healthier whole beings. The 'healthy' manner in which she expressed herself and acted towards her patients determined who she was, shaped her ethical care-giving and led to these persons achieving more than physical healing.

In the context of caring May focussed on healing. I had asked her what she meant by this term. Suppose I had asked May: Why be caring? She could still answer:

> "To me healing of the body isn't sufficient, to me the body is the flesh in its health and inner state. If you just heal me, the outward flesh of an inner injury, it will either recur again or appear in some other sign because ultimately the whole person has got to be healed. And if a nurse was involved at that particular time in that particular way it might be that caring is then surely given. As in the example of an alcoholic person. It

> would be more than the body that would need healing. Hopefully the nurse would identify the person's mental state..."

May stresses that by caring the whole person not just their body will be healed. Healing through caring involved identifying a patient's mental state which is tantamount to saying one is identifying where they hurt, or in her example, where they hurt themselves [as in ethanol abuse]. Such healing could

> "occur at night when people could not sleep, when there was fear, or unspoken things, and there was a need that could be filled by someone caring. Being there and talking of spiritual matters. Not evangelising, but meeting the person where they were. And that's caring. Caring really is getting alongside the person with healing".

The answer to why she cared for someone's health [as a chaplain, spiritually] was that for her caring meant 'getting alongside the person with healing'. Healing in her context meant helping to change an attitude of fear, listening to unspoken things, paying attention to another's [or one's own] pain. The reward for practicing this kind of caring attention was healing.

Susan, though not using the word 'health' implied that she cared with specific goals in mind: bringing 'health' to others in pain, whether that pain was emotional, physical or mental.

> "It was caring for the mind, body, physical - where the symptom control is at. Caring for the family, where they were [emotionally]. It was being concerned about everything that is going on, at all levels. Being aware all the time if things are changing. And you must not care from your (stressed) point of view, you must care from their point of view".

She saw these caring responsibilities extending to the living in their dying and their families. Health implied an ethical goal: that of caring well for others in their dying.

Henrietta wanted nurses to get away from a disease-oriented model of health. She wanted them to see patients could be 'healthy' even when suffering from leukaemia or cancer.

> "... I want them to see the patient ... can be physically ill but can be healthy emotionally, or intellectually, spiritually, in any sphere. The patient's physical component may be a little component of an [otherwise] very healthy person".

Henrietta was advocating seeing health as more than a physical approach to patients. Health was being able to perform activities of daily living. These activities incorporated more than mechanical physical functioning. Ideally they included learning, leisure, worship communication [mental, emotional and spiritual activities of living] and creativity. Health for Henrietta was therefore not just a question of being disease-free. Rather, even when there was no longer complete physical health the richness of the gift of health, the value of health could be realized. This value included the aesthetic in the patient's environment. Therefore Henrietta was willing to focus on these aspects in their environment to discover what was missing from the person's life, what could be added to bring healing: more life, beauty and spirituality to the patient's space. The person, to Henrietta, was not just a figure standing in the middle of an otherwise empty tapestry, the background had to be filled in too.

> "It was the things which to me were telling me what was happening to this person, and those things around their lives .. things that were important in their lives and made them ... respond because they realised that I was more interested in them than in a body with a disease".

Graphically she continued,

> "I think that the little pictures are as important as the big, bright, bold ones because it is often those little ones that make us".

Why was Henrietta caring? Patients would realize that someone was interested in the details of their lives, their lifestyles because as a care-giver she attuned her care to fit that lifestyle. She believed that a caring person worked at enabling patient's to constantly engage with their environment. Doing this she felt she was caring for the whole person's health: body, mind, emotions and spirit. To call forth health in others in this way would give them fulfilment. They would overcome fragmentation and become whole persons. They could not find fulfilment without others caring. Being cared-for, or caring about, was part of becoming fulfilled and such caring was healthy: it desired health in another for their own sake.

A total contrast is seen, for example, at one hospice where during a medical hand-over it was said of a dying patient that she was "falling apart". This meant that she was feeling the pain of being bereft, abandoned, distraught and overwhelmed. This is the opposite of what is implied in these discouses or, to bring in a new element, by the Hebrew term for health: Shalom. Shalom carries the meaning that the 'wholeness and well-being' within health includes that inner personal peace at the core of one's being: a spiritual core. It is that wholeness and well-being arising out of relationships where trust and faith are implicit. The person is nurtured to health: their inner core is kept at peace [the physical, mental, emotional, volitional integrated through the spiritual]. To greet a person with 'Shalom' is to desire that person's health: peace within their inner core of being. 'Caring' with its baggage of meaning as given in this thesis is towards another's health: an integrated wholeness and well-being. It includes nurturing [or caring for] persons through their dying and preparation for death. No one being cared-for should be allowed to "fall apart".

7.5. Conclusion

There are those that feel health should not be viewed narrowly. Wilson [1975] and Stacey [1977] take the concepts of pain and suffering into consideration. They found these concepts to be lacking in discussions on health. A person's growth towards maturity, includes a growing ability to withstand the distress of disappointment and pain, failure and depression, loss and bereavement. Stacey concluded that if the reduction of suffering [environmental and social] were to be taken as the core of the health service, then the divisions between health and welfare would dissolve. Disease would not be the dominant factor [that is in the sense of the emphasis on the medical model]. The African concept of health demonstrates the welfare dimension Stacey desired.

From the recipient's point of view, health is knowing, willing and feeling wholeness and well-being. The patient may be grossly diseased, [naming any disease that one can think of], may have less of their body than there was at birth in that a person may have had amputations, organs removed, trauma, infections, burns or suffer from self-inflicted or other-inflicted conditions. Although individuals may suffer some form of health-breakdown or even be dying, unless this breakdown in health totally affects their mental capacities they are not diminished as persons. The individual can still be a fully integrated whole person in body, mind and spirit. In other words a healthy person. Health is the positive integration of these elements.

What are my thoughts concerning the meaning of health in relation to compassionate care? Let me relate a situation: a second-year nurse and I were discussing psychology in a ward. The first 'learning outcome' to be considered was the term 'health'. I reminded her that the term 'health' viewed wholistically meant wholeness and well-being and included being at peace with yourself. In considering this we thought of physical, emotional, mental, spiritual, social and environmental aspects.

The nurse pointed to an African patient with pulmonary TB who she said had had no visitors during his stay. It was Friday and he had been discharged. The cubicle was empty of other patients and the beds made up. A letter to the Day Hospital explained his TB treatment. 'Home', the nurse said, was not even a shack. She thought he could be from a 'cardboard city'. The day was windy and cold. He only had R3 another patient had given him to get 'home'. He would not get another meal until Monday when community health services would re-open. She felt he would be back sometime the next week.

What did I see? A sad-looking stooped man, let me call him Mr Tsolo, sitting in an ordinary upright chair, waiting. He looked too tired to sit up straight. He was pathetically thin, dejected, seemingly worn-out with shabby unkempt clothes.What did I feel? I felt welfare and health should go together. Mr Tsolo's basic needs were money for food, shelter and support. Our health care system could not supply him with any of these. Both health and welfare departments would be closed by the time he reached wherever. We left the cubicle. Later when we passed by I pointed to the man and said, "Look, he's lying on a bed".

I was teaching psychology as wholistic health. Health incorporates wanting Mr Tsolo to have wholeness and well-being. We want to 'get alongside him with healing' [May] If we care we assess his needs compassionately. Such an assessment implies that I want him to have bodily, emotional, mental, spiritual, social and environmental health. Rakel [1996] has said, "The essence of the art of medicine is the compassionate and effective application of technology to the care of a particular person ... not neglecting the important and social issues that make each patient unique ... [and] good interpersonal skills" [pp:477]. He goes on to talk of trust, respect and listening. My assessment may use this technology, may use all these aspects and skills but there needs to be a mutuality between patient and I if I really want his full health. We must 'meet'. We do not necessarily need the same language or culture [they certainly help]. A bond of trust, faith and respect needs to be established either verbally or non-verbally. Ideally I should care about Mr Tsolo's health because I want to enable him to be empowered to develop as an integrated [holistic] person.

But does he value health as I value it? Mentally: what would health mean to him? Is he motivated to want health? Has he ever had absolute health? Emotionally does his community make him feel he belongs, is loved and supported? Spiritually, has any family or community nurtured him, helped him to find meaning to his life? What does he actually think of himself? Is he self-aware, does he have self-knowledge? What of his self-image, self-esteem? Has he anything of himself to self-donate? Physically, is he capable of self-care? Can he get his daily pottage, meet people, be in community? These questions are important if I care about him holistically.

He can be distraught and overwhelmed with the vicissitudes of life There can be self-hate because he has lost all semblance of self-respect. He can get worse and be re-admitted. Then his basic needs will be met, at least temporarily. Then he would get shelter, warmth, a bed to himself, three meals a day, drinks, people to talk to, perhaps they will even make him feel cared-for and nurtured. The welfare could provide him with a disability grant. There is a danger of building dependency. I have to be enough of a person to want him to grow in health as a person and therefore encourage him to be free and independent.

How I assess his health needs, treat him bodily and spirituallly defines me as a compassionate care-giver or not. My volitional willingness to take a comprehensive knowledgeable assessment of his health-needs is dependent upon whether I care compassionately or not. If my care is mechanical, routine or duty-bound it loses its ethical-ness: I treat him as an object to do things upon. Thus I can diminish Mr Tsolo's health further. The very essence of care is to show respect, feeling, to respond to need, to express concern, to act towards his health. Compassionate-caring [caring about what happens to this man in the short- and long-term] reveals my ethical stance towards this patient. My attentiveness and caring concern could be a turning point in this person's life. If I invest care with emotional feeling [like desiring his health, showing sympathy or loving-concern] from whence do I draw the energy to express these aspects? I need an energy field or trancendent resource to draw from. I can obtain this so that my ability to assess, plan, implement and evalute health-care strategies for his health draws from this source for this patient.

This last thought refers to that spiritual dimension that forms part of being a person and this is discussed in the following chapter.

CHAPTER SEVEN [continued]:

7.6. Part II: The spiritual

7.6.1. Introduction

There were twenty-seven interviewees: eleven referred to the 'spiritual', two imply spiritual awareness. The thesis, up to this point has over 90 references to the spiritual. The context ranges from being a capacity within us, a feeling of pain, an equation with the transcendental and as being an essential aspect in nursing particularly centring on health. Therefore, this concept should be taken seriously as a dimension of care. The many authors mentioned in the text do take this topic seriously particularly Montgomery, van Hooft, Shutte and Watson.

This chapter will consider why the spiritual is necessary in the concept of care. Why ministering to the spiritual needs of a person is an important aspect of deep caring which, as van Hooft reminds us, is part of that innate capacity within us. Lastly, what qualities are inherent in the spiritual dimension of a person?

7.6.2. Why consider the spiritual?

There is confusion as to what is meant by the term 'spiritual'. This confusion lies in linking the spiritual merely to religion and/or culture. These material artifacts express the spiritual in specific ways for specific persons. Many, like interviewee Kay, make a distinction between the two. Some textbooks, ostensibly discussing the spiritual, refer only to approaching patients from different religions or cultures: for example, Jews, Moslems or Hindus [to name but three religions]. They discuss what persons holding to these Faiths believe, and the expected behaviour towards the dying and dead.

Claire van Deventer [1995] in quoting the World Health Organisation's definition of health was troubled at its lack of a spiritual dimension. [This has now been added]. In an illustration she used to make her point, she writes of a patient who had lost her joy as a Christian and who when questioned felt fearful of, guilty towards and condemned by, God. In her use of this illustration, one could not be blamed for thinking the spiritual dimension was to do with religion. However, in her next illustration, where a girl of fourteen years of age dies for no identifiable medical reason, Van Deventer realized she had failed to recognize this patient as a person. "No-one", she writes, "had spoken to her about her fears or her thoughts on death". Instead, they had "smiled brightly, greeted her and [did] more and more tests" [1995:787]. van Deventer felt a low premium was placed on spiritual health and that medical lecturers asserted there was no spiritual dimension therefore no need for sensitivity in this area [1995:788]. van Deventer's story enables one to understand why interviewees like May, Lesley, Cindy and Susan were at pains to say patients must be given time when dying and that one should not put one's own agenda onto them.

Long [1997] and van Deventer [1995] bewail the fact that although nursing is supposed to have an holistic approach little is said about the spiritual dimension constituting persons. Yet, the spiritual, as with deep caring, evolves from a capacity inherent in man's humanity. As such, it should be part of holistic nursing. By focusing on the spiritual, a person pays attention to the felt experience of the relationship incipient in this concept. Through focusing on a resource greater than themselves, persons gain bodily experiential self-awareness of their inner capacity for the spiritual rather than understanding the spiritual as merely an abstraction.

The spiritual dimension is viewed as an aspect of common humanity: an aspect of being a whole person. It has a relational nature, expressed through particular interpersonal relationships between persons and through a transcendent relationship with a power greater than self. These relationships produce behaviours and feelings demonstrating the existence of attributes like love, faith, hope and trust, therein providing meaning and fulfillment to life and a reason for being. It is not religious concepts, like prayer, worship and ritual, or cultural practices that create the spiritual. Rather, our common humanity forms the connection between persons because our beliefs, values and behaviours can be intentionally developed. Caring for others is one of the means of integrating the spiritual with these aspects.

Nurses themselves have a need to find meaning in the suffering [pain, loss, grief] they encounter. It was seen that attempting to understand the meaning of suffering should be part of our health service to patients [de Jong, 1987]. A case was even made by a theologian, William May, that there should be "a study of the ethics of suffering". His reason being that this would "focus on the patient and practice rather than on the profession" [Melia, 1994]. Being able to discuss the meaning of life's tragedies, death and dying is a need, not only on the part of patients, but on the part of professionals too. As Diana showed nurses have spiritual needs. If these are unmet (or there is limited understanding of what the concept spiritual means) this will firstly, affect the nurse as a person and secondly, affect how patients' spiritual needs are perceived and met. Montgomery [1991] showed that the ability to care comes from having an inherent spiritual capacity because of being a person. True care is embedded in one's spirituality: they have the same inner source. Therefore the more fully the one capacity is developed the more the other will be.

7.6.3. The meaning of the spiritual in relation to care

The following interviewees' discourses identify a spiritual dimension:

1. Ruth said: "A patient would spend a week ... two weeks here in hospice, and build very strong ties with each other. I think of two in particular a few years ago. An older woman and a very much younger woman who spent a lot of time talking [being present to each other] in the ward and they planned their funerals. Even such things as what hymns they would have at their funerals. This kind of thing, and it was not done in any kind of morbid way. They were just very realistic about the fact that they were both going to die. [T]hey were looking ahead at how the families would cope, what the funeral would be like, whether it would be helpful for the family members. How it could be helpful for the family members. They looked at all this together. [T]hey built up this very good relationship ... [It] was really very, very special. The older woman and the younger one were both supportive of each other. It was a very special patient to patient relationship that happened here..."

The ties that Ruth highlights are what others describe as 'relationship'. As Nouwen [1994] would say, these persons are caring for each other in a 'special' spiritual relationship by preparing each other for their deaths.

2. Lesley said: "We were nursing a nurse, a matron from Z Hospital. In addition, she had [cancer], she was dying, but she was very firmly placed in the Lord, she was a very spiritual lady really. BJ and I would do a full wash.

You know it was a spiritual experience to come and do a full wash on this matron, because she was so incredible. She had a wonderful sense of humour, and then we would sing together, you know, sing lovely hymns. I go goosey when I think about it. [O]n the day she died, in this ward, there was a very close nursing friend also there, and the spirit, the feeling in this ward was so majestic at the moment of her death, that BJ and I both sank to our knees. We felt this feeling of such awe that we were both on our knees (she chuckled at the remembrance). Could it be true (continuing to chuckle)? Anyway that was a deeply spiritual experience".

Here Lesley sets forth the experience as spiritual. It has a religious quality about it too, but pre-eminently it was spiritual. This Matron had prepared for her death: she had found fulfillment. Lesley recognized the patient relating to a spiritual dimension and far from devaluing the individual for it, she recalls patient and memory, many years later, with great enjoyment.

3. Lesley was being observed when the following occurred. The patient had an open cancer of the mouth and throat. He could not speak. Lesley picked up that he was afraid. She went up to him and asked,

"You're frightened aren't you?" He nodded. We prayed having asked him if the two of us should offer a "little prayer for you". Outside Lesley asked me: "What is it like to be alone (he was in a side ward), bubbly [that is, one could hear the intake of air running through the fluid congesting his lungs], with cancer, and different people dealing with you differently at different times? What is the emotion of the nurse?"

In this discourse Lesley, whilst on a medicine round, identified fear, aloneness and spiritual distress. During and after the round she gave practical help: suctioning, assisting, being there, and making some small difference to the patient. These aspects of practical spiritual care give meaning, purpose and fulfillment to the nurse. They enabled the patient to relax and to be somewhat at peace. However, at the end the patient had no one helping him. He died alone because no constant carer could be there for him alone. There were too many patients that evening and not enough staff. It is as Susan said: there is a need for a place of care for those dying 'here and now'.

The first and third discourses contrast each other. The nurse in the first tells about a beautiful spiritual relationship that evolved because two persons met spirit to spirit in their common humanity and discussed what was for each something meaningful, precious and fulfilling. As the nurse herself said, there was nothing morbid about it. Nouwen [1994] would see them giving each other the greatest of gifts: preparing for and befriending death.

Human experiences have no meaning in and of themselves. The person experiencing the illness or event can discover value, purpose, and meaning in the experience. Nietzche is often quoted as saying, "He who has a 'why' to live can live any 'how'" [Frankl, 1967]. Frankl also felt if people could find meaning after what they had been through [e.g. the Jewish holocaust] they would survive. People [patients, nurses, others] seek meaning from the inexplicable mysteries of life. Lesley and other interviewees sought meaning from that which they and their patients experienced.

The discourses demonstrate Labun's [1988] view of spirituality. She felt it was an aspect of the total person that related to, and integrated with, the functioning and expression of all other aspects of the person [their essence and spirit]. Spirituality produced behaviours and feelings demonstrating the existence of three main virtues: love, faith, hope, therein providing a meaning to life and a reason for being. The discourses bespoke a spiritual dimension within care-givers towards cared-fors. Ross' [1994] and my own research show that nurses who give spiritual care demonstrated that:

i) They were aware of the spiritual dimension in their own lives, and this dimension is of more import than their religious orientation in determining how they gave spiritual care.

ii) They experienced crises that seemed to act as forces for growth, enabling them to become more self-actualized. This suggested that life experiences or maturity factors are more important than the grade of the nurse in determining the spiritual care given.

iii) They were willing to give of themselves at a deep personal level that correlates with their life experience and spiritual awareness.

iv) They were particularly sensitive and perceptive persons. [adapted, Ross, pp. 446].

Sr W demonstrated that her belief system shaped her nursing life: she said she nursed someone as if she were nursing Christ. Trevor Hudson [1995] added an aspect that would have included Sr W's attitude: "Spirituality is being intentional about the development of those convictions, attitudes and actions through which the Christ-following life is shaped" [pp. 15]. Where Hudson has 'the Christ-following life" one can show that any transcendent belief system or ideal can shape one's spiritual behaviour [e.g. Islam or Communism].

May had insight into care being instrumental in enabling the elderly to relate with others. This was important for these persons in their continuation as persons. This would give purpose to their living and lead to their dying well. The practical reality of discussing details of their funerals was the spiritual manner in which she knew they found value, purpose, and meaning.

7.6.4. What then is spiritual care?

What is implied in the concept spiritual care is an extension of a caring relationship. Spiritual care is deliberate spirit-to-spirit care: a special engagement between one caring and the cared-for. As May said, it was not an attempt to evangelize a person. It was an unselfish donation of the self. Most times mutual reciprocity occurred, at other times the recipient may not be able to respond as in the physically handicapped person; or someone critically ill; or parents angry at the inexplicable death of their child after an appendicectomy.

Montgomery quotes one of her care-givers: "Spiritualness ... comes from a deep sense of ministration to the individual. You minister to the spirit within the body. Sometimes you will not even recognize the person outwardly because of deterioration" [1991:97]. Furthermore, the one ministering to spiritual needs has a belief in the existence of personal capacities in the cared-for and values the cared-for not merely as someone with needs or problems, but as a person for his/her own sake. To the extent, the carer cares, she is presenting herself to the cared-for, and 'adds' to her own personal growth as well as that of the cared-for. The motive for caring is not merely out of 'duty' or the meeting of a personal need to care for others, neither is it to solve the problems of the cared-for. It comes from valuing the cared-for as a person in their own right then these other aspects are dealt with.

Humanity's search for meaning is a spiritual need. The spirit in this search needs personal relationship as interviewees May, Diana, Bekkare, Susan, Ruth all intimated. Patients need tangible evidence of trust, love, forgiveness, joy and hope. Spiritual care focuses on the carer's relationship to the one being cared for. Stiles [1994] gives examples of spiritual relationships. These included: 'sitting with', 'talking with', 'holding hands', 'sharing similar experiences', 'humour' [such as Lesley showed with the Matron], 'truth-telling', 'answering questions', 'listening', or that which is identified as giving 'felt presence' or what RNs, in this research, described as 'being there for the patient'. Yet, this cannot be done when there are drastic cutbacks in staff numbers.

For it is not any type of sitting, talking or holding hands, with every patient, but when these actions are that 'conscious willingness' of which Susan spoke, an intentional compassionate response, a willingness to 'meet' one spirit to another spirit in dialogue and mutuality then there is a continued presence: the giving and receiving of the gift of self. [As Lesley [interviewee], and Nouwen [1994] declared when they described caring as a gift]. As one nurse put it: "the first time they say anything to me that sounds the least bit like they want to talk, I sit down. I am available" [Stiles, 1994:21].

Provision is made to ascertain the patient's perception of his or her condition and to have someone at hand to listen to what that patient is saying. Listening to the patient's story about their illness: its antecedents, implications and perceived consequences is important. The patient needs to reflect upon this and know someone is listening to their expressions of fear and their dreams [those that re-occur and those perceived to be shattered]. One hospice told me of the trouble they take to meet their patient's dream-wishes where this was possible.

7.6.5. The spiritual dimension in philosophy

Before one can move from examining spirituality to the qualities of the spiritual one needs to understand the meaning of 'spiritual' from a philosophic standpoint. It was said that nursing should have a holistic approach. There are no divisions or compartments in the idea of holism. The physical, psychological, social and spiritual nature of a person should be one integrated unit. The spiritual person is matter. This substance is the living animated manifestation of the person in relation to the world. Instead of the word spiritual, one could use the phrase 'the inner life of a person' [a phrase May used when discussing healing]. This inner life searches for meaning and value. It is inner because in this search a person is consciously present to him/herself. The spiritual is relating to oneself. The spiritual is ministering to that inner self and the need to relate to a "transcendent force greater than oneself" [Montgomery, 1991]. As one of Montgomery's interviewees said: "It is pulling from abundance" [pp. 97]. Montgomery explains that spirituality implies the existence of some greater force. One needs this spiritual force - a transcendent aspect outside of one's normal resource to 'pull from'.

The spiritual is that aspect of human being neither bodily nor physical. It includes the emotional [grief, joy], volitional [acts of will], acts of reasoning [the life of thought, intuition, reflection] and feeling [sensation, imaginations]. These are non-material aspects of human being. The intellect and volition lead to thinking, judging and choosing. These activities distinguish us from animals. They enable us to know [about and how] and to value [evaluate, consider]. Within the intellectual-volitional realm [as peculiar to persons unlike creatures] persons become persons, or are constituted, by their spiritual activity. What we know or love leads to beliefs and choices. The spiritual is composed of belief, faith, commitment and choices. One nurse 'gate-keeper', when asked to comment on the fact that so many nurses discussed the spiritual, reminded me that it is a highly personal 'space' within us. It is our inner-self life. It makes us capable of a relationship with a transcendent being. We are not the source of our spirituality. We can only desire the relationship. Such a relationship is necessary for our actualization and our integration and fulfillment as persons.

The person is a single integrated being. This principle of unity makes the person a spirit. Other aspects are self-determination and self-consciousness. Because we are spiritual, there is unlimitedness about us. Consciousness is limitless. It knows no boundaries. We can make choices about anything. This lack of limitation leads to questions about life, concerns, or meanings. It leads to seeing one's life as a whole, the possibility of understanding everything, to be completely self-possessed. The connection with religion is that because we are spiritual we can ask about all our needs: meet them with certain practical demonstrations or ritual. Questions like: is such and such possible and how is it possible? This is the origin of a power to fulfill our deepest and most fundamental needs. Religions occupy the field of the spiritual but demonstrate diverse ways of fulfilling these needs. Spirituality as such is one aspect of our humanity. However, if it is not taken seriously, if it is not recognized, there can be no meaning, value, purpose, fulfillment or integration for human beings. Everyone has a notion of this inner life. As already mentioned it is the amalgam of one's beliefs, convictions, choices, consciousness and self-realization [autonomy, self-creation and self-determination].

Where one is alive to one's spirituality, it is an experience of wholeness with oneself, other human beings, and a transcendent being. A person can deny their spirituality by being over-whelmed by the material or the self or allow it to lie latent or be un-nurtured. As one of Montgomery interviewees stated: "I wasn't aware of [spirituality] twenty years ago and I think for many nurses it lies dormant" [1991:97].

Diana's narrative epitomizes a tension that Frankl [1967] wrote about. He said, "There is a tension between being and meaning". Her patient, Mrs Parke, consciously or unconsciously approaching her death, represented Diana's unspoken struggle: a struggle between being and the meaning of life. The struggle with learning about the spiritual leads one to become more of a person through beginning to grasp the meaning of life. This struggle, Frankl maintains, is indispensable to mental well-being. It is a normal and necessary tension inherent in being human. Diana did not know what meaning this patient fulfilled but she accepted it as something transcendental and not just for herself. Meaning, for patients expecting their deaths, has to be harmonized with their being. Meaning runs ahead of their being: it is a journey of discovery, of learning to continue to be self-realizing, becoming fully fulfilled because of the meaning one obtains from life and in one's dying [Nouwen, 1994].

7.6.6. Qualities of the spiritual

Persons are spiritual beings. They are just as much spiritual as they are physical, mental, emotional and social beings. They are rational, free, self-aware and self-determining. This is what makes them persons. This basis of personhood gives humankind the power of choice. Inherent in awakened spiritual nature is the ability to distinguish between what is right and what is wrong. Spiritual choice becomes moral when the spiritual capacity is actualized and judges or evaluates between good and evil.

The spiritual combines with conscience, volition and affect. This is integral to the idea of choice. I can will to do right. I can will to do wrong. I can will to give good health-giving compassionate-care. Before action, a choice based upon my will is necessary. I analyze my disposition: is it bent toward the right or toward the wrong? The spiritual embraces a person's deepest non-material centre: the conscience, together with the volitional and affective domains. Conscience can be aroused if I make a choice that subsequently I deem to be morally wrong. My action has consequences whether just to my personal being or to others. This again is where the spiritual enters. My feeling guilt or despair becomes spiritual not merely emotional. Guilt for what I have done, despair that I lacked the self-control to will what was right. There is loss because I have diminished others and myself in the area of intersubjectivity. There is also loss because the self is no longer integrated, but alienated, as another self, a changed self. I question which is my true self.

The above spiritual qualities appear to be directed toward the negative. There are positive qualities in spirituality. These positive attributes are also known as virtues. Self-control has been mentioned. For every positive quality, a negative dwells in the realm of the spiritual. For example, there is love but also hate. This couplet could be said to be in the realm of the emotions only. They are emotions. If it were permitted, they could be called spiritual emotions. For neither love nor hate are merely impulses or inclinations. There are other qualities of the spiritual. These cannot only be put into the emotional or psychological realms. These would include kindness and its opposite, cruelty; forgiveness and unforgiveness; humility and arrogance; gentleness and harshness; compassion and unconcern; patience and impatience; peace and restlessness; joy and sadness; trustfulness and untrusting. I give such a long list because these negative aspects have been found in nurses who do not treat their patients caringly. This means that these nurses are damaging their health.

In giving this list, it is not that at any time these qualities are spiritual but in particular incidences, where one has the freedom of choice to exercise them as virtues one possesses, then they are. In my innermost being, something within says there are qualities that may appear negative but the more I dwell on their nature and source, the more I become convinced these qualities are both positive and spiritual.

One example is jealousy. The lover is jealous of any blemish within the beloved because he sees that she can only become fulfilled by showing virtues like love and self-control. It is not for him that he is jealous but for the growth and fulfillment of the beloved, he has only the beloved's welfare at heart. He is like a brooding spirit keeping watch over these spiritual qualities so that they remain pure for the beloved's use [Pieper, 1972]. Another is where love turns to hate. For example, "One tends to hate that to which one is not equal" [Lipps cited by Løgstrup [1997:33]. Løgstrup questions why experiences of sublime love and of sublime hate alternate like the tides [1997:31].

These qualities summarize what constitutes the spiritual not only in an abstract sense but also concretely within the spiritual realms of cared-fors and carers. They form the spiritual level where deep caring lies. If these qualities are latent, as was hinted at earlier, then caring for others could be absent. What must be allowed is that the spiritual may have full expression in the lives of the cared-fors and the care-givers.

To explain the reason for this is to enter again into the philosophical world but in doing so I will be drawing into the discussion the links and ideas held by authors already mentioned.

Three main ideas are being addressed in this concept of the spiritual: transcendence, freedom and unlimited consciousness.

They arise from, for example, the African proverb discussed in this text that could be said to be Wittgensteinian in essence. The proverb allows for the constitution of social, spiritual, even aesthetic dimensions through others. Wittgenstein's view of human being make it possible to understand how one acts out one's freedom in relationship. For him there was no other alternative. If we understand his ideas, we can understand better how the African proverb ties in with his thoughts. Although this world is socially constructed, yet it does not lead to determinism. Freedom, far from abolishing individual autonomy, lies in understanding the possibilities of our relationally responsive ways of acting both with each other and with our surroundings. Wittgenstein's spirituality, ontology and philosophical project was that of creating a renewed sense of humanity's connectedness and relatedness, both with each other, and with our larger surroundings [Cunliffe 1997].

Knud Løgstrup [1997] presents an understanding of interpersonal life similar to that of 'ubuntu' and the above-mentioned proverb. In so doing, he breaks with Kantianism. His premise is that all interaction between human beings involves basic trust. Through the trust that a person either shows or asks of another person, s/he surrenders something of her/his life to that person. This becomes 'the ethical demand'. Unlike Kant's Categorical Imperative, it is not derived from any rule. Rather it is rooted in a transcendent base. For example, he asks: "What must the man-to-man relationship involve if it is so closely tied in with the relation to God?" He answers, "All the while that God is determining His relationship to me He is also caring for that other person, the neighbour". These points arise out of Gogarten's statement: " ... men's relationship with one another [is] the one and only point at which the relation to God is determined" [quoted in Løgstrup [1997:4]].

The theme of relationship is consistently mentioned by Carol Montgomery who had, in discussing her research, stated that what emerged "as a theme of caring, was the experience of spiritual transcendence". This she defined as, "experiencing oneself in relationship as part of a force greater than oneself" [1991:92]. She felt caring to be a natural capacity developed through a relationship of being loved and protected, that is [in Shutte's terminology] by being self-affirmed and self-determining. She acknowledged that the source of energy required for caring was seen to come from outside oneself [from our spirituality]. Those who utilized this source [her research and mine identified many] 'pulled from abundance' [as her interviewee represented this] and became renewed. This transcendental source of energy gave personal empowerment or, self-affirmation and self-enactment. Persons are self-enacting in the sense that our acts [even nursing acts] can be free from external determination for we *choose* to obey and follow orders]. If a patient is the direct object of my action in nursing him or her, I also act upon myself. I develop my capacities through this other person. [Shutte, 1987:158].

To explain our spirituality is to attempt to explain the paradox of relationship and our dependence upon others. At the same time, explaining our freedom to be self-determining, or, our 'unrestricted capacity of knowing through transcendental experiences' [Rahner cited by Kerr, 1986:7]. Kerr felt that to "recognize one's limitations is to have transcended them" [p. 12]. Here Kerr is discussing Wittgenstein, and his philosophy of meaning. Wittgenstein's idea was that although our understanding of this world is socially constructed yet, notwithstanding its vast complexities, this does not lead to determinism. We recognize our self-limitations. Even the Christian tradition of the concept of man's creation reveals the insufficiency of human power. Man cannot make himself. Philosophers have argued long and hard as to how, and with what, to complete this insufficiency. This very 'insufficiency', in 'the mystery of humanity' [Shutte, 1993], reveals the need for a transcendent power. Such consciousness constitutes our spirituality. Only such a power and our consciousness of it [limited or conditioned] is able to bring about the reality and growth of freedom. Persons have the capacity to freely choose and to freely act according to their own decisions or desires. It is this 'acting', 'doing' or 'making' that makes us spiritual beings. In using the latter two terms, I am following a thought [based on Aristotle] from Wittgenstein's philosophy of meaning.

Wittgenstein wrote of 'possibilities', 'surveying' and 'criss-crossing' particularly in connection with his 'territory of meaning'. His philosophy encompasses a wider spiritual, ontological and philosophical project of creating a renewed sense of our connectedness and relatedness with each other and with our larger surroundings. His notion of freedom, as understood by Cunliffe [1999], lies in understanding the possibilities of our relationally responsive ways of acting with both each other and our surroundings. This does not abolish individual freedom. Being human implies that it is only in relation to this that it is possible to act out one's freedom. Secker [1999] writes of a concept of patient autonomy that is not purely Kantian. Her feeling is that a person is neither wholly socially constituted, nor completely independent. Persons, and she is thinking of those persons who are patients, [one could include nurses here] often make major choices in the company, and with the assistance, of persons who help to shape their lives: their characters, beliefs, values and goals [1999:57]. Shutte [1993], and Løgstrup [1995], in line with others' understanding of Wittgenstein, [or Wittgenstein's understanding of Aristotle [Cunliffe, O'Neill [1996], both state that we constitute, and are constituted through, persons and situations. Persons depend upon persons to become free persons, paradoxical though this seems.

In my self-transcendence, and self-donation [caring] I *can* become progressively more self-possessed. The *possibility* remains within me. An uncaring person will neither tap the source nor become renewed. For this reason, Montgomery felt, burnout occurred. This is a distinct possibility because where our capacities are undeveloped there is diminishment of the person – they are incomplete and unfulfilled. Many of the nurses interviewed, who felt this 'insufficiency' within them, connected with a transcendent other. They entered into a relationship [union] with a force greater than themselves. They drew 'from abundance'. An impersonal environment is insufficient to develop our capacity for caring, or our self-consciousness and self-determination. To be developed in these areas persons must be recognized and valued as persons by other persons. The ideas of self-transcendence, self-donation and self-possession reach even greater depth. As Shutte explains:

> "In the intimate knowledge of the other person that personal growth makes possible I enter so fully into his life and mind that it is as though I have overcome the limitations of my separate individuality. We seem to share a common mind. This is self-transcendence; you remain yourself but you have overcome your separateness and closedness so that you are able to fully enter into the life of another. The same is true of the love I have for the other person. It is him whom I love, and for his own sake, not just for mine. It is gift-love not need-love. Moreover, the gift is myself. This is self-donation. It is the attitude revealed in all genuine self-sacrifice, and in that mysterious activity of human re-creation, we call forgiveness. ... [We] get glimpses of its true glory in moments of ecstatic love, creative effort and the experience of beauty" [Shutte 1993:87].

All this can be applied to the spirituality inherent in caring. In addition, the qualities of a nurse, as developed in this thesis [see section on: "What is a nurse"], reveal a person displaying such attitudes through their knowledge, competence, confidence, and creativity. Shutte also explains self-possession in the context of his argument for the existence of God:

> "[T]he more one is influenced by another in a strictly personal way, the more one comes to gain possession of oneself, the more completely self-enacting one becomes. The more I am affirmed by the other, the more I am able to affirm myself; the more completely the other knows me, the more I am able to know myself. One could even formulate a 'law of personal causality' thus, that persons develop in direct and not inverse proportion to the strictly personal influence on them of other persons. A condition of such a law holding however would be that the system of interpersonal relations

> includes a person who is transcendent in the manner of the Christian God [1987:173]". "The better we understand persons and personal growth the more convinced we shall be of the activity, and therefore of the existence, of one who is not limited in any way as we are and who is the sole sufficient cause of our growth and community and therefore entitled to be recognized as God" [1987:175].

Personal growth, whether in spirituality, freedom, self-determination or self-knowledge, is only available through persons who themselves have knowledge of their own growth, to those who in fact have grown as persons themselves. It exists always and only as a part of a comprehensive personal attitude, that includes volitional and emotional elements as well as purely cognitive ones.

Lest Shutte's 'intimate knowledge of the other person that personal growth makes possible' or 'enter[ing] so fully into his life and mind that it is as though I have overcome the limitations of my separate individuality' be critiqued as being an impossible goal to strive for, I refer to Murdoch and Weil.

Iris Murdoch [1970] developed a concept of 'unselfing' that she describes as the self-oblivious engrossment experienced when confronted with an object of attention that is appreciated, loved and cared about. It is in these situations that one can assist the self in making the 'I' disappear. Persons can be prised away from seeking their own desires or self-centred purposes because the recipient of the attention elicits a person's ethical attention thereby making the attendee aware of the possibilities of this 'unselfing' in other contexts. This in turn results in heightened self-understanding and the gaining of access to oneself from the perspective of the other.

Reference has already been made to Simone Weil[i], [1950] who is more mystical. She refers to a mind unencumbered by conditioning attachments. A mind also open and receptive. Such attention is both ethical and spiritual because it is a particular comportment motivated by a conscious willingness to 'enter fully', 'make oneself present' in giving support, love and compassion. These are qualities of the care-giver and are revealed by giving patients respect, dignity, and a sense of personhood.

As has been previously mentioned both Murdoch and Weil reveal a determination to expel the influence of the will in terms of self-seeking. Instead, the volitional attribute, will, is seen more in terms of 'giving consent to'. For example, giving one's consent to being present, as one person to another with one's whole presence when caring for another.

These authors appear to be guilty of a type of Uriah Heep, self-sacrificing, self-effacement and submissiveness. One that feminists are at pains to avoid. However, this is not intended. The nature of the 'unselfing', 'ethical-attention' or 'demand' is that of an active ethical and intellectual informed style of looking or observation. One that is intent on gaining information or trust in order for one to be there for the patient and to care for the patient's well-being expertly.

In relationship to freedom there is a paradox. The paradox is that human life has the character of predicament especially if we accept that man is a created being ... created by and in the image of God. Essentially, in discussing a person's freedom, unlimited consciousness, self-possession and transcendence, we are discussing aspects of a person's growth. This growth fundamentally consists in discovering and satisfying my desires. Not any desire but those deep inner profound desires that may take a lifetime to fulfil. It is these "deep" desires that both Shutte [1987/1993] and van Hooft [1996] write of and that we must come to know. They are knowable because they are common to humanity. One has to gain knowledge of what one's true self is, and to affirm the deep desires that constitute this self. For, it is this self-knowledge that will become the chief principle of integration within and between the cognitive, volitional and emotional systems of my being [Shutte, 1993]. It is this integration that is the cause of a progressive growth in freedom, transcendence and unlimited consciousness. These constitute my spirituality.

7.6.7. Conclusion

Some RNs discussed care as a positive spiritual quality. They are jealous, in the positive sense explained above, for the their patients, the nursing profession and the individual nurses that comprise it. They have patients' and nurses' welfare at heart. For this reason some are fearful of nursing becoming too professionalized or scientific. They are jealous for the humaneness of nursing. Therefore, they see care as a virtue to be encouraged, a virtue that can become part of the spiritual when actualized through compassionate-care. This is why van Hooft [1995] explains caring within the context of the spiritual as the integration of all our levels of being. This is how he distinguishes between deep care as a capacity within us and caring, not only as the outworking of that capacity, but also as contributing to a philosophy of ethics.

The possibility of a philosophy for nursing is one that draws from the past and moves through the present to uncover an ethic grounded in nurses' practice. Participants' discourses seemed to anticipate such an ethic. Having discovered practitioners' meanings of care, the philosophy behind that meaning needs to be revealed. This leads into studying the ethic of care and is the intention of the next chapter.

> A woman phoned in to a radio talk-show to tell the following story. A patient had wet the bed because a bed-pan had not been given in time. This patient asked a nurse if she could clean the bed up. The nurse to whom the request was directed refused to clean the bed or the patient. She justified this by saying: "After all I did you a favour by giving you a bath this morning".
>
> "Talk at Will" (SABC, Will Barnard, 12.11.96)

CHAPTER EIGHT: The findings and discussion

8.1. Introduction

This research was undertaken to discover the meanings RNs gave to the concept care. This chapter discusses the findings and their implications. Possible further research is identified. Particular findings to be discussed are:

i) The 'family resemblance' of meanings between participants and authors.
ii) The philosophy and ethic emanating from the meanings given by RNs.
iii) The implications of these meanings in the real world of nursing practice.

8.2. Respondants' meanings and family resemblances of care

From participants usage of the term 'care' family resemblances emerge and these resemblances in relation to meanings link with those of the authors used. Drawing these meanings together does not result in a dictionary definition but different views as in a kaleidoscope. If I say the different pieces of glass within a kaleidoscope represent respondants' different aspects of the concept 'care' then at every twist [representing participant's configurations of care] a new picture of care with a rich meaning is observed and often profound insights revealed.

That each 'twist' can demonstrate different meanings and insights illustrates the wideness of the concept 'care'. This conclusion is similar to the breadth of meaning given by Wittgenstein in his example of the word 'game'. One example of this family resemblance of care is the kaleidoscopic picture configurated in the narrative given by Bekkare depicting African culture. Though differences between Western and African cultures exist, yet family resemblances of care are distinguishable when Bekkare's narrative is compared with Western stories.

Shutte [1993] shows that the African proverb Bekkare used has definite Thomist philosophy affiliations in that it seeks to provide an understanding of our humanity. Our humanity, our primordial existential being, relates to care [van Hooft, 1995]. The commonality is that ideally we care about others, as Bekkare did, because we want their health. In this way, we want to enable them to develop as persons. This interviewees Amanda, Bekkare, Susan and others portrayed through narrative pictures of compassionate-care. Various other kaleidoscopic pictures of care will be drawn together from the narratives.

8.2.1. A summary of meanings.

This implies that there was no one meaning. The following are a few loose categories. Many of the meanings have been discussed earlier in the text and I do not want to be too repetitive. The emphasis is on the meanings of the discourses unless actual practice was observed, in which case that will be mentioned.

8.2.1.1. People mattered

Participants' meanings of care were often deep. People mattered to them. Care included definite relational asoects that involved loving and bonding with their patients. They formed such deep relationships often because their patients had lethal or terminal illnesses. Their care portrayed particular bonding relationships. Amanda bonded with her paediatric patients, Susan in her special care to the dying, Cindy felt she could not nurse oncology patients without bonding. Care-givers had to have particular characteristics in order to care. Characteristics that bespoke particular attitudes. They had to be perceptive, brave [or bold] and comfortable enough with themselves to face others' dying. This 'braveness' van Hooft writes of as courage [1990:213] It implied being strong enough to be 'one's own person', even though circumstances sometimes prevailed against giving care according to an intrinsic standard. Some testified to nursing establishments unconcerned about ethical-care. Lesser persons, without these characteristics, may have changed their care-style but, exercising a courage that came from within they allowed their understanding of care to lead them to do more for their patients because presumably they drew from spiritual sources outside of themselves.

8.2.1.2. Having the right attitude

Care-givers had to have a right attitude. They had to make choices about whether they established a rapport that showed they cared from the outset. Some participants differed on aspects like "care was not an innate thing", "not everyone had the ability to care" and that it was 'something in your being' but 'not a moral duty'. Some differed as to whether the concept 'love' featured in care or whether some patients needed to be loved. But Kay formed a bridge between the two views in feeling it depended on the meaning given to the word 'love' Mary, for example, felt "love was not an imperative" though her perception was that care showed compassion. Collectively and individually, participants' meanings of care gave this picture of compassionate-care often because they themselves had felt loved, cared-for and treated with compassion. Their care-giving was not exclusive but a mutual 'transaction thing' that would come back to a person because of its two-way nature. Something was added to the cared-for and both care-giver and cared-for would get something out of such care. Some learned the meaning of compassionate care-giving from the personal experience of being vulnerable or discovering what pain could do. And, they learned to cry.

8.2.1.3. Professionalism

Some felt that care had become lost in an over-emphasis on the scientific or professionalism. Professionalism, and large hospitals with a particular ambience, they felt, served to dehumanize students and patients. Perceiving nursing as still a vocation, some felt that when nurses demonstrated genuine caring attitude, they cherished the whole person unconditionally through their affirming and being affirmed. Their care was an intimate mutuality of relationship with others that became 'special' through listening, presencing, knowing and investing care with volition and an affect that was ethical. There was a reciprocity, that for example, terminal illness brought. They wanted their care to make a difference and for patients to feel that they 'mattered'. It was to be knowledgable, skilled, competent and given with confidence. In this manner it would be professional.

8.2.1.4. A normative standard

Participants revealed a normative standard of care-giving. These standards included seeing someone as valuable, giving caring-attention showing respect towards and dignity for persons who mattered. In Private and State hospitals a picture emerged of individuals wanting to practice deep care according to natural caring skills. This kind of care, had to be tangible and was based on patients' needs. RNs sought to care for patients in the expert way they had learned from past experiences. However, some felt they could no longer reach the standard of care they had given before fiscal changes and cut-backs had been instituted. They grieved for the 'optimal' care they were used to giving. Their discourses on care spoke of an underlying ethic based on personal beliefs, values and strong desires for positive attentive care-relationships often within a spiritual dimension. Their deep desire to continue to care, in the way many had cared in the past, was not being fulfilled because of demands on their time and this led to feelings of dissatisfaction and non-fulfilment.

Their compassion would be revealed in the quality of their care-giving. It was for the benefit of an other and not given for their own sakes. It could be a turning point in an other's life. It was being attentive to needs especially in the realm of pain of whatever nature. Such attentive-care was wholistic: it included getting alongside another with healing and the spiritual, being concerned for families and social aspects. It developed, like self-awareness and self-recognition, through persons, that is, through particular relationships with particular others. This desire to give quality care was revealed in the manner in which needs, at all levels, were identified. They discoursed on being present existentially, of giving loving attention and consciously-willing the health of others because of the persons their patients were. This presencing, they felt helped patients overcome feelings of diminishment and vulnerability.

8.2.1.5. Finding identity through care

The meaning care has for a person has volitional roots: choices have to be made. For example, Bekkare deliberately chose to give "another kind of love". This revealed an attitude that in itself would imbue care with an ethic. This type of attitude would define a person as to whether they were self-donating care-givers. Their normative ethic would give respect, dignity, and value to others. It would make persons feel they belonged. These meanings should have established attitudes, beliefs and understandings that emanated from experiences about being cared-for and learning to care-about others.

Their meanings included belief in the humanity of persons and showed in the firm conviction there was something within persons that could not be demolished. Through developing the spiritual within, persons could become integrated and have the freedom to rise above circumstances and have a resource greater than themselves. Some grew in self-realization, self-affirmation and became more aware that they were free, spiritual individuals whose lives had purpose. Some RNs found their identity through being caring.

Care, for some, acted as an evaluative tool. Through learning the value of healthy self-care attitudinally, persons become more self-aware and could identify particular ways they thought about themselves. Part of this learning became a growth aspect. It included the need to find oneself', to be more reflective and thereby become more authentic. Another part was a deepening inner self-knowledge which itself led to a mounting spiritual awareness and integration both for oneself and for others.

8.2.1.6. Categories of care

Morse et. al. [1990/1] identified categories into which she and her co-workers classified care. These were care as a human trait, moral imperative, an affect, an interpersonal interaction, and an intervention. The family resemblances from participants could be sorted into these categories without diminishing the meanings given; for as Bruner [1996] confirms, meaning can be made by comparing narratives to the shape of particular categories and Morse' categories, if used in this way, validate the meanings given to these discourses.

However, the purpose of using Wittgenstein's approach to find family resemblances between participants' discourses on care went deeper than the formation of categories. Though patterns that could have been categorized emerged, the approach delineated different possible ways of looking at care to determine a theory of meaning. Most important is the point that these family resemblances, by revealing a complicated network of over-all similarities and similarities of detail, revealed hidden aspects of the meanings of care. These may normally be taken-for-granted or remain hidden because of the simplicity and familiarity they represented but, these caring aspects that went beyond dictionary definitions, were aspects that truly mattered to patients like Sue Baier [1985] and Richard Zaner [1982].

Consequently, the term 'care' becomes imbued with compassion, a spiritual dimension and an ethic by including, going deeper and perhaps beyond, the categories that Morse, et. al. [1990/1] identified. For care to be complete, it needs to include that "mysterious mix" of affect, knowledge, determination, commitment, ideals, thought, and the agent's human traits [van Hooft, 1990:213]. There are over-all similarities and similarities of detail with Morse's categories but there is more too. For family resemblances themselves [whether of care or some other concept] show neither good nor bad associations. However, it is attitudes-in-action that reveal a person's habitual way of regarding or valuing someone or something. Ideally, the moral imperative, affect, interpersonal interaction and intervention would have been observed as habitual human traits. These traits could make for fulfilled persons and for them to be ethical. To be true ethical-caring, participants' meanings should juxtapose with the meanings of the authors below. They must be experienced as RNs combining their mental, emotional and physical activities and be imbued with ethical meaning.

8.2.2. Authors' meaning of care in relation to ethics

The authors drawn upon before are used as authorities on the subject of care again, but this time in the context of an ethic. This is done for two reasons. Neither the word 'care' nor its family resemblances delineate good or bad. To give these terms positive value they must be comprehended within an ethical dimension.

Gaut's analysis showed that the language used to define caring had to be precise, unambiguous and able to be readily communicated to nurses. Though I agree with this, her desire for a definition runs counter to what I have attempted to do in this thesis. A definition of care does not necessarily convey what participants described as care. Portrayals of care must communicate what patients, like Baier [1985] and Zaner [1982], wanted from nurses in terms of care. Such care, if deliberately chosen and given, is ethical. Bowden's concern for those trying to apply a single concept, or definition of care, to the context of nursing can be repeated at this stage: single concepts or definitions could seriously undermine the rich variety and 'complex-specific ethical possibilities' of nursing in general and care in particular [1994:13].

van Hooft [1990/5/6] claimed that an ethic of care would be an expression of deep caring in the sense that it was a socially constructed form through which we constitute the integrity of our being and the quality of our engagement with the world and with others. Such caring defined the self. This type of care was for the health of patients. Its aim would be personal integrity and self-transformation.

As early as 1988 van Hooft had said that he frequently met nurses who after 40 or 50 years still questioned some of the ethical decisions they had made. He talked of the conflict arising from the tension between their private relational notions of caring and institutional and operational notions of caring. He highlighted another conflict: that between commitment and social permission. By this he meant [following Yarling and McElmurray (1986)] that nurses needed their internal commitment to be empowered in order to exercise professional autonomy or the freedom to be moral. Therefore, his focus became the moral education of nurses. He rejected putting ethics into the same context as professional codes and law as these codes and laws related to nursing. Moral education he felt should not be used to discuss and impart moral principles but to show the basis of how we should act [pp. 211/2]. He felt that what we did in situations of moral difficulty would be an expression of what was cared about most deeply [1996:83]. This is an important statement in relation to the findings to be discussed.

In place of these principles, laws and codes he felt that moral education should concern itself with the formation of specifically caring attitudes centring on a commitment to caring for the health of patients [pp. 213]. This commitment was inherent in, and compelled by, a distinctive attitude. He wanted nurses to see caring role models and discussions that focussed on ethically correct caring attitudes. Orientees to nursing needed to see, for example, attitudes that called the care-giver to love, take delight, and effort, in showing forth their values and integrity in acts of generous self-donation towards the living and dying.

Bowden offered a gender-sensitiveness to care and a rich description of ethical-/ attentive-caring. She felt the practical nature of caring could display a range of ethical priorities. These consisted of commitments, attitudes, beliefs all of which were on the behalf of, and central to, the health of persons. She felt an ethic of care was constitutively shaped by the practices in which it was embedded and intricately connected with responsiveness, vulnerability, self-understanding, reciprocity, trust, respect and openness.

Benner [1984/91/94/96] cannot be discussed without seeing her stress the importance of knowledge, clinical judgement, the primacy of caring and ethics. For her, care and responsibility were one. Ethical comportment did not consist merely of words, intents, beliefs and values. It encompassed a particular stance, touch and orientation of thoughts and feelings fused with physical presence and action. The hands-on-caring expert nurse engaged in these aspects. Their focus being on what was right to do rather than what it was good to be. This is particularly poignant and noticeable in her book, "Expertise in nursing practice: caring, clinical judgment, and ethics. Her focus on action, good and right is particularly relevant to what follows later.

Nouwen's [1994] care applied the outworking of justice: fairness, compassion and non-discrimination. Nouwen's belief was that to care was the privilege of every person. Caring with, and for, others was the basis of community and this was his particular ethic [1994:66]. He made me realize that if we were alone, we could not be ethical. Being human, and in relation, is part of being ethical. Caring with one's volition and affect was another aspect in Nouwen's concept of community.

Montgomery does not explicitly refer to care in an ethical sense. But in discussing the quality of care-givers' engagement with patients and themselves, and care relationships that lead to growth and 'healing through communication', she deals not just with bare human traits but moral character. This moral character is enfolded in the unity of persons becoming persons through other persons [in particular relationship]. It includes spiritual and ethical dimensions. In writing of care-givers having the virtues of courage, hope and 'volitional willingness' in terms of connecting with patients she is on a par with van Hooft. Finally in discussing our common humanity as the fundamental sacredness and unity of all life she reveals a wide conception of the ethic in care.

The aspects of care embedded in this thesis, through participants' discourses, show that they had knowledge of what it was to care. Their verbal attitudes displayed an understanding of what sorts of affect would imbue their activity with ethical meaning and the quality of their engagements for the moment. The next section builds on what has gone before and reveals that out of the many meanings of care a philosophy and ethic does become evident. An ethic, or morality, materializes from the humanistic philosophy embedded in interviewees 'sayings'. A strong spiritual dimension became evident showing a personal unity that should have sustained the beliefs and ideals of many of the interviewees. This philosophic base should be fundamental to research participants' intrinsic ethical-caring. It should be given more attention by them because from developing an intrinsic philosophy and ethic of practice the moral support for nurse professionals is constituted. Therefore the following is an attempt to show that a philosophy and ethic was inherent in their statements and that if it were drafted and understood, together with the meanings RNs gave, they could formalize it and structure their own ethical practice.

8.3. The philosophy and ethic from the discourses

8.3.1. The philosophy

Formulating a philosophy for nursing is a first step towards constructing an ethic. The words: 'ethics' and 'morals' are derived from the same root. It means 'custom'. The inference is that persons should behave in principled or correct manner. The discourses [taken together] revealed a humanistic philosophy in which persons were to be respected, accorded dignity and treated fairly with love, compassion and justice. For most of these RNs, this was not a question of formally learned ethical principles but fundamentals they had acquired through cultural and social learning. As a unitary whole, this philosophy included an integration with the spiritual. The African proverb and 'ubuntu', taken as part of this philosophy [via culture], has been discussed.

What their philosophy also revealed was that humans cannot live alone. They both need and want human relationship. Interviewee May saw it with her elderly, Diana in her own growth, Bekkare in being a nurse for other people and there were other examples. Participants discussed their willingness to bond, love, and relate meaningfully with others. In this they concurred that what capacities a human is born with, develop through contact with others; and persons become constituted by relationships with others. That participants also gave understanding of, and meaning to, a spiritual dimension within humans: the desire to experience life meaningfully and as fully as health allowed, has been discussed in the context of the spiritual [chapter seven].

Europe's different philosophers, mostly Thomists, and theologians, developed an ethic that harmonizes with ideas inherent in the traditional African thought depicted by Bekkare [Shutte, 1993c]. Some idea of this thought has been explained. An ethical framework is hinted at by Holdstock [1987:226] when he asked, 'What can Africa teach us'? His reply was wholism, spirituality, ubuntu, communalism and emotionality [pp. 226-236]. These too are ingredients for an ethic. As sometimes separate, sometimes mixed, ingredients they appeared in nurses' discourses. These 'ingredients' will be blended together to reveal an ethic that gives fuller, intrinsic meanings of care.

8.3.2. The ethic

The way the words care/caring were used showed the meanings RNs infused into them through their 'sayings'. These meanings mainly expressed the idea of a relational ethic. This meaning is ethical if it combined with their contextual practice. As Bowden confirmed: "Ethics is recognized as constitutively contextual and based in the actual experiences of actual persons. [I]t is a continuous process of mutual responses and adjustments that recognizes the inherent relationship between the practical details of that process of mutual response and its ethical possibilities" [1997:4]. If RNs recognized these 'ethical possibilities' and became aware of how to use them, their meanings would become more than ethical possibilities that lay dormant. They would be showing that their sayings echoed their doing. But, something was missing between these saying and the reality of the nursing observed. To discuss this the following will be addressed:

8.3.2.1. An enriched conception of ethical caring
8.3.2.2. Attributes of the ethic herein

8.3.2.1. An enriched conception of ethical caring

'What can [nurses in] Africa teach us'? And the answer is their wholism, spirituality, ubuntu, communalism, relationship and mutuality. These qualities are not the birthright of nurses in Africa alone because of the inborn capacity to care within each of us but ubuntu is a distinct and highly valued attribute. To reiterate its meaning, this time as given by Desmond Tutu "[W]ithout ubuntu, one lacked an indispensable ingredient to being human ... It denoted the quality of being human and so also humane. The person who had ubuntu was known to be compassionate and gentle, [and] used his strength on behalf of the weak, ... did not take advantage of others - in short he cared, treating others as what they were, human beings" [cited by Holdstock 1987:228].

RNs discourses had touched on compassionate-care by expressing significantly ethical ways in which persons mattered to them. Interviewees, whose stated motivational disposition was to nurture the nurse-patient relationship, discussed 'presencing' of a self-donating [gift-love] nature. They wanted to 'make a difference' because persons 'mattered'. This involved giving a patient the assurance of one's attentive-caring presence. There was almost a felt physicalness about it, a going beyond the obligation of fulfilling patients' felt needs. Duties were performed in the light of "care not being just hands and feet", as Henrietta said. Physical care was seemingly their weakest form of presence. They recognized that a nurse could be present in body but not necessarily in mind or affect and that mere physical care did not alleviate vulnerability.

Their compassionate-care was ethical presencing in a cognitive sense: it involved knowing, reflecting, creativity, critical thinking all with intentional attentiveness not only to what patients said, but to what was unsaid, and in anticipating real needs. This was the ability to know and 'read' that patient. 'Being there' was, as Amanda recognized, also affective presencing, 'bonding' with a child not only legally and cognitively as "loco parentis" but as consenting to the value of the person the patient was. These RNs gave verbal expression to their availability as persons to other persons.

Amanda was a the sort of pattern van Hooft wanted for nurses to learn caring attitudes. By her own account she exercised self-awareness and self-knowledge as a self-determining being free to value persons as persons; free to be self-enacting and self-giving and based on her knowledge of, and feelings, towards persons. Her bonding, like that of some of the other participants, was in the nature of 'union' with them. This 'union', such as she experienced with her mother as a child, is the highest form of mutuality. She encouraged bonding so that both became wholly present to each other as a fully-developed person to a developing person. There was a sense, in such union, of direct love: her patient's being in her, and she in them, such was the nature of this bonding or presencing. Care-givers said they perceived patients in their actuality, took them as they were and treated them as the unique persons they knew them to be. And I observed that this was true of many. They certainly sought to protect patients against the vulnerability of pain [emotional and spiritual], suffering, and/or depersonalization. Their discourses bespoke comfort and sympathy, valuing a person above their needs and problems.

Compassionate-care as a relational ethic was given meaning, moving from being neutral and abstract to affirming [for example] a diminished person by consciously presencing, and valuing that person. It became affirmative by the use of its very nature. Ideally such relationships allowed for growth: wholeness and well-being to evolve. As Bekkare put it when explaining her African proverb [including the concept ubuntu]: "I am a nurse because of patients. We give nursing to patients not to ourselves". In this self-giving she was saying: "I am a person through other persons. I am a nurse because we are nurses; we are nurses because I am a nurse for the patients". This African perception is totally relational: towards community and self [Goduka, 1996]. From this ideal relationship arose the freedom to be authentic, to have joy and freedom from fear.

Astrom, Norberg & Hallberg [1995]; Cohen & Sarter [1992], Swanson [1986a] show in their research this intensity of emotion. this love, in their description of the relational caring of their interviewees. Partly this love was dependent upon their nursing situations, the type of patient they nursed [terminally ill persons]; partly it came from their experience and maturity and partly it was the meaning caring had for them [Astrom, Norberg, Hallberg & Jansson, 1993].

8.3.2.2. Attributes of the ethic herein

These attributes are those beliefs, values and standards that emanate from the study. The overall standard set is a relational ethic: where Bekkare in her cultural context can say a nurse is a nurse for her patients [or a person is a person for other persons]. There is the concept ubuntu. This traditional African idea can also be found running through any genuine nursing practice: it is the ideal of compassion, justice and responsiveness through personal engagement in mutual relationship. A person who 'mattered' is valued, treated non-judgementally, respected and given the dignity that defines not just the receiver, but the giver of this care. Integrating these aspects was the value that the spiritual had for practitioners. This domain was an integral aspect in the practice of wholism, and, it also spoke of a relational ethic that will unfold when Parker's [1990] contribution is discussed.

Intentional attentive-caring [attentive in the sense of listening and not putting one's own feelings onto another as Susan had explained] has already been imbued with an ethical dimension by Bowden [1998b]. Together with compassion and justice, such ideal caring forms a foundation for morality: It is that 'humaneness' in ubuntu. In having a caring, ethical comportant one is showing an attitude that has its basis in one's volitional, cognitive and affective domains. It is wanting to do something for someone, not for personal reasons, nor because of a deep-rooted feminine servile mind-set, nor because of emotional needs; but out of benevolence [Curzer, 1993] because one wants growth and healing for oneself and others. Through benevolence, "the nurse takes responsibility for the other's well-being ... [and] in caring for others we ourselves grow emotionally and morally" [Wilkinson, 1998:5/6].

In the research discourses of this thesis no particular named ethic is exposed, rather an explicit ethic is hidden but it is an implicit, latent, many-faceted ethic. For example one could identify an ethic of care, a virtue ethic, covenantal aspects and a definite relational ethic [such as Fry [1989] and Parker [1990] called for]. These will be made explicit.

1. Gilligan's ethic of care meets concerns about sensitivity towards, responsibility for, and attentiveness to, patients' vulnerability. This ethic of care was to counteract what she

perceived as the 'masculine ethic': moral principles attributed to Kant and implemented in universalistic and non-contextual ways through learning particular principles. This 'masculine ethic', in her eyes, involved a particular way of conduct emphasizing justice [in the sense of rules, rights, duties, general obligations [and in bio-ethics the equal distribution of resources]. In contrast, an ethic of care involved the need to understand context-sensitive issues with a tendency towards non-generalization and no abstract formulations of moral problems. Being affective in nature it embraced care, responsiveness, responsibility, and interpersonal relationships [Cooper, 1989]. Interviewees 'sayings' could be said to meet these criteria except for responsibility and an awareness of subjects' understandings of their moral agency.

2. Virtue ethics embraces care as an inherent capacity, as something to be worked at, and, as a rational, volitional and emotional virtue [Noddings, 1984; Brody, 1988]. To be virtuous [having virtue] ran parallel to the idea that "to act well was to act in a way that fulfilled oneself as a person" [van Hooft, 1990:213]. In this van Hooft was quoting Aristotle as the representative of a Greek ethic that held acting well to be a virtue [e.g. being caring] [Shutte, 1993c]. Virtue ethics portray actions reflective of the agent's personal nature or attributes and actions that meet the agent's role obligations: for example, practical wisdom, conscious intentionality, courage, responsibility, and other attributes.

3. Covenantal ethics was a nurse's implicit "promise of care for the physical, social, and emotional [and I would add, spiritual], needs" of the patient [Stenberg, 1979]. It emphasized the nurse-patient relationship. Fidelity, mutuality and reciprocity [such as Noddings [1984] discussed] were bound up with this covenantal idea. Fidelity was taken to mean responsiveness to the patient's initiating presence [1979:51] rather than faithfulness, responsibility or loyalty. Stenberg wanted a covenantal framework for ethics that could be used "to articulate our concern in concrete ways, based on the patient's deepest needs". She goes on to ennumerate the outcomes of a covenantal ethic. These were responsiveness in promises made and truth telling; the skill to do the care; safeguarding the personhood and preservation of the self [keeping one's own and others integrity]; freedom from fear, pain the possibility of abandonment and, the provision of hope [1979:21].

There were additional criteria: those of 'faith', trust or covenant inherent in the 'promise' to care rather than the obligations expected with the 'duty to care'. This ethic required proficiency: the faith of the patient became based in the belief that the nurse had the skill to do a particular thing correctly [Stenberg, 1979]. It also lay in the context of a patient submitting himself to a health-care institution. Their agreement implied faith, submission, fear and confidences shared. The idea was that nurses were not free moral professional care-givers if they could not enter into this covenantal type of nurse-patient relationship.

4. In asserting the need for relational ethics Parker [1990] had asked, "Within an ethic of care, what does it mean to be 'responsive'? His answer was, "a willingness to accept a [his] patient's invitation [Mike] to be a close travelling companion on an uncertain journey ... [S]omeone ... willing to make sense out of holding onto life and ... to make sense out of letting go of life". Parker felt that "the coconstruction of meaning [in order to practice an ethic of

care] was a dynamic process...". This process "necessitated engaged listening, authentic responsiveness, mutual disclosure, and negotiation". He had given Mike that. The search for [and discovery of] meaning within the nurse-patient relationship [came] from within [his] posture of personal attachment..." [pp. 38]. The uncertain journey Parker discussed is similar to that Nouwen took with Adam. Nouwen's community did not appear to experience the constraint Parker felt. Nouwen could embark on his journey, have rich and diverse experiences of care, be free to be moral and to reflect on his experiences. As a result, he could derive a meaning of care that connected with his community's meaning. Meaning was not made for Nouwen by an external authority it came from his commitment, inner reflection and inner conviction. Attributes van Hooft had looked for.

I believe the RNs in this study did feel passionately about care and I justify this statement based on the attitudes and affect I generally observed. Seemingly, some RNs [in State and private units] had become desensitized to the ethical, or, had little perception as to the meaning of an ethic of care, or of caring ethically outside of a 'private' domain. Certainly the term 'ethic' was not mentioned. It was as if what RNs said about not being able to practice care [as they had before] had no ethical import on their situation at present. Or, as if 'optimal' care, if not given, would not have any ethical impact on the patients who needed this type of compassionate-care whilst they were choking or dying in fear and RNs were either on their own or busy in the office with their administrative tasks. Concern was voiced, nevertheless what was said, by some, and what was actually observed was not being translated into 'public' ethical action.

Admittedly, I did not observe for more than a fortnight at any one time. Then it was the busiest of times. I frequently 'dropped-in' to certain units and base my statements on these and subsequent observations. Basic physical care was given, but patients were being deprived of that process that "necessitated engaged listening, authentic responsiveness, mutual disclosure, and negotiation" [Parker, 1990]. In short, quality time was not being spent with patients by those who could help them most. What this implied, for me, was that RNs had two meanings for 'care'. A private meaning of care of a compassionate nature that was not being allowed to be expressed through 'doing', and a public meaning of care [that was neither good nor bad]. It conformed to managerial expectations and included the basic nursing care being given by unqualified persons; whilst qualified persons completed their administrative and managerial functions.

8.4. Private versus public meanings

An explanation is needed as to the idea of 'private' and 'public' meanings. Firstly, the idea was used by van Hooft. He talked of the conflict arising from the tension between the private relational notions of caring, and institutional and operational notions of caring [1990:211]. Secondly, Bowden [1997:7] in her supporting Gilligan's 'voice of care' deliberates on the allegation that the ethical possibilities of caring were limited to a private domain only. In other words an 'ethic of care' was seen to be subjective and constituted only by private relationships. Although ethical care could provide passionate grounds for personal practice [as in this thesis], it was suggested in Bowden's refutation of critics that this alone was where its value lay. Subjective caring practices were said to fail in the context of impersonal values crucial to public relations and the requirements of a universalizable moral theory. The idea that caring was subjective and therefore private could account for the lack of its mention by RNs in their discourses. Thirdly, the use of words, as in these discourses, is perceived as 'a kind of doing, a kind of deed': 'hence it is a social act' - a way of being that is public rather than private. Meanings do not have independent existence [Austin in Morrow 1994:117]. They are embedded in narrative that are also social. The 'social' way in which words were used determined:-

8.4.1. The 'truth' or 'falsity' of meanings
8.4.2. The relationship of meanings with practice;
8.4.3. How meanings of care shape ethical understandings

8.4.1. The 'truth' or 'falsity' of meanings

The way I can verify RNs meanings of care is to establish whether their doing disproved their sayings. One must consider whether the conflicts van Hooft or Bowden discussed are true, those arising from tension between private relational notions of caring and institutional notions of caring or an ethic of care and an ethic of justice. One can go back to Bruner [1996] and ask his question in the context of nursing: "What is lost and what is gained when nurses tell their narratives of care?" What is lost if RNs social acts [public practice] do not compare with their private meanings are those profound enriched understandings of care that have been expressed. If their private and public meanings compare what is gained is an ethic of care showing an attitude of passion in desiring compassionate-care of an ethical nature. If they do not compare then questions need to be raised. If an RN gives personal care today but tomorrow she cannot for organisational reasons that she accepts will this falsify her intrinsic private meaning of compassionate ethical-care?

In establishing the 'truth' or 'falsity' of RNs meanings of care their 'sayings' [private meaning] are compared with their 'doing' [public meaning]. For example, at a hospice where there had been severe cut-backs a RN who had given a beautiful portrayal of care admitted with dismay that she no longer had time to do what she felt was necessary for patients. She "could not do one-to-one patient care", nor "counsel patients as we would like to" [sitting with them for hours and listening as Stiles [1994] had suggested]. Another was at pains to explain that "normally new patients were welcomed with flowers and a card" but not now they were so busy. She supposed that "patients were getting a lot of loving care but they were not getting 10/10, perhaps 7/10". This represented a "fair amount of good care but not her optimal care". Optimal care could only be given at week-ends. Even a RN who was a patient at this time commented on the fact that the Sisters were kept busy doing office-work. Then when the week-end was finished there was no nurse-to-nurse hand-over. Doctors were handing over to nurses because RNs worked 12-hour shifts that meant no continuity of care. This affected other members of the multi-disciplinary team..

Weekend' caring?

Participant's picture of caring showed family resemblances between units but an RN is honest enough to state that she only gives her 'special' or 'optimal' care at week-ends. Organizational constraints shaped by the cut-backs, regulations and new policies affected the quality of her care-giving. She, and others, were no longer granted the freedom to care as they wanted. Their private meaning of care became a constant 'balancing' act between implementing public and private meanings. This resulted in a compromise. They conformed to managerial expectations during the week and gave optimal care at week-ends [this is based on observational periods during week-ends]. Though they could have shaped their care themselves, their caring role became shaped by others. Their narratives revealed an intrinsic mode of care but their situations showed them losing their freedom whilst managers gained RNs conformed, or shaped, behaviours. Thus, the private meanings of many RNs compassionate-care was proved to be false: they could not sustain this type of care under bureaucratic or managerial pressure. In contrast. there is Bekkare who, while being shaped as a student nurse to run to and fro among 90 patients, had pity on ladies with cervical cancer and sustained an intrinsic private meaning by practicing an ethic of care. She felt free to be moral towards these particular patients notwithstanding cultural and fiscal constraints.

8.4.2. The relationship of meanings with practice

The meaning of any concept has to be seen in context. In nursing this is the institution in which one works and where the patients are cared for. In chapter one the problem was raised as to whether our values towards, and therefore our meanings about, a concept were dominated by the roles we played [in the sense of putting on a role and of being authentic or not] or by the processes through which we were socialized [for example, at work]. If RNs roles were influenced more by a prevailing ethos of control than their intrinsic desires to care this devalues their meanings of care. This would make these meanings confusing or ambiguous for themselves, those they cared-for and others. It is this ambiguity I believe Morse et. al. have centred upon.

Fulfillment?

What was observed during the research journey was that many RNs were defined more by their conformity to their authority's style of management than by their own ethic of care. [Not necessarily Gilligan's as their ethical awareness was not so acute]. van Hooft believed this type of conformity showed weakness of will [1990:213]. My research question about fulfillment□ had been formulated before reading van Hooft's work.

Combining the questions on fulfillment with that of change I found those RNs who were not fulfilled wanted to make changes. An interesting point was that when they discussed what would make them feel fulfilled and the changes they would make [which were other-person centred] three asked for the tape recorder to be switched off. Then they listed organizational, bureaucratic or managerial obstacles that they would have to counter.

Thus, the prevailing culture in some institutions eclipsed RNs 'private' meanings by keeping them more occupied with paper work and non-professional duties than with the living dying. Wards were short of the right skill-mix and volunteers. RNs put more emphasis on office work [some of which was medico-legal], ward and doctors' rounds and the doing of routine tasks: injections, dressings, medicines whilst auxiliaries exercised some form of care through doing tasks that allowed for more interaction and communication: e.g. bathing, making patients comfortable and meals. Dying persons could die alone which was Susan's grief and why she wanted a hospice 'just for the dying' and not only for the terminally ill having palliative care. A Matron in one hospice feared that if one included the near-to-dying the community would view the hospice only as a 'death house'. Yet the expectation in that community was of a hospice giving quality care to persons actually expected to die in a short space of time [when home-care became impossible or non-existent]. In the early days of this hospice, the dying had been nursed "without all this professionalism and fuss about paperwork" [local hospice Founder]. These illustrations served to show that unless RNs private values about ethical-care was implemented patients and others would continually be vulnerable: they would not be cared for fully as persons for their health and the possibility of patients becoming spiritually distressed was high.

8.4.3. How meanings of care shape ethical understandings

Are RNs unwittingly being shaped by their caring practices? To answer is to go back to Zimbardo's [Maslach, 1983] mock prison experiment where 'guard' persons chosen for their normalcy through personality tests treated 'prisoners' brutally. The 'guards' chose to create a particular type of relationship. No meaning was imposed upon them. They were free to decide on the meaning of their situation and their relationship to it. Their behaviour was intentional: they chose not to care. They chose to create a non-caring environment. The meaning 'guards' perceived from their roles was that the vulnerabilities of 'labelled', but normal, persons could be abused. This private meaning functioned to shape collective behaviour although each 'guard' was a morally free, self-enacting person. Of their own volition they went beyond the expectations, beyond stereotypical behaviour ascribed to real prison-guards, beyond the normative ethic for research. When 'prison' supervisors were not there, especially at night, 'guards' chose to exacerbate brutality, power and control. They took it for granted that they had permission to be disimpassioned and dehumanizing.

This had nothing to do with the subject of Maslach's book: burn-out. It had everything to do with private and public role expectations and the meanings given. The point being made is that as persons we shape or are shaped by the meaning put upon a situation. My professional autonomy involves creating and shaping my freedom to be moral through the attitudes and actions I choose to display.

Meaning therefore can be made for one by others. It can be made because of organizational factors: for example, organisational role expectations, bureaucratization, routinization, poor skill-mix and rule following. Both State and Private institutions revealed the role expectation of RNs: administrative tasks to be completed, paper-work, interruptions to be answered because there was no clerk or volunteer appropriately trained, and the continuation of routine and technical tasks e.g. checking morphine infusions, administering medicines or giving some form of treatment. They were not able to 'be there' for someone who wanted answers, assurance or comfort. Private units had a policy of patients having their own nurse, especially when it was their day for intensive IV therapy. Otherwise, as Henrietta and Amanda [from State hospitals] implied rules and policies played a part in obstructing their rendering of care. Aspects that could give comfort were denied patients, sometimes for legitimate reasons, nevertheless these 'rules' caused patient and nurse distress. Hospice personnel suffered from the distressing aspects caused by minimal-standard care. They were the ones who noted that this minimal-standard mainly affected those dying.

The implication of cut-backs on care could be of a more personal nature Firstly, exercising the capacity to care ethically enables personal growth and this growth would be denied if RNs were not permitted to care according to their private meanings or intrinsic standards of care. Paula shared how she had grown through nursing a particular patient but she and others, had at that time been able to spend 'quality time' with this person. Writing about the art of nursing, a Nursing Times Editor [1945] had recognized that: "[N]ursing was seen as stimulating when it could be done as nurses wanted nursing to be done, distressing when the art could only be practised if time and circumstances permit, dismaying if nurses were not able to pick out the essentials, and satisfying if they could". RNs were finding, fifty years later, that they could not care as they wanted, that care could only be practised if time and circumstances permitted and, they were becoming dissatisfied which affected care-giving.

Secondly, moral development issues could arise if others 'public' meanings of care were imposed as being the standard required. If a nurse exercised responsible reflective choice in consideration of her cared-fors, she was expressing her authentic nature. If greater emphasis was put on a RN's individual moral development than on a rule-bound imposed morality then an ethos in which that development could take place was imperative. A person is a person through persons for better or worse. If when being socialized into nursing I am able to act from the good care examples of peers and seniors and taught how to reflect on these examples then I form habits that strengthen my motivational disposition and my morality. As van Hooft says, "Strength of will comes from feeling good about oneself" [1990:215]. He felt that the processes of forming habits and reflection-on-action interacted with one another and the inculcation of attitudes [1990:214]. Becoming a more authentic person is possible as one becomes more free to exercise one's morality. This adds-to one's ethical self and thereby to others [Noddings, 1984] and thence to an improvement in care standards leading to the health of others. Mention was made of Stenberg's [1979] idea that nurses were not free moral professional care-givers if they did not enter into a covenantal type of nurse-patient relationship. Yarling and McElmurray [1986] found nurses were not allowed to enter into such relationships and therefore were indeed not free to be moral.

Free to be moral?

Free to be moral?

Yarling and McElmurray began their paper by stating that nurses are often not free to be moral [1986:63, their italics]. They supported their argument by telling of a physician who, when asked whether a nurse had the right to disclose information to a patient if the physician had disallowed it, was emphatic that a nurse had no moral status: "nurses have no duty to make autonomous moral judgments about what their relationships with patients require" [1986:66]. Morality in this physician's thinking did not exist for professional nurses. In one statement he dismissed nurses' freedom to be moral. If they could not make autonomous moral judgments about what their relationships with patients required then they were virtual zombies: they would not be free to be moral. Relationships are the crux of everything ethical. Without them they would have to treat patients purely as objects, there would be no worthwhile intersubjectivity. This physician's expectation is interesting for many reasons. Firstly, it was not in the 1950's or 60's when nurses where more handmaidens than in the 80's. Secondly, quality caring is related to morality and this has been emphasized in that it has been said that unless care is imbued with an ethic the term is neutral. Where morality is absent so quality will be. Thirdly, even in the 80's [and I am aware of generalizing now, but let it be said], doctor's attitudes often set the prevailing ethos.

Although Yarling and McElmurray are not referring to the transcendental freedom of the will yet this is important because persons are born free, becoming more so through a particular kind of dependency on another person who is free to choose and enables this other to grow in their freedom. Growth through caring, such that allows moral development and freedom of the will, must be included in an ethic. This freedom is part of exercising personness. The fact that some nurses do not exercise this aspect of their personness is often because they have not previously been allowed to be authentic nor have they grown in self-knowledge and self-determination. They have not learned to choose moral rectitude. This may be because there are not enough persons of a particular kind [caring role models] to enable other persons to become the ideal person they should be, or they do not question the existing state of affairs.

Yarling and McElmurray [1986] sought to base their ethic on the social reform of an institution, or the role of the nurse on the health care team [where no single person would act autonomously]. But the weakness in their argument, as Cooper pointed out, is a failure "to provide a convincing account of the nature of this nurse-patient relationship" [1988:49]. Although Cooper based her argument on 'covenantal relationship ethic', [1988:51] the contention concerning the importance of the nature of the nurse-patient relationship is strengthened when she expresses that "ethical choices cannot be guided solely by rules and principles ... they require thoughtful analysis of feelings, intuitions and experiences" [1991:49]. These are derived from an ethic of care such as Gilligan propounded [Cooper, 1989]. Cooper also draws from Parker [1990] in validating that "nursing narratives depict the uncertainty, complexity and contextually dependent nature of nursing ethics through a far richer medium than theoretical constructs" [1991:30].

Parker's [1990] relational ethic depicted the 'continuous process of mutual responses and adjustments' that Bowden [1997] called for in an ethic. He described the moral conflict of nursing Mike, a long-term patient who could not communicate normally, who died alone because relations between him and Parker became broken. Parker, like Nouwen, had learnt from Mike about patient's vulnerabilities: powerlessness, suffering, fear, patience, courage and hope. The break in relationship happened because Parker attempted to explain to medical staff why life-sustaining treatments for Mike should be discontinued. He found he could not translate his moral experience into traditional moral language: the scripts were different [1990:33]. And this thesis found that some RNs discourses and their practice had different scripts. Their doing 'spoke' a different language.

Yarling & McElmurray's physician appears to be proven right: nurses like Parker had no duty to make autonomous moral judgments about what his relationship with Mike would require. Using Parker as an example, one feels both his and Mike's diminishment as persons, because he exercised his moral freedom to choose. Mike, instead of having someone stand with him in death, had to die alone because of this choice. Such is the predicament of caring and perhaps such moral conflicts account for why nurses are reluctant to enter the ethical arena. But Parker stated [and I suggest many participants would echo his words], "My experience ... suggests that the values essential to the moral foundation of nursing cannot be extracted from any abstract or decontextualized moral theory. These [ethical] values derive from generations of nurses' relational stories of caregiving. If ... woven together [they] collectively fashion a tapestry of rich and diverse experiences from which to pattern a nursing ethic" [1991:34]. These patterns are what is wanted for the RNs in this thesis, they are what van Hooft wants to use to teach ethics to students. But, we have some RNs unaware of the ethical, or that meaning is being made for them.

In the physician's opinion, nurses could be told how to relate towards patients. Nurses could have meaning imposed upon them. If, like in Zimbardo's prison story, this meaning dehumanized persons because nurses [or 'guards'] had 'no duty', no freedom to think for themselves then this also proves Goffman [1961], Laing [1965] and Szasz [1961] right: nurses could be totally insusceptible towards the vulnerability of persons merely because persons had 'non-health' labels attached to them. Perhaps this explains why eventually nurses become insensitive and do not care ethically for their patients.

What is portrayed from participants discourses is a conception of ethical caring but there is this down-side and a warning. Ethical caring, the freedom to be moral, takes courage, a toughness, in the sense of moral strength grounded in responsibility. Responsibility was not a word used by any participant and this is an interesting omission. There are other omissions.

8.4.4. The need for an ethical demand

Morse et. al. [1990/1] had found that theorists identified a moral imperative among the uses of the term 'care' and they were right to call it an imperative. Simply put if one is not fully moral or ethically developed one is not fully human in the sense of being fully developed. This is said in the light of what van Hooft has said [1990], that is, that by caring we constitute the integrity of our being and that what was done in situations of moral difficulty decided what was cared for most deeply. van Hooft had in mind the health of the patient but, as has been discussed in the section on 'health', this word has a wide meaning incorporating all that a person is wholistically and contains a socio-environmental meaning too. To be ethical is not only an attitude, nor just doing the right things to safeguard the patient mentally, physically, emotionally and spiritually. It encompasses this socio- environmental aspect too. If cut-backs imply that patients are to die alone. If they do not have quality time spent with them when they are morbidly choking, desperately afraid and lonesome. If they also then become tuned into nurses' busyness to the detriment of their health, one has to ask: where is patient advocacy, or the quality of the engagement, commitment or the moral imperative? Where is the 'different voice' that says "enough is enough" to wrongly balanced skill-mixes, too many beds, the non-employment of a ward clerk or other hindrances to the compassionate ethical-care that RNs spoke of?

Non-commitment to ethical care enhances persons' vulnerability by excluding the person, becomes a caricature of care and dehumanizes patients. Each of these would also diminish the care-giver. Rather than focussing on what was right to do I believe the discourses reveal an over-emphasis on what it was good to be: particular attributes. The being good is correct, it reveals a right attitude but it was not sufficient to empower RNs in the way van Hooft [1990] envisaged, nor would they make the role models he wanted for his students to learn ethical caring. He would want RNs who would overcome the ethos that swamped the 'good' caring attitude they voiced and firmly believed in, or the ethical 'lag' between their sayings and their doings. RNs seemed to be short-changed and passive when it came to being able to put into actual practice what they said.

Bowden can be forgiven for not identifying nurses' ethical omissions. She had neither taught nurses, as van Hooft had, or done empirical research. Therefore, she would not realize the extent of patients' vulnerabilities in the form of the lack of skilled RN hands-on/sit at the bedside care-giving. Benner et. al.'s research however kept her team in touch with RNs busyness and with the 'messes' they had to cope with. For this reason she could identify that ethical behaviour did not consist of words, intents, beliefs and values alone. There had to be a good attitude combined with right action not just in RNs private domain but their public domain too. Caring in that domain would show their earnestness about what really mattered. This is ethical comportment or the moral imperative.

Benner [1991] in discussing quandry ethics highlighted that quandary ethics focuses on "defining the content of the obligation rather than the nature of the good life" [pp. 2]. She felt that an ethic of care had to be learned experientially. This was dependent upon the recognition of ethical behaviour, in specific situations, located in concrete specific communities, practices and habits. This 'recognition' with its appendages was one aspect that I felt was missing perhaps had not been taught. This ethic of care needs to be practiced publically.

Rubin [1996] puts her finger on another aspect though we come to the same thought by different routes. She felt nurses shared a common structure of practice. This is true of the research participants: in their common structure of practice they were nursing persons [child or adult] who had lethal conditions: cancers. Yet, within this common [though public] structure of practice Rubin observed what she called 'ethical blindness' which led to inadequate care. Now this is a damning statement to make and it needs justification whether it relates to Rubin's research or this thesis. She tells of a nurse who cared for a patient with a terminal illness. The nurse gave a medication that relieved the patient's suffering but hastened her death. Rubin's concern was that the nurse [whom she describes as not falling into any of Benner's domains (expert-proficient-competent-beginner)] when asked, did not remember the patient's medical condition, her age or any of the details that make for a story. Rubin suggests, because of this finding, that there are nurses who have 'blunted ethical perceptions' that directly affect their quality of care.

This paradigm case that Rubin discusses [pp. 172-4] does not tally with any of the narratives in this thesis. However, I believe the drastic financial cutbacks some RNs were being made to feel affected them and led them to become ethically blunted and this would ultimately affect their clinical and ethical care. It is difficult to express this because firstly, I do not want to generalize, especially as I did not see all the RNs mentioned in this thesis in action and because I went to different institutions. But, it is a common complaint that care [of an ethical nature] is not being given as many would like it to be [Drew, 1986; Irurita, 1993; Street, 1992]. I put 'of an ethical nature' deliberately in brackets because many who complain about the deficiency of care do not realize that in and of itself care can be good or bad. It is ethical care, that moral aspect being denied patients.

8.4.5 Summary: private and public meanings

The truth or falsity of RN meanings of care has been discussed. Although there were notable exceptions amongst them, especially in units where there were not stringent monetary restrictions, it was found that many RNs were not able to practice care in the way they had described, that is, according to their intrinsic capacities and private meanings. In those institutions where there had been severe financial cutbacks, RNs seemed reluctant to state this plainly. Instead, they focused on themselves [blaming themselves] stating what they could or could not do in the way of care. They realized that it affected their patients and was less than the standard they wanted to give but were unable to put this into any ethical construction. The rights or wrongs of this type of situation were not mentioned. The anger generated was directed against 'them': managers or administrators who had made the decisions, sometimes unilaterally. Nor was there, to my knowledge, a concerted combined effort to look for alternative, more ethical, solutions to this care-shaping dilemma. The financial situation was accepted as a controlling obstacle to caring: one that dictated the role-expectations and shaped a public meaning of care-giving. If care is to be measured out according to the budget available one can agree with Clark [1995] who said to the nursing world: "If expert nursing is an extravagance try inexpert care". I agree with this statement but I would add: if moral nursing is an extravagance try unethical care. Care that is less than moral is not going to have benevolent value to nurses or patients nor will nurses will not be fully fulfilled.

In contrast were those hospices that had management boards that either included a RN, or had one as chairman. Cut-backs affecting staff:patient ratios and skill-mix were not so ethic-effacing and drastic. The atmosphere was permeated by benevolent or compassionate-care. This extended from equipment, to ambiance, to staff morale. Ideally, to be ethical, care must be according to an intrinsic meaning and this could be both problematic and far removed from public rule-following, care-giving standards. If one says that nurses are morally obliged to keep the duty-to-care-rule [and they do so blindly without reflection], then a nurse adhering to this rule is providing care purely on a prescriptive base, on an unreflected conformity basis. They are ethically blunted.

The argument for an ethic of care, hinges on whether such care as this is merely private [personal] or whether it includes the public [professional] domain [Cooper, 1988]. In this thesis the ethic of care is viewed as both. In a previous chapter, it was seen that Bekkare's ethic was 'personalized'. She particularly entered the realm of showing fairness and compassionate-care towards cancer victims. The situation was highly public. The nature of collectivism is the cultural background against which the narrative is portrayed. It was public in that it concerned the nursing profession and patients' vulnerability. Care is not only a matter of obligation; nor is care genuine unless freely given, freely donated and ethically correct. The word care, in its relational and compassionate sense, refers to the quality and virtue of the volitional acts of its care-givers and to the kind of attitudes or virtues that the care-giver chooses to bestow upon it.

The narratives display compassionate-care as a reasonable and defensible value therefore universally and socially specific. Care that is not a reasonable value is wrong and not to care ethically violates the characters of care-giver and care-recipient, it deprives persons of their worthwhileness and makes them vulnerable. Care is a defensible value because to care for a person is to affirm the dignity of that person. Valuing care could be seen to be incredibly individualistic. The concept of care is on a deeply interpersonal level in how persons relate to and treat one another individually or as community. A spirit of justice expects individuals to relate in a caring, concerned and compassionate manner to others. To this end care is the expression of the extent of one's willingness to enter a relationship of care with a person arising out of one's sense of justice towards that individual. Such care relationships can be the most enriching aspect of life. This aspect in itself calls forth a justice-compassionate care ethic.

The puzzle is why nurses cannot combine their 'good' with their 'right': their attitude of being with their correctness in doing. It would be disappointing to find that all RNs sayings were rhetoric or that their intentions were suspect. Is it that as RNs we all have 'feet of clay' when it comes to the reality of being authentic in the socio-environmental ethos in which patients are nursed? Perhaps RNs do not see ethical significance in this area. Perhaps they have become ethically blunted from being 'put down' by the likes of Yarling and

McElmurray's physician. Perhaps it is the old adage 'they do not know what they do not know' in relation to the ethics of situations. The nature of the nursing ethics taught has centred on principles, codes, rules and laws. These were used for solving ethical dilemmas rarely, if ever, have they applied to the ambience or ethos of clinical practice. Nor do the debating parties include the patient and representatives from management or administration.

8.5. The impact of the spiritual

It was found that there was a strong spiritual overtone in the discourses of many of the participants. This was of the sustaining nature that Montgomery discussed [1991] but it also seemed to be an integral aspect of the majority of care-givers relational compassionate-care. The spiritual gave direction, purpose and meaning to many, but not all, of the interviewees. If anything it called forth spontaneity by enabling care-givers to enter into meaningful relationships with their patients that were not necessarily of a religious nature. It gave participants courage to face patients' emotional and spiritual pain. I believe it enabled particular RNs to grow by choosing that which seemed good to them. It brought forth a certain spirit of excellence in that participants were more aware of their patients' needs than their own. And van Hooft indicated that this dimension of our common humanity could contribute to a philosophy of ethics.

It was said in chapter seven that there is a definite moral aspect to the spiritual, and that where this was lacking there could be a diminishing of the self. Moral responsibility towards the ethos of the unit as a whole appeared to be lacking. On an individual person-to-person level most RNs realized the relational nature of the spiritual and the special engagement involved. But, their caring should have integrated with their spirituality through a concern for the care that was not being given. These were their words, their concerns. Thus although team-work was in evidence, and there was this one-to-one spiritual engagement yet the wider ethos: that being affected by socio-economic aspects seemed to be taken-for-granted from the point of view that nothing could change it. Or that it was beyond RNs control. Were it addressed it could radically improve the quality of time spent with patients and prevent the spiritual distress that I observed on more than one occasion and enrich the ethical aspect of their care.

8.6. Conclusion of whole thesis

In this thesis, I used a strategy previously untried in nursing practice. I evaluated participants' meanings of care against the possibility of conformity to an ethos set by others, and asked whether this meaning of care was their own: an expression of their own beliefs, values and attitudes? Was the meaning of care imputed to them? What this approach did was show:

1. The different layers of understandings RNs gave to the term care. These understandings showed great similarities with other interviewees as a whole and with the various authors used as authorities to validate these meanings. In other words there were strong family resemblances in meaning. But, it seemed that what was ascertained. was that

these meanings were more private than public. There was a private world of care being expressed: that is, particular meanings of care impossible to implement because of the particular ethos in particular health institutions With the present economic climate State hospitals give stories of tight budgets and care is being seen as a luxury, certainly a facet not [willingly] costed [Kitson 1996:1651]. Hospital staff tell of being too busy to care. Matrons stated I would not find caring. This was right in one way, but wrong in another. A hospital's milieu can militate against ethical-care taking place. But, they were wrong in the fact that there are individuals who despite circumstances have shown that courage and toughness that revealed excellence in care. These particular nurses gave different, and similar, portrayals of care in understaffed, busy circumstances and yet maintained an ethical comportment.

2. Although there was a deep spirituality inherent among the different interviewees and an implicit ethic of a strong relational nature. This ethic had elements of a virtue ethic, an ethic of care [as Gilligan described it], aspects of Stenberg's covenant between patients and nurses. The ethic emanating from this combination was frankly patient centred. The contradiction lay in the fact that when there had been a good staff:patient ratio, when there had been a good skill-mix and when patients were nursed as dying persons then this spirituality and ethic was perhaps sufficient. But since the advent of the 'swampy ground' of nursing reality: cut-backs, personnel shortages and systematic nursing approaches neither the spirituality that gave meaning to their caring or their innate capacity for deep care was sufficient to spill over into the public domain. This was the detrimental effect that socio-economic, organisational or managerial factors was having on their particular wards in terms of patients' spiritual distress, staffs' morale and the public's perception of care. An ethic is necessary: one that would empower RNs, one constituted from their spirituality and deep caring. One that would safeguard the [nursing] ethos[21] of units and relieve the pressures and spiritual distress felt in the everyday reality of nursing.

8.7. Further research

1. Further research needs to be done on the research strategy used. Bowden had used it successfully in theory. This research was an attempt to use her survey approach in practice and perhaps because it is the first time such a Wittgensteinian approach has been used it needs refinements. However, I believe it succeeded in revealing different 'layers of understanding' thereby determining the uses to which they put the term and the meanings RNs made of 'care'. I believe too that it showed that definitions of terms like care/caring only serve to restrict meanings and can negatively affect their ethical dimensions. There are other terms used in nursing that are taken for granted that could be investigated using this approach [e.g. spiritual, ethic, culture, suffering].

2. The idea of an ethic of care being limited to private or public zones of meaning would be another area for research. If RNs are being shaped by others' meanings of caring or

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[21] Ethos as meaning that spirit of nursing rooted in, and foundational to, professional practice formed by an ethic of justice [incorporating and contributing to care and compassion].

a caring-ethic perhaps action research could find out who or what shapes authentic ethical-caring in the messy reality of everyday life, or, what shapes persons to be moral examples of caring, suitable for van Hooft's role-modelling?

3. Frick [1987] had thought to open up a theory of learning that would lead to SGE's. Further research on these, in conjunction with nurses' moral development, needs to be done.

4. If care-giving institutions assume that the ethical ideals of its care-givers are beneficial and cost-effective how beneficial and cost-effective needs to be analyzed.

5. Some research has aimed at finding out what meanings caring has in clinical areas for student nurses, but perhaps it should be done in correlation with those meanings imparted to them by their mentors/educators/others? Since the term 'care' becomes imbued with compassion, a spiritual dimension and an ethic by including, and going deeper and perhaps beyond the categories that Morse, et. al. [1990/1] identified perhaps for care to be complete it needs to include that "mysterious mix" of affect, knowledge, determination, commitment, ideals, thought, and the agent's human traits [van Hooft, 1990:213] and this needs to be explored.

6. Many nurses are not themselves cared for or affirmed and therefore cannot help others in this direction. Further research into the reasons for this assumed failure, or the influence of institutions upon individuals is necessary.

7. The link between spiritual and ethical could be investigated. It would seem that the one aspect might not influence the other. The spiritual is another private meaning but its relationship with the ethical is important.

Peabody said: "The treatment of a disease
may be entirely impersonal; the care
of a patient must be completely personal"
Robert E Rakel, 1996, p. 477.

CHAPTER NINE: Summary of thesis

The research sought to answer the question: "What meanings has the nursing profession given to the concept 'caring'"? The question came from O'Malley's chapter on meaning: "[W]hether in encounter man himself makes his own meaning or is made by the meaning made of and for him ..." [citing Shutz, pp. 111]. Seeking to answer this question, a mixed qualitative approach: interpretive phenomenology combined with Wittgenstein's linguistic analysis [as interpreted by Bowden] and a conceptual-philosophical framework is used. Discourses were obtained by requesting RNs to draw on memories of being cared-for or caring. These were analyzed through juxtaposing them with selected theorists and each other [using Bowden's 'survey' method]. This led to discovering rich descriptions and family resemblances, the construction of 'layers of understanding' of care. The constitution of a relational justice ethic is discovered embedded in the discourses and experiences of these practitioners.

The research discloses that the reality of the practice setting can be shaped by others' meanings of caring and acts to constrain practitioners' intentions. 'Private' meanings evolved from personal sets of values. Institutionalized caring often fell below practitioners' ideal, whether hospice, State, or Private hospitals. This gives forth mixed messages that could influence others especially new entrants to nursing. This finding would have to be confirmed by further research specifically angled at, what meanings caring in clinical areas has for nurses in general and for student nurses in particular.

Although not true of all respondants, a reason for this less-than-ideal-type of caring is the possibility that in institutions nurses, although drawing on their spirituality, fail to become fully integrated persons able to act wholly according to their intrinsic capacities and ideals. This may be a moral development problem. It was shown that personal growth and the alleviating of vulnerability are integral aspects of caring. As Mayeroff declared, "To care for another person [patient, staff or student] ... is to help him grow and actualize himself" [1971:1]. Many nurses are not themselves cared for or affirmed and perhaps because of this, or their failure to apply their personal ethic more 'publically', cannot help others in this direction.

The idea of persons being self-aware and self-actualizing is discussed. It was widened inasfar as Shutte [1993a,b,c] [and others] showed that this development is dependent upon other persons: a mutuality of personal relations. Noddings [1984], van Hooft [1990/95/96] and others, include an emphasis on moral education through an ethic of care. Frick believed that symbolic growth experiences (SGE) could serve as a model for a learning theory that would emerge from the creation of meaning [through an individual's reflection on their experiences [1987:70].

If one takes Frick's [1987] idea of formulating a learning theory adds it to Mayeroff's [1971] and others' concept of care and Shutte's [1992, 1993a,b,c] idea of persons with authors' emphases on moral education there is the thought of achieving an ethical ideal: caring for others in relationship to persons, through dependence upon others resulting in the integration of holistic health. Put another way, if every student who came to train in nursing knew how to care [physically, cognitively, affectively, and volitionally] then there would be no problem, but there is a problem. The problem is within nursing and about caring because there are insufficient role-models depicting how to implement an ethic that deals with caring from an macro institutional point of view.

The findings showed it was not possible to give a particular meaning or once-for-all definition to explain the concepts: 'care/caring'. The usage and subsequent meanings, contained in these discourses revealed that no one single understanding of the terms exists. Instead. one obtains strong 'family resemblances': mainly similarities with a few dissimilarities amongst the combined experiences of the researcher and the participants especially when these understandings are linked with authors used as 'validators'. This verifies the Wittgensteinian observation that no singular essence captures every cultural, individualized use of a term.

Caring is about experiences of giving or receiving, or, to use the African expression: it is about Ubuntu in its ideal form. Much of caring is based on memories, feelings and experiences: existential material. In its ideal application compassionate-care is ethical, that is, protection of the vulnerable. Caring was affirmed as: "A natural capacity that by valuing, and commitment to, a person motivates one to be concerned and acknowledge need in another, and, by means of an empowering relationship leads one to act so as to promote and foster the personal growth of another by enhancing, or diminishing or removing impediments to, their health". But, this statement falls short of the rich ethic of caring emanating from the portrayal of 'family resemblances' within the narratives of research participants. Caring as a natural capacity, an ethic of compassionate-care, is thriving on a micro level, but failing to thrive in our institutions at a macro level.

REFERENCES

Allen D G (1990) The Curriculum Revolution: Radical Re-Visioning of Nursing Education. **Journal of Nursing Education** 29(7)312-16.

Allmark P (1995) Can there be an ethics of care? **Journal of Medical Ethics**, 21:19-24.

Astrom G, Norberg A, Hallberg I R, Jansson L (1993) Experienced and skilled nurses' narratives of situations where caring action made a difference to the patient. **Scholarly Inquiry for Nursing Practice**, 7(3)183-93.

Astrom G, Norberg A & Hallberg I R (1995) Skilled nurses' experiences of caring. **Journal of Professional nursing**, 11(2)110-8.

Axline V (1964) **Dibs: in search of self. Personality develpment in play therapy**. Penguin Books, London.

Baier S, Schomaker M Z (1985) **Bed number ten**. CRC Press, Boca Raton, Fl.

Bambrough R (1968) Universals and family resemblances. *In Wittgenstein: the philosophical investigations* (1968) Pitcher G.(ed.) Macmillan, London.

Barker P and Reynolds B (1994) A critique: Watson's ideology - the proper focus of Psychiatric nursing. **Journal. of Psychosocial Nursing**, 32(5)17-22.

Beales J G (1978) **Sick health centres and how to make them better**. Pitman Medical, London.

Beck C T (1991a) Undergraduate nursing students' lived experience of health: a phenomenological study. **Journal. of Nursing Education**, 30(8)371-4.

Beck C T (1991b) How students perceive faculty caring: a phenomenological study. **Nurse Educator**, 16:18-22.

Beck C T (1992) Caring between nursing students and physically/mentally handicapped children: a phenomenological study. **Journal of Nursing Education**, 31(8)361-6.

Becker H S, Geer B, Hughes E C, & Strauss A L (1961) **Boys in White: student culture in medical school**. University of Chicago Press.

Benner P (1984) **From novice to expert: excellence and power in clinical nursing practice**. Addison-Wesley, Menlo Park, Ca.

Benner P and Tanner C (1987) Clinical judgement: how expert nurses use intuition. **American Journal of Nursing**, 87:23-31.

Benner P, Wrubel J (1989) **The primacy of caring. Stress and coping in health and illness**. Addison-Wesley, Menlo Park, Ca.

Benner P (1991) The role of experience, narrative, and community in skilled ethical comportment. **Advances in Nursing Science**, 14(2)1-21

Benner P (ed.) (1994) **Interpretive phenomenology: embodiment, caring and ethics in health and illness**. Sage Publishers. Thousand Oaks, Ca.

Benner P, Tanner C A, Chesla C A (1996) **Expertise in nursing practice: caring, clinical judgement and ethics**. Springer Pub. Co., New York.

Bevis E O (1993) All in All, It was a Pretty Good Funeral. **Journal of Nursing Education**, 32(3)101-5.

Bevis E O & Murray J P (1990) The Essence of the Curriculum Revolution: Emancipatory Teaching. **Journal of Nursing Education**, 29(7)326-31.

Bevis E O & Watson J (1989) **Towards a caring curriculum: a new pedagogy for nursing**. National League for Nursing, New York.

Bishop A H, Scudder J R (1987) Nuring ethics in an age of controversy. **Advances in Nursing Science**, 9(3) 34-43.

Block I (1985) Wittgenstein, Ludwig (Joseph Johann). *In Thinkers of the 20th century [eds.: Devine E, Held M, Vinson J, Walsh G]*, Firethorn Press, London.

Bluebond-Langner M (1978) **The private worlds of dying children**. Princeton University Press, New Jersey.

Botha C J (1996) **Statutory interpretation: an introduction for students**. Juta and Co, Kenwyn, South Africa.

Bowden P L (1993) Theoretical care: feminism, theory and ethics. **Critical Review**, 33:129-47.

Bowden P L (1994) The ethics of nursing care and 'the ethic of care'. **Nursing Inquiry**, 2:10-21.

Bowden P L (1997) **Caring: Gender-sensitive ethics.** Routledge, London.

Bowden P (1998) Ethical attention: accumulating understandings. **European Journal of Philosophy**, 6(1)59-77.

Brody J K (1988) Virtue ethics, caring and nursing. **Scholarly Inquiry for Nursing Practice**, 2(2)87-96.

Bruner J (1990) **Acts of meaning**. Harvard University Press, Cambridge, Mass.

Bruner J (1996) **The culture of education**. Harvard University Press, Cambridge, Mass.

Brykcznska G (ed.)(1997) **Caring: the compassion and wisdom of nursing**. Arnold, London.

Candy P (1989) Alternative paradigms in educational research. **Australian Educational Researcher**, 16(3)1-10.

Carper B A (1979) The ethics of caring. **Advances in Nursing Science**, 1(3)1411-19.

Carr W & Kemmis S (1983) **Becoming critical, knowing through action research**. Deakin University Press, Victoria.

Chase D (1986) Dying at home with hospice. St Louis, USA. *In Oliver B (1992) Towards a living place: hospice and palliative care in Western Australia*, 1977-1991. Cancer Foundation of W.A., Perth.

Clark J (1995) Expert nursing: a necessary extravagance. **European Journal of Cancer Care**, 4:109-17.

Cohen M Z, & Sarter B (1992) Love and work: Oncologoy nurses' view of the meaning of their work. **Oncology Nursing Forum**, 19:1481-6.

Cooper M C (1988) Covenatal relationships: grounding for the nursing ethic. **Advances in Nursing Science**, 10(4)48-59.

Cooper M C (1989) Gilligan's different voice: a perspective for nursing. **Journal of Professional Nursing**, 5(1)10-16.

Cooper M C (1991) Principle-oriented ethics and the ethic of care: a creative tension. **Advances in Nursing Science**, 14(2)22-31.

Coulson C W (1979) **Life sentence**. World Wide, Minneapolis [reference to Nouwen not given].

Crigger N J (1997) The trouble with caring: a review of eight arguments against an ethic of care. **Journal of Professional Nursing**, 13(4)217-221.

Cunliffe L (1999) *After late and post-modernism – a Wittgensteinian reconstructive and tranformative aesthetics, art practice and art education*. Paper given in Australia; September, 1999.

Cunliffe L (1999) Personal correspondence, October, 1999.

Curzer H (1993) Is care a virtue for health care professionals? **Journal of Medicine and Philosophy**, 18:51-69.

de Tornyay R (1990)(Editorial) The Curriculum Revolution. **Journal of Nursing Education**, 29(7)292-94.

de Jong, Joop T V M (1987) **A descent into African psychiatry**. The Royal Tropical Institute, The Netherlands.

Diekelmann N (1990) Nursing education: caring, dialogue, and practice. **Journal of Nursing Education**, 29(7)300-5.

Diekelmann N (1992) Learning as testing: a Heideggerian hermeneutic analysis of the lived experiences of students and teachers in nursing. **Journal of Nursing Education**, 14(3)72-83.

Drew N (1986) Exclusion and confirmation: a phenomenology of patients' experiences with caregivers. Image: **Journal of Nursing Scholarship**, 18(2)39-43.

Drew N (1989) The interviewer's experience as data in phenomenological research. **Western Journal of Nursing Research**, 11(4) 431-9.

Dunlop M J (1994) Is a science of caring possible? *In [ed] Benner P [1994] Interpretive Phenomenology: embodiment, caring, and ethics in health and illness [ch. 2]*. Sage Publishers, Thousand Oaks, California.

Dyck, B (1989) The Paper Crane. **American Journal of Nursing**, (89):824-6 [With commentary by Patricia Benner].

Farmer E (1992) Promoting caring in nursing (editorial). **British Journal of Nursing**, 1(11)537.

Field P A (1983) An ethnography: four public health nurses' perspectives of nursing. **Journal of Advanced Nursing**, 8:3-12.

Frankl V (1967] **Psychotherapy and existentialism: selected papers on logotherapy**. Pocket Books, New York.

Freire P (1968) **Paedagogy of the oppressed**. Seabury Press, New York.

Frick W B (1987) The symbolic growth experience: paradigm for a humanistic-existential learning theory. **Journal of Humanistic Psychology**. 27(4)406-23.

Fromm E (1957) **The art of loving**. Unwin paperbacks, London.

Fry S T (1988) The ethic of caring: can it survive in nursing? **Nursing Outlook**, 36(1)48.

Fry S T (1989) Toward a theory of nursing ethics. **Advances in Nursing Science**, 11(4)9-22.

Gadow S (1988) Covenant without cure: letting go and holding on in chronic illness. *In Watson J and Ray M A (eds)(1988) The ethics of care and the ethics of cure: synthesis in chronicity*. (pp. 5-14) National League of Nurses, New York.

Gaut D A (1983) Development of a theoretically adequate description of caring. **Western Journal of Nursing Research**, 5(4)313-24.

Gaut D A (1986) Evaluating caring competencies in nursing practice. **Topics in Clinical Nursing**, 8(2)77-83.

Gelfand M ((1958) **African Medicine**. Juta and Co, Cape Town.

Gelfand M (1975) **Law and Custom**. Juta & Co, Cape Town.

Gendlin E T (1962) **Experiencing and the creation of meaning: a philosophical and psychological approach to the subjective**. Free Press of Glencoe {Collier-Macmillan, Toronto.

Gilligan C (1982) **In a different voice: psychological theory and women's development**. Harvard University Press, Cambridge.

Goduka I N (1996) Challenges to traditionally white universities: affirming diversity in the curriculum. **SAJHE/SATHO**, 10(1)27-36.

Goffman E (1961) **Asylums**. Harmondsworth: Penguin.

Griffin A P (1983) A philosophical analysis of caring in nursing. **Journal of Advanced Nursing**, (8) 289-95.

Haegert S (1989) **Creating a reflective nurse practitioner**. Dissertation submitted in part fulfillment of the MA[Ed]. University of East Anglia, Norwich.

Haegert S (1995) *Moving outside in ...* Paper delivered at the Road to Research UCT Nursing Department Conference.

Haegert S (1996) Health-seeking behaviour by Cape-townians: a mini-research by first year nurses at a college for nursing in Cape Town. **Curationis**, 19(4)81-4.

Harbison J (1992) Gilligan: a voice for nursing?. **Journal of Medical Ethics.** 1992, **18,** 202-5

Henderson V (1966) **The nature of nursing**. Macmillan, New York.

Hodgson J (1980) **Ntsikana's 'Great Hymn' - a Xhosa expression of Christianity in the early 19th Century Eastern Cape**. Communications no. 4/1980 Centre for African studies, University of Cape Town.

Holdstock L (1987) **Education for a new nation**. Africa Transpersonal Association, Riverclub, RSA.

Hudson T (1995) **Signposts to spirituality: towards a closer walk with God**. Struik Christian Books, Cape Town.

International Council of Nurses (1973) **International Council of nurses code for nurses. Ethical concepts applied to nursing**. ICN, Geneva.

Irurita V F (1993) **From person to patient: nursing care from the patient's perspective**. Dept of Nursing research, Sir Charles Gairdner Hospital, Perth, Australia.

Jabavu N (1960) **Drawn in colour - African contrasts**. John Murray, London.

Jecker N S and Self D J (1991) Separating care and cure: an analysis of historical and contemporary images of nursing and medicine. **Journal of Medicine and Philosophy**, 16:285-306.

Jetter M (1994-6) **Mind-mapping**. Future Communications Systems.

Fox, M A Spirituality named compassion and the healing of the global village, Humpty Dumpty and us. *In Jobson R (1996) Compassion: our true vocation? S A Family Practice,* November, 1996, pp. 475. Harper Collins, San Franscico.

Kerr F (1986) **Theology after Wittgenstein**. Basil Blackwell, New York.

Kitson A (1996) Does nursing have a future? **British Medical Journal**. 313:1647-51.

Kramer M (1974) **Reality shock**. CV Mosby & Co. St Louis.

Kubler-Ross (1969) **On death and dying**. MacMillan, New York.

Kuhn T (1970)(2nd ed.) **The structure of scientific revolutions**. University of Chicago Press, Chicago.

Labun E (1988) Spiritual care: an element in nursing care planning. **Journal of Advanced Nursing**, 13:314-20.

Laing R D (1965) **The divided self**. Penguin, New York.

Larrabee M J (ed.)(1993) **An ethic of care: feminist and interdisciplinary perspectives**. Routledge, New York.

Lave J & Wenger E (1991) **Situated learning - legitimate peripheral participation**. Cambridge University Press, Mass.

Lederman E K (1979) **Philosophy and Medicine** Tavistock Publications, London

Leininger M M (1980) **Transcultural nursing: teaching, practice and research**. University of Utah, Salt Lake City.

Leininger M (1981) The phenomenon of caring: importance, research questions and theoretical considerations. *In M Leininger [ed] Caring: an essential human need.* Charles B Slack, Thorofare, NJ

Leinginger M M (1991) **Culture care diversity and universality: a theory of nursing**. National League for Nursing, New York.

Leonard V W (1989) A Heideggerian phenomenological perspective on the concept of person. Advances in Nursing Science, 11(4)40-55.

Lewis C S (1960) **The four loves**. Fount paperbacks, London.

Løgstrup (1995) **The ethical demand.** University of Notre Dame Press, Indiana.

Long A (1997) Nursing: a spiritual perspective. **Nursing Ethics**, 4(6)496-510.

Magee B (1987) **The great philosophers: an introduction to Western philosophy**. Dialogue 15: Wittgenstein: with John Searle pp. 322-47. BBC Books, London.

Makwanyane S V (1997) **Ubuntu as given in the South African Constitution**. Government Printing Press, Pretoria [501D-E]. Malan J S (1990) **The aged in Lebowa and Venda**. Human Sciences Research Council, Pretoria.

Marks S (1994) **Divided sisterhood: race, class and gender in the South African nursing profession**. Witwatersand University Press, Johannesburg.

Maslach C (1983) **Burnout: the cost of caring**. Prentice-Hall, Englewood Cliffs, New Jersey.

Maslow A (1958) **On Motivation**. Harper and Row, New York

May R (1969) **Love and will**. Penguin, New York.

Mayeroff, M (1971) **On caring**. Harper & Row, New York.

McCormick R A (1981) **How brave a new world: dilemmas in bioethics**. Georgetown University Press, Washington.

McFarlane J (1975) A charter for caring. Nursing Mirror. Dec., 4:40-42.

Meleis I A (1997)(3rd ed.) **Theoretical nursing: development and progress**. Lippincott, Philadelphia.

Melia K M (1994) The task of nursing ethics. **Journal of Medical Ethics**, 20: 7-11.

Menzies I (1970) **The functions of social systems as a defence against anxiety**. Tavistock, London.

Moccia P (1988) A critique of compromise: beyond the methods debate. **Advances in Nursing Science**, 10(4)1-9.

Montgomery C L (1991) The care-giving relationship: paradoxical and transcendent aspects. **Journal of Transpersonal Psychology**, 23(2)91-104.

Montgomery C L (1993) **Healing through communication: the practice of caring**. Sage Publishers, Thousand Oaks, Ca.

Morrow R A, with Brown DD (1994) **Critical theory and methodology**. Sage Publications, Thousand Oaks, Ca.

Morse J M (1992) Comfort: the refocusing of nursing care. **Clinical nursing research**, 1(1)91-106.

Morse J M, Solberg S M, Neander W L, et. al. (1990) Concepts of caring and caring as a concept. **Advances in Nursing Science** 13(1)1-14.

Morse J M, Bottorff J L, Neander W L, et. al. (1991) Comparative analysis of conceptualizations and theories of caring. Image: **Journal of Nursing Scholarship** 23(2)119-126.

Moustakas C (1994) **Phenomenological research methods**. Sage Publishers, Thousand Oaks, Ca.

Murdoch I (1970) **The sovereignty of good.** Routledge & Kegan Paul, London.

Nightingale F (1952 ed.) **Notes on Nursing**. Foreword by Ottley L J. G Duckworth & Co., London.

Noddings N (1984) **Caring: a feminine approach to ethics and moral education**. University of California, Berkeley, CA.

Noddings N (1988) An Ethic of caring and its implications for instructional arrangements. **American Journal of Education**, Feb: 215-30.

Nouwen H J M cited by Coulson, 1979 [op. cit.] no reference given.

Nouwen H J M (1994) **Our greatest gift: a meditation on dying and caring**. Hodder & Stoughton, London.

Nouwen H J M (1995) **The path of peace**. Crossroad, New York.

Nursing Times Editor (1945) The art of nursing. **Nursing Times**. April 7, 1945 pp. 219.

Oiler C (1982) The phenomenological approach in nursing research. **Nursing Research**, 31(3)178-181.

Oliver B (1992) **Towards a living place: hospice and palliative care in Western Australia**, 1977-1991. Cancer Foundation of W.A., Perth.

O'Malley J [undated] **Sociology of meaning**. Human Context Books, London [pp. 111 citing Shutz].

Omery A (1983) Phenomenology: a method for nursing research. **Advances in Nursing Science**, 5:49-63.

O'Neill O (1996) **Towards justice and virtue – a constructive account of practical reasoning**. Cambridge University Press, England.

Parker R S (1990) Nurses' stories: the search for a relational ethic of care. **Advances in Nursing Science**, 13(1)31-40.

Paterson B, Crawford M (1994) Caring in Nursing education: an analysis. **Journal of Advanced Nursing**, 19:161-73.

Paterson J G & Zderad L T (1976) **Humanistic nursing**. John Wiley & Sons, New York.

Pieper J (1972) About love. (trans. by R & C Winston) Franciscan Herald Press, Chicago.

Powell, J (1972) **"Why am I afraid to tell you who I am?"** Argus Communications, Illinois.

Praeger S G (1995) Josephine G Paterson and Loretta T Zderad ch. 17 *In George J B (1995)(4th ed.) Nursing theories: the base for professional nursing practice*. Appletone & Lange, Connecticut.

Purkis M E (1994) Entering the field: intrusions of the social and its exclusion from studies of nursing practice. **International Journal Nursing Studies**, 31(4)315-36.

Quinton A M [1964] Excerpt from "contemporary British philosophy". *In: Pitcher G (1968)(ed.) Wittgenstein: the philosophical investigations: a collection of critical essays.* Macmillan, London.

Rack P (1982) **Race, culture and mental disorder**. Tavistock, London.

Rakel R E (1996) To care with caring: compassion and the art of medicine - Part I. **Family Practice**. Nov., pp. 476-8.

Revans R W (1964) **Standards for morale: causes and effect in hospitals**. Oxford University Press.

Reverby S (1987) **Ordered to care: the dilemma of American nursing**, 1850-1945. Cambridge University Press, Cambridge.

Rieman D J (1986) Noncaring and caring in the clinical setting: patients' descriptions. **Topics in Clinical Nursing**, 8(2)30-36.

Richards L O (1985) **Expository dictionary of Bible words**. Zondervan Corp., Grand Rapids, Michigan.

Rispel L & Schneider (1988) **Professionalization of nursing: who benefits?** University of Witwatersrand (Wits).

Roach Sr M S (1987) **The human act of caring: a blue-print for the health professions.** Canadian Hospital Association, Ottawa.

Ross L A (1994) Spiritual aspects of nursing. **Journal of Advanced Nursing**, 19:439-447.

Rubin H (1996) Impediments to the development of clinical knowledge and ethical judgement in critical care nursing. *In Benner P, Tanner C A, Chesla C A (1996) Expertise in nursing practice: caring, clinical judgement and ethics.* Springer Pub. Co., New York. pp. 170-192.

Saint Christopher's hospice (1984) **The cost of caring**. Newsletter, St Christopher's hospice.

Samuelson L H (1974)(new ed) **Zululand: its traditions, legends, customs and folk-lore**. T W Griggs & Co., Durban, pp. 122-8

Sandelowski M (1986) The problem of rigor in qualitative research. **Advances in Nursing Science**, 8(3)27-37.

Schon D (1983) **The reflective practitioner: how professionals think in action**. Basic Books, New York.

Schon D (1987) **Educating the reflective practitioner**. Jossey-Bass, San Francisco, CA.

Schmier L (1996) Random thought: a small bit of advice. lschmier@grits.valdosta.peachnet.edu; news@picasso.wcape.school .za

Schmier L (1997) Random thought: what is an education. lschmier@grits.valdosta. peachnet.edu; news@picasso. wcape.school.za.

Secker B (1999) The appearance of Kant's deontology in contemporary Kantianism: concepts of patient autonomy in bioethics. **Journal of Medicine and Philosophy** 24(1)43-66.

Shutte M F N (1982) **Spirituality and intersubjectivity: a philosophical understanding of the relation between the spiritual nature of persons and basic structures of intersubjectivity**. D. Phil. Thesis, Stellenbosch.

[NB: Although initials are different the following are the same author].

Shutte A (1987) A new argument for the existence of God. **Modern Theology, (3)**157-177

Shutte A S (1993a) **The mystery of humanity**. Snailpress, Cape Town.

Shutte A S (1993b) **Philosophy for Africa**. University of Cape Town Press, Cape Town.

Shutte A S [1993c] **History of ethics**. Unpublished paper.

Shutte A S [undated] **Ubuntu- an ethic for a new South Africa**. [in draft].

Spradley J P (1979) **The ethnographic interview**. Holt, Rinehart, and Winston, New York.

Stacey N (1977) **Concepts of health and illness: a working paper on the concepts and their relevance for research. Health and Health Policy - priorities for research** (1977) Social Science Research Council, London.

Stenberg M J (1979) The search for a conceptual framework as a philosophic basis for nursing ethics: an examination of code, contract, context, and covenant. **Military Medicine**, 144(1)9-22.

Stiles M K (1994) The Shining Stranger: application of the phenomenological method in the investigation of the nurse-family spiritual relationship. **Cancer Nursing**, 17 (1)18-26.

Street A F (1990a) **Nursing practice: high, hard ground, messy swamps and the pathways in between**. Deakin University Geelong, Victoria

Street A F (1990b) **The practice of journalling for teachers, nurses, adult educators and other professionals**. Deakin University Press, Geelong, Australia.

Street A F (1992) **Inside nursing: a critical ethnography of clinical nursing practice**. State University of New York, New York.

Swanson-Kauffman K M (1986a) Caring in the instance of unexpected early pregnancy loss. **Topics in Clinical Nursing**, 8(2), 37-46.

Swanson-Kauffman K M (1986b) A combined qualitative methodology for nursing research. **Advances in Nursing Science**, 8(3)58-69.

Swanson K M (1990) Providing care in the NICU*: sometimes an act of love. **Advances in Nursing Science**, 13(1)60-73. *Neonatal intensive care unit

Swanson K M (1991) Empirical development of a middle range theory of caring. **Nursing Research**. 40(3)161-166.

Szasz T (1961) **The myth of mental illness**. Hocber & Harper, New York.

Tanner C A (1990) Reflections on the Curriculum Revolution. **Journal of Nursing Education** 29(7)295-99.

Toner J (1968) **The experience of love**. Corpus, Washington.

Travelbee J (1971)(2nd ed.) **Interpersonal aspects of nursing**. F A Davis, Philadelphia.

Tronto J C (1993) **Moral boundaries: a political argument for an ethic of care**. Routledge, New York.

Urmson J O (ed.)(1960) Wittgenstein, Ludwig Joseph Johann. *In The concise encyclopedia of Western philosophy and philosophers.* Hutchinson Group, Johannesburg, South Africa.

van Deventer C (1995) Spiritual Care. **SA Family Practice** December:786-90.

van Hooft S (1990) Moral education for nursing decisions. [A paper originally read at a conference of the Australia Nurse Teachers' Society (1988)] **Journal of Advanced Nursing.** 15:210-5.

van Hooft S (1995) **Caring - an essay in the philosophy of ethics**. University Press of Colorado.

van Hooft S (1996) Bioethics and caring. **Journal of Medical Ethics**, 22:83-9.

Vincent M (1989) **Preparing for internal supervision: a journey in self- reflection**. Dissertation submitted in part fulfillment of the MA[Ed] for the University of East Anglia, Norwich.

Vorster P J (1996) **Some thoughts on Africanization**. CSD Bulletin, Feb, 2(10)13-8.

Watson J (ed.)(1979) **Nursing: The philosophy and science of caring**. Little, Brown & Co., Boston.

Watson J (1985) **Nursing: human science and human care: a theory of nursing**. Appleton-Century-Crofts, Norwalk, Connecticut.

Weil S (1950) **Waiting on God.** Routledge & Kegan Paul, London.

Wilkinson J R (1998) What it means to care. **Curationis**, 21(2) 2-8.

Williams M (1922) **The Velveteen Rabbit**. (Reprinted 1995) Wm. Heinemann, London.

Wilson M (1975) **Health is for people**. Dartman, Longman & Todd, London.

Winland-Brown J E (1996) Can caring for critically ill patients be taught by reading a novel? **Nurse Educator**, 21(5)23-7.

Wittgenstein L J J (1958) **The Blue and Brown books: preliminary studies for the 'Philosophical Investigations'** (2nd ed. Basil Blackwell, 1975 paperback edition.

Wittgenstein L (trans. G E M Anscombe)(1953) **Philosophical Investigations**. Blackwell, Oxford.

Wittgenstein L J J (1961)(trans. 1974) Pears D F & McGuiness B F) **Tractatus logico-philosophicus**. Routledge & Kevin Paul, London.

Wittgenstein L J J (1968) **The philosophical investigations**. Macmillan, London. (Modern studies in philosophy series).

Wittgenstein L (ed. G E M Anscombe & G H von Wright)(trans. G E M Anscombe & D Paul)(1969) **On certainty** Blackwell, Oxford.

World Health Organisation (1947): "A state of complete physical, mental, social and spiritual well-being and not merely the absence of disease or infirmity" WHO, Constitution adopted by the International Health Conference, New York. Amended to include 'spiritual' 1998.

Wright A (1981) **"This death in the mud ..." A study of the significance of theme words occuring in interview with a group of social workers at Baragwanath Hospital**. A dissertation presented to the University of the Witwatersrand, Johannesburg for the BA (Honours)(Sociology) degree.

Yancy P (1995) **The Jesus I never knew**. Zondervan, Michigan.

Yarling R R and McElmurray B J (1986) The moral foundation of nursing. **Advances in Nursing Science**, 8(2)63-73.

Zaner R (1982) Chance and morality: the dialysis phenomenon. *In Kestenbaum V (ed) The humanity of the ill: phenomenological perspectives.* University of Tennessee Press, Knoxville pp. 53.

List of Appendices

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Appendix Ia

A list of all Interviewees: interviewed between September, 1995 and January, '96. Three further interviews in January 1998.

Column 1	Column 2	Column 3	Column 4	Column 5.
No. Name	**Discipline**	**Age**	**Yrs Nursing** including training	**1st Language**
1. Vera	Hospice Sr	40	**12**	English
2. Frieda	Hospice Sr	41	**20**	English
3. Bekkare	Oncology Trainee	30	**13**	Shangaan
4. Paula	Hospice Sr	43	**25**	English
5. Lesley	Hospice Sr	58	**35**	English
6. #Ruth	Hospice Sr	51	7- 22 yr break	English
7. *Laura	Soc. Worker	40+	**non-nurse**	English
8. *Gertrude	Ward Sister	51	**18**	Afrikaans
9. Amanda	Unit Matron	41	**22**	English
10 Henrietta	Oncology Wd Sr	35	**16**	Afrikaans
11 May	Matron/Chaplain	59	**not known**	English
12 Diana	Matron/Tutor	55	**37**	English
13 Breakfast Gr	Dr/SW/Chap/Mo	40+	**N/A**	English
14 Sr W	Ward Sister	60	**38**	Afrikaans
15 *Ann	Maternity Sister	25	**6**	English
16 *Pamela	Stomatherapist	56	**32**	English
17 *Jean	Hospice Sr	46	**15**	English
18 *Liz	Hospice Sr	57	**40**	Afrikaans
19 *Jill	Hospice Sr	38	**20**	English
20 Maureen	Tutor/Hospice Sr	42	**22**	English
21 #Prudence	CommHospice Sr	34	**12**	Zulu
22 Brenda	Hospice Sr	56	**38 1yr hspice**	English
23 Susan	Chrge Sr Hospice	52	**32**	English
24 *Sue	Soc Worker/RN	45+	**not known**	English
25 Cindy	Oncology Unit Sr	35	**16**	English
26 Kay	Oncology Unit Sr	25	**7.5**	English
27 *Mary	Tutor/Unit Sr	40	**21**	English
			Average Age 44 years.	1 x Shangaan 1 x Zulu 4 x Afrikaans 21 x English

NB:
See over for further information

Legend:
 # indicates persons interviewed but only mentioned briefly
*** indicates persons interviewed but not discussed in the thesis**

`Column 1:`

The names of all participants interviewed.
Names have been changed for reasons of confidentiality.
* Indicates persons interviewed but not discussed in the thesis.
# Indicates persons interviewed but only mentioned briefly.
Participants are given in the order in which they were interviewed.

`Column 2:`

Indicates where interviewees worked and their discipline. This is done because two social workers, two chaplains, a doctor and a nurse stomatherapist were interviewed to obtain background information, and to validate other information. Some nurses had dual qualifications e.g. social worker & nurse x 2
chaplain & nurse.

`Column 3:`

Gives the ages of interviewees.
The average age of all participants was 44 years. That of those included in the actual research was also 44 years.

`Column 4:`

Gives the number of years of experience interviewees had had in nursing. This includes their training years. The average length of time in nursing was 22 years. One interviewee had had a 22 year break from nursing.

`Column 5:`

This gives the first language of each participant [English was predominant; Afrikaaans the second biggest group]. Many would have a second language , some even a third [usually Black South Africans e.g. English, Sesothu and Zulu; or English, Twsana and Xhosa.]

Appendix II a

Participants' consent form

RESEARCH TOPIC:

"A CRITICAL ANALYSIS OF THE CONCEPT 'CARE' IN THE PRACTICE AND DISCOURSE OF NURSING".

PARTICIPANTS' INFORMATION SCHEDULE AND CONSENT FORM.

I am conducting a study looking at the ways in which Registered Nurses [RNs] use the terms 'care' and 'caring' in their actual nursing practice. The aim is to learn what meanings RNs give to these terms when narrating their own experiences of caring for others, or, memories of having been cared-for themselves.

The study will:

1. Describe the circumstances and context in which caring occurs;
2. Identify nurses perceptions/meanings of that caring through describing their memories of being cared for or of giving care themselves
3. Determine how nurses think, act and reflect upon caring.

The research will involve nurses from a variety of hospice, oncology and haematology care settings. Information will be obtained through the researcher being an observer, and, in the form of tape recorded interviews. These will be approximately of 45-60 minute duration each. The interviews will centre on nurses' usage of the terms and the meaning behind their use [through their narratives/discourses].

Tape recordings will be transcribed; thereafter the tapes will be held for verification purposes only; and will then be erased. Extracts of the transcribed interviews will be used in the research. Confidentiality will be assured: patients [that a nurse may be working with], or nurses interviewed will not be identified in any way.

Participation is VOLUNTARY. You may withdraw from the research at any time.

If there are any questions or concerns about this project please do not hesitate to contact: Miss S Haegert
Carinus Nursing College
Private Bag X1
Groote Schuur, 7700
or, Telephone office: [021] 404.6151; home: [021] 614439

Appendix II b

Participants' consent form

I, ...

[Please print full name].

have read the enclosed information on the study relating to *"The concept of care in the practice and discourse of nursing"*.
I understand the nature and intent of the study; and that I have the opportunity to ask questions/make comments. I understand where to direct any questions I may have.
I have received a copy of the proposal and understand that my participation is voluntary and that I may withdraw at any time without disadvantaging the project.

..

Signed ....

Dated ....

Thank you for your willingness to participate in this research.

As the topic is about care and caring it is hoped that the results will make a contribution to nursing specifically and other health care professionals generally.

Miss S Haegert
Carinus Nursing College
Private Bag X1
Groote Schuur, 7700
or, Telephone office: [021] 404.6151; home: [021] 614439

Appendix III The interview schedule

Demographic Data

Age Gender

No. of Years Nursing

No. of Years since training

Further Training:

....

....

....

Other courses..

(not necessarily nursing courses)

....

....

Nursing Experience

....

....

....

1. Describe memories you have of being cared for?

2. Describe your best memory of care giving?

3. Are you fully fulfilled in your nursing career?

4. What does 'fully fulfilled' mean to you?

5. What changes would you make?

6. Why did you become a nurse?

Appendix IV

Paula's Interview data

1. Paula's written response

2. The transcripts
   - 2.1. The verbal interview
   - 2.2. The written response

3. Mind maps
   - 3.1. The written questions
   - 3.2. The verbal questions

4. The transcript as narrative

Appendix IV Written response to interview schedule

①. Just before my youngest son was born I was "persuaded" to join a Bible Study class. I was somewhat reluctant + unsure as to whether I wanted to join a bunch of "Holy Joes". However, my son was born with club feet and I am convinced that God placed me amongst that wonderful group to help me through those difficult years. I have been with them now for 10 years and they have helped me to grow in so many ways not least in spirituality. Their caring, uncondition love has been an inspiration to me + together we have struggled through + grappled with many thorny issues, fears, doubts etc etc along the path of life.

②. There have been so many families in my 10 years at St Luke's that it is hard to isolate one particular memory. We had a 29 year old girl who stayed with us for 2 years. She became an enormous nursing problem during this time + took all the patience and professionalism that our staff could muster. "having" her and caring for her in spite of her very gruelling demands was an incredibly stretching experience + one which taught me a great deal about suffering and caring.

③. Yes - I feel that I have found my niche at St Luke's. This is nursing as it should be done

④. Doing what I love and believe in + making a difference to my patients.

⑤. Some staffing changes. My hours are long and arduous. Different in service training. Perhaps another academic course. Training in administration + man-management

⑥. I have wanted to be a nurse for as long as I can remember - - to give to my fellow man. I am a nurturing type!

c:int\pwker.txt interviewed 9.1.96
transcribed 15.1.96: TRANSCRIPT

I went to the Hospice with the express purpose of booking folk for interviews, and seeing the SW, she was away so I went to the ward. There I met PW and told her of my dilemma about time and interviews. She was extremely helpful and we arranged that I would phone and confirm that it would be convenient to come the next afternoon. She said she had filled in my interview sheet and would bring it.
9.1.96 I phoned before two, and PW said to come for three that afternoon. I arrived at afternoon visiting. I noticed relatives all over. One relative was answering sister's questions in the office. This was PX whom I had not really met, only seen around. I was unable to meet her properly so as I was not going to interrupt the proceedings. I learnt later that she had exchanged with LH. This was regular practice. FD wanted all the sisters to have experience with AIDS patients especially as she had the feeling that one or two of her sisters were not comfortable with them.
I went to talk to the auxiliaries. One (the older BX) wanted to try on my epaulettes. So I handed my coatee over and she put it on. Then she said that when staff left, or were sick, or so on, there was a 'kitty' for funds. "There are more of them [aides] than sisters", she said, "and yet they tell us what to do with the money". I wondered why she had told me this. Interesting!
Now, as a result of reading Spradley, I have completely restructured my approach to questioning. I shall delineate where I believe I was going wrong some place else.
Also because PW had filled the interview sheet in I did not want to repeat what she may have answered in it - thinking of the SS interview. Though repeating the questions can have advantages and disadvantages.
PW took me to the Gazebo [outside in the garden] for the interview but there were folk there so we proceeded to a bench just beyond and in the shade. I asked permission to tape record. I was worried that my machine would not pick up the sound in the open, and this probably caused me not to press the right buttons, else the batteries were dead flat. I had to capture what I missed on tape in writing from memory as soon as I was able lest I forgot. I missed about 10 minutes.
I started the interview by giving a re-explanation of what I was doing. I mentioned about care and about needing to teach students about care, and asked what she thought they be taught and how?

"IF I WAS A PATIENT NEWLY BEING ADMITTED FOR PAIN CONTROL, WHAT WOULD MY DAY BE LIKE IN THE HOSPICE?"
PW turned out to be a lovely informant: she just started and continued with almost no prompting and was very explicit. It was a delight after my recent despair.
This first part is from memory.
She talked of my being initially assessed, of prioritizing my needs or symptoms whichever the patient gave. That they would start a care plan and describe what had been assessed, discuss with me what I saw as my problems; maybe use a pain chart in which case she would explain how it should be used. That she would welcome the family and reassure them that the staff were there for the patients. That if it was necessary, for psycho-social reasons, that they would point the social worker in my direction. Much of the initial assessment would depend upon the perceptions of the multi-disciplinary team and the patient.

CAN YOU CLARIFY 'PRIORITIZING' USING YOUR LANGUAGE, AS I DO NOT WANT TO TAKE ANY TERMS FOR GRANTED.
PW went into details about identifying what I, as a patient, might feel is important to be dealt with, eg. nausea. That although I might have psycho-social problems that were evident to the health care team, the nausea was the presenting problem for me, the patient, and therefore had to be dealt with first. They would seek for opportunity to discuss the psycho-social aspect from a broader perspective at first.
PW said that it was very complex, and "one that one learns as one goes on especially in a hospice. Part of this 'complexity' was learning to help the patient help themselves. For example in much earlier days, when I was to bath an old lady in her 80's and I had gone to the ward sister to ask her about bathing this person. The ward sister had said, "ask her". Which I did. And I realised that although this lady would have liked to have been bathed, when she went home she would have to do it herself, and therefore thinking of her being discharged to being alone without help, I enabled her to wash herself at the basin. I never forgot that experience.

PW had mentioned the role of the social worker,

WHERE DOES YOUR ROLE END AND THE SOCIAL WORKER'S BEGIN?
PW felt that: "There is a very fine line indeed. But ultimately that if there were deep psycho-social problems cropping up then the social worker would be called upon. Also they were far more trained to deal with the stages of bereavement and loss, and were able to concentrate on that.

THE TAPE ...
PW I think we have to be careful as nurses that we don't try and do counselling that we are not capable of doing. We need to know our limitations. But I think just sitting chatting to patients we're doing a form of counselling - just listening to people and encouraging them to talk. And I asked permission to tape record. SW is a very skilled social worker and she has taught us the kind of things to look for and the kind of things to encourage and the sort of things that we shouldn't be doing, asking questions and so on. So I think we have all gained a lot from her teaching along the way. And um one of the things she insists on is that we need to um help the patient to realise the reality of their situation and quite often we run away from that.
They'll go step by step forward asking questions and blocking, and asking questions and blocking and we are quite often able to help them to look at issues that they have not wanted to look at before or issues that the families are struggling with and the patient needs to talk about. So I think we fill the important counselling role but um we need to, as I said, we need to be careful that we don't try and do things that we are not really trained for.

YOU DON'T THINK THAT OUR TRAINING (GOING BACK NOW) WHEN DID YOU START YOUR TRAINING?
Here?

NO, WHEN DID YOU START YOUR GENERAL TRAINING?
Oh, in 1970, no, I don't think my nursing training taught me uh um anything like what I have learnt since I've been at the Hospice as far as the psycho-social side of nursing is concerned. Practical training yes, basic nursing care training from the point of view of doing procedures and making beds correctly. Absolutely no um question it was good in my day.
Um, but the counselling skills that I've learnt, some of them come from life experience, I mean they've come through what I have learnt from my own life. But it's been clarified and put into some form of structured meaning for me here through our training course - it's been very valuable.

HOW LONG HAVE YOU BEEN HERE?
9 years.

SO YOU HAVE SEEN A LOT, AND YOU HAVE ALSO DONE SOME COURSES?
Mm I'm doing the palliative course now. And I've done little bits and pieces but no any real studying, no. Um, I went to Bristol for two months which was very special, I learnt a lot.

TO A HOSPICE?
It was an exchange programme. It was a wonderful experience for me, um, it was a great experience in every way work-wise and personally. I'd been on night duty for a long time before then. HERE?
Ja, I think what I learnt on night duty was fairly limited in that I didn't have anyone to tell me whether I was doing things correctly or not. It was very long, isolated and lonely. I"ve learnt a terrific amount since I've been on day duty. Working with the teams. Seeing why things are devised and why things happen. I can understand, I think it's been helpful to my night duty colleagues having me on day duty because I can sometimes clarify some of their queries by explaining why and what and how. Whereas the day girls who have not been on night duty don't always understand their queries. They're baffled by them, mmm, ja.

YOU WERE TALKING AND YOU QUALIFIED YOURSELF WHEN YOU TALKED ABOUT THE THEORY IS THIS BUT THE ACTUALITY IS SOMETHING ELSE?
As far as nursing is concerned? Yes, I think, my practical training at [a State Hospital] you mean?

NO, YOU WERE TALKING OF THE TIME YOU GIVE TO PEOPLE
Oh yes, Yes, I do feel that since we have lost some of our staff they are not able to do as much, um, one to one

patient-care counselling as we would like. The amount of time that I can spend with my patients is limited. And the nurses, the assistant nurses, do a lot of the hands-on nursing. I would like to be able to do either a back-round or a wash-round or something at least once a day to be able to spend that time talking to the patients apart from seeing their bottoms and their feet and their whatever. I am seeing them with my own eyes. The nurses don't have the same empathy and understanding, ah, I don't think, that we have and then that is deliberately ungentle, but they are practically quite harsh in a way, they work and do their washes and they toss the patients round the bed but I don't think their intention is to be rough at all, but I know that I would wash a patient very differently. And I think that it would be beneficial both to me and my knowledge of the patient, and the patient if I was able to work the routine somehow so that I was involved in at least one pressure care round or um washing. And what used to happen was that our part-time sisters used to go in in the morning and help with the washes. Now there is only one and she is answering bells, and answering the 'phone and she is manning the ward while we are in the ward round. And it just doesn't happen.

Breakfast is another time: very often you walk into a ward and the patient is sitting with the breakfast at the foot of the bed and the nurse is busy feeding two patients next door and the others are busy on the other side. You've got one pair of hands and you have medicines to give out, and 'phones to answer and the doctor's ward round to do.

This morning I gave my medicines out after nine because we had our ward round and then the doctor's come to the ward, to write out their orders and I am doing the medicine round and they need the charts. And these charts change the times and we haven't found a slot that best suits both parties other than this time. The other option would be to change the medicine round. So those are some of the practical things that we would like to improve on. To actually make, we, we've introduced volunteers now in the ward, to help us so that there is more patient care. There are people going round now sitting and talking to patients. Perhaps doing the waters or the teas. Um, going down to the shops, getting the newspaper, talking to families, filling in when we are unable to get there.

It's not ideal because they have not all had our length of training or experience, but it is better than it was. We've been chasing our tails for a long time. And, if you look at the direction in which we are heading I don't know that it is going to change. Um ..

WHAT DO YOU MEAN BY THAT?

Well the powers that be are trying to meet the needs of the larger community and to ummm try to cut the enormous costs down a bit so that we do not just fold up and collapse and go away as a nice to have, and not a need to have. And while one understands the financial realities I am frightened that we might lose some of this very special hospice care in the process. Not so much in the unit but out in the community, but I think even in the unit. We have got to retain certain numbers in order to be economically viable and in order to maintain those numbers we cannot possibly continue the kind of care that we used to give.

SO CAN YOU DESCRIBE WHAT YOU USED TO GIVE

We would, we had a high nurse-patient ratio. So that the pace was slower and the patient care was, I think, better. When we were here we had six or seven patients here, and we had three or four sisters floating around. And it was just wonderful, we had endless time: for cutting nails, and combing hair, and washing hair and while that was happening the patient might break down and say "I can't bear to be leaving my family. Or um a husband, or wife might come in and say that I can't bear to see my intelligent bank manager husband reduced to this or whatever.

S.H. MM.

It sounds paltry and there are those who would find it tedious and boring but I felt that it was very important, very special.

MM. NOW WHAT INTERESTS ME BECAUSE AS YOU KNOW I HAVE BEEN ON BOTH SHIFTS IS THAT YOU ARE EXPRESSING THAT, OR EXPRESSES THAT, THE OTHERS EXPRESS IT TOO, UHH ...

And the powers that be? Well D says, and we've been chatting to him. I'm nervous of being quoted here, no I don't mind if you tape me, he said that we have got to face certain realities, and we cannot have the wonderful staff ratio that we used to have because of present constraints, financial constraints. So, um, aahh, we've been told that getting more staff is absolutely not on. And you've seen our present ratio of staff, we've well we're achieving a sort of [State Hospital] kind of day, and when I say that I don't mean it in a derogatory sense. I mean that a lot of people that I know who are working in training hospitals are going off at the end of the day knowing that they haven't perhaps tied up all the little knots, and dotted their i's, or crossed their t's and that is something that I just did not feel here.

I knew that there were days that I went off drained and emotionally tired and maybe run off my feet but I had been able to tie up most of my little knots and that I had made a difference to people, and I would hate to think that we are headed down that way where we are going to be racing from one end of the day to the next.

MM .. MM ALRIGHT, LET US GET BACK TO REALITIES AGAIN. HERE I AM YOUR PATIENT, QUITE ILL. LET'S SAY ON SECOND ADMISSION. HOW MUCH OF YOU WOULD I SEE?
You would see me in the mornings, initially. You might be awake, you might be asleep. You would see me first thing in the morning and then you will see me ...

WHAT WILL YOU BE DOING FIRST THING IN THE MORNING?
When I first come in in the morning I go in and say good-morning to all the patients, or just have a look at them before I go to the ward round so that the night duty report and my visual picture give me a more complete picture. I don't like to just go with the night sister's hand over report without having seen the patient. It may not all tie together the patient may be fast asleep or they may be sort of raging or confused and that was not what they were the night before, but I always look in at the patient before I go in on a ward round. If they are awake I'll ask how they feel, or what kind of a night did they have, so that I can give the patient's perception of his night, my perception of what he looks like and the night sister's report to the doctors.
And then after the ward round I do a medicine round. And then I spend a bit of time with each patient.

NOW THE WARD ROUND, EXCUSE ME INTERRUPTING, THE WARD ROUND IS A MULTI-DISCIPLINARY ROUND ITS AWAY FROM THE WARD.
That's right, that one. That's what I would be giving.

IS THIS THE ROUND OF THE PATIENTS IN THE WARD WITH THE DOCTORS?
No, the doctor's room. It's the main doctor's round. Then I would come back to the ward and straight after the ward round the doctors have a journal club so we have half an hour while they have their journal club, in which to sort out our patients and again theoretically if we were able to give out our medicines then by the time they came back to the ward we would be finished and ready for them and we could all sit down. But it doesn't work like that. But that is when I would spend quite a good time with the patients. I usually sit and chat with them. They might be having breakfast or whatever.
And then during the course of the morning depending on how many admissions there are I would be in and out of the ward but if there are no admissions and it is quiet I will spend a fair amount of time just going from patient to patient talking to them if that is appropriate and if they are amenable. Otherwise I would be admitting patients and doing quite a bit of admin. or rushing around most of the morning. Um, and lunch time there would be once again a meal and then staff lunches. So they would see me briefly. Lunch time I don't usually spend a lot of time with the patients because they are having their lunch and getting ready to sleep so that it is not a good time to speak to them. Then the afternoon is quite a good time for me to catch up with myself and to see if I have tied up all the morning's work and the patients sleep until three. Then visitors come in and that is a busy time. Families are with the patients and we very often get families coming into us and asking questions. So we will spend time with families. I try not to intrude when visitors are with the patients, uhh, more so in the afternoon than in the morning. And then five o'clock it is medicine round again. So they will see me at least three times a day for medicines. Plus times in between depending on the work load. But my best times are the week-ends. Then there is no huge ward round, there is no traffic.
One of our major problems is that the office becomes a major thoroughfare and you cannot concentrate and you, it is very difficult to get even a small work load done because of the ins and outs, to-ing and fro-ing that takes place in that ward, in that room. However the week-ends are wonderful (said slowly and dreamily). There is nobody around. We can literally sit on someone's bed and have a natter with them. We can walk round the garden with the family, and I love the week-ends. From the staff point of view we get to know each other. From the patient's point of view they are wonderful. These are the times, I always feel, that are the best times with the patient. And it's a three-day week-end. During the week we work two days, um ja, two days and then three days and the following week two days and two days so it's a good time.
[SH comment: 3:2:2/3:2:2 working time = one week 2 days; the next 5 days]

SO THERE IS A CHANCE THEN THAT I COULD BE HERE AND APART FROM YOUR (LONG PAUSE) LET

ME CALL THEM 'OFFICIAL TIMES' WHEN YOU COME TO SEE ME, THAT YOU MAY NOT BE ABLE TO SEE ME AT ALL?

I don't think so because of the medicine round. I'm almost certain that you would see me, ump

BUT JUST AT THOSE TIMES?

Correct. Yes, there are times like that, yes. But it is also possible that I would give one medicine round out and the part - timer would give out lunches while I am going to lunch. And when we are doing our palliative care course on Wednesdays I am out of the ward between one and five. Yes, so there are times, days, when you might get a glimpse of me in the morning only which is not ideal.

THEN YOU MEAN THERE IS NO CONVERSATION

Yes, just hello, and how are you? Yes, very little.

NOW BEING RUDE,

Yes, you're allowed.

WHAT DOES TAKE UP YOUR TIME?

A lot of the time is taken up with admin.

WHAT DOES THAT MEAN?

Uhh?

LET US SAY I COME FROM MARS!

The word administration um paper-work, ummm admitting a patient, discharging a patient, a death; a whole lot of your time is spent finding doctors, to write up thises and thats;

ADMISSIONS, .. OR ...?

No, write up medicine or if there is a crisis and the patient suddenly needs ahhh, morphine out of context. One cannot find them, they may be in a clinic looking at a patient. And one has to look around to find them. Um, a lot of the time is spent answering phones and dealing with families. Showing .. We've got a few problem areas. One area is that telephone calls are not screened at the desk (reception).

THAT IS TRUE. I HAVE PHONED THE WARD, AND NO-ONE ASKS YOU WHO YOU ARE OR WHAT IT IS YOU WANT. YES, THAT CERTAINLY IS TRUE.

So that we are receiving a lot of calls that we shouldn't. At least ones that are not necessary, that someone else could handle. And then there is a lot of unnecessary paper work which we are working on just now. Our new folders. And some of it is, I think, the calibre of staff that we have working with. Nurses, so that we do not have as much support as we should have. And some of it with our new volunteers. I don't think that they have been given a proper structure. Though some of them are wonderful. Some will flap it's all over their heads: no feeding a patient or wiping a brow. Some of them are better, and have an idea, and ask where can I help you? Or sitting reading a book and I think we have to sort that out. We have to give them some very clear guidelines as to what sort of things would help us, and what they are here for. And that is our fault, we started out with that in mind, but partly because of our day, and now the person who is in charge of that has not had a good opportunity to get hold of all the vols. and teach them properly.

In fact FD and I are having a meeting with EP tonight to discuss a whole lot of these little things that are slipping through to see if we cannot put this right.

THAT IS IN YOUR OWN TIME?

Yes, a lot of stuff happens in our own time, a lot of our meetings happen in our own time. But I don't see a way round it really.

NOT WITH YOUR PRESENT OFF-DUTIES?

Mmmm, no.

SO WHERE DOES CARE COME INTO ALL THIS, IN YOUR OPINION?

Well, I suppose our patients are getting a lot of loving care. But it's not, perhaps as HZ, our old matron, would say, we are getting seven out of ten, not our ten out of ten. I don't know if we will ever get ten out of ten. I still think that our patients are getting a fair amount of good care. But it is not optimal care.

WHAT IS OPTIMAL?

I think as I have said earlier, going back to a bigger staff ratio. And having um, I think we need to do some in-service training with our assistant nurses. And we need to do a little bit of in-service training with our new volunteers so that we are running in conjunction with each other, and not having people a lot of the time, we are getting slowed by people stopping us and asking all the time what can they do? We waste time in answering and going off at a tangent to teach someone who is there to help us and it ends up as a hindrance. So that needs to be looked at, we need to address that for a start. It should not be happening, it, they.. are there to take some of this away from us and fill in the gaps and so...

Yes, it is difficult for me to compare because I have not worked in a training school for a long time. But from persons, and families' comments and other staff members' comments who visit here, still think we do achieve, um, I still think we do achieve a good amount of good old Florence Nightingale care. But from the inside looking out I can see lots of holes.

PW was called away at this juncture. Which was probably not a bad thing as we had been going for over an hour, I had not noticed the time up to this point, and this is something that I will have to watch in the future.

I received the interview sheet some while after this interview although PW had said that she would bring it to the session. She had forgotten. The following is her written response to the questions. I have put them as a spoken interview for ease of analysis by NUD-IST. It is typed as PW wrote it.

DESCRIBE MEMORIES YOU HAVE OF BEING CARED FOR.

Just before my youngest son was born I was "persuaded" to join a Bible Study class. I was somewhat reluctant and unsure as to whether I wanted to join a bunch of "Holy Joes". However, my son was born with club feet and I am convinced that God placed me amongst that wonderful group to help me through those difficult years.

I have been with them now for ten years and they have helped me to grow in so many ways not least in spirituality. Their caring, unconditional love has been an inspiration to me and together we have struggled through and grappled with many thorny issues fears, doubts etc. etc. along the path of life.

DESCRIBE YOUR BEST MEMORY OF CARE GIVING

There have been so many families in my ten years at the hospice that it is hard to isolate one particular memory. We had a twenty-nine year old girl who stayed with us for two years. She became an enormous nursing problem during this time and took all the patience and professionalism that our staff could muster. "Loving" [PW's quotation marks] her and caring for her in spite of her very gruelling demands was an incredibly stretching experience and one which taught me a great deal about suffering and caring.

ARE YOU FULLY FULFILLED IN YOUR NURSING CAREER?

Yes - I feel that I have found my niche at St Luke's. This is nursing as it should be done.

WHAT DOES FULLY FULFILLED MEAN TO YOU?

Doing what I love and believe in and making a difference to my patients.

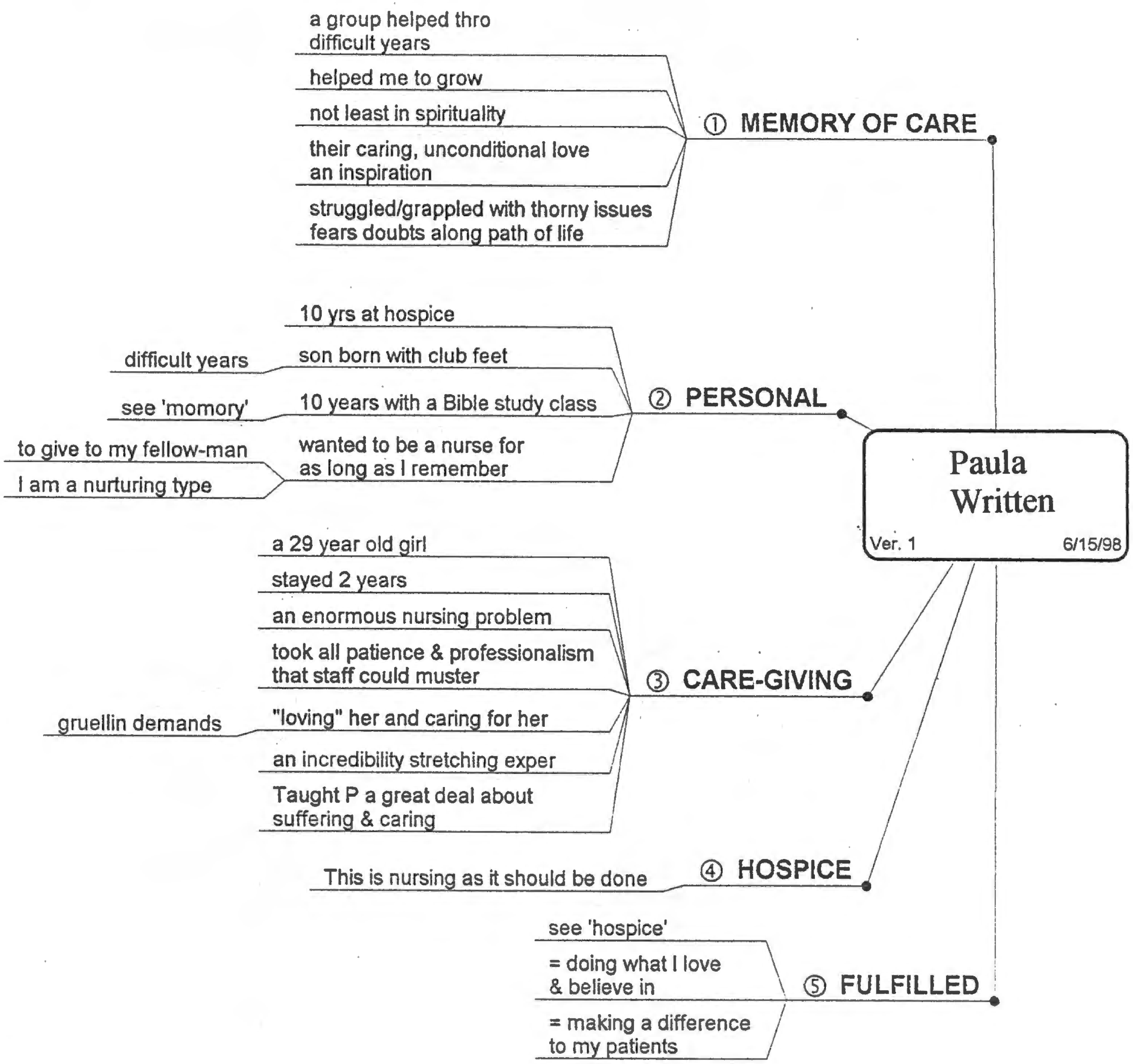
WHAT CHANGES WOULD YOU MAKE?

Some staffing changes. My hours are long and arduous. Different in-service training. Perhaps another academic course. Training in administration and man-management.

WHY DID YOU BECOME A NURSE?

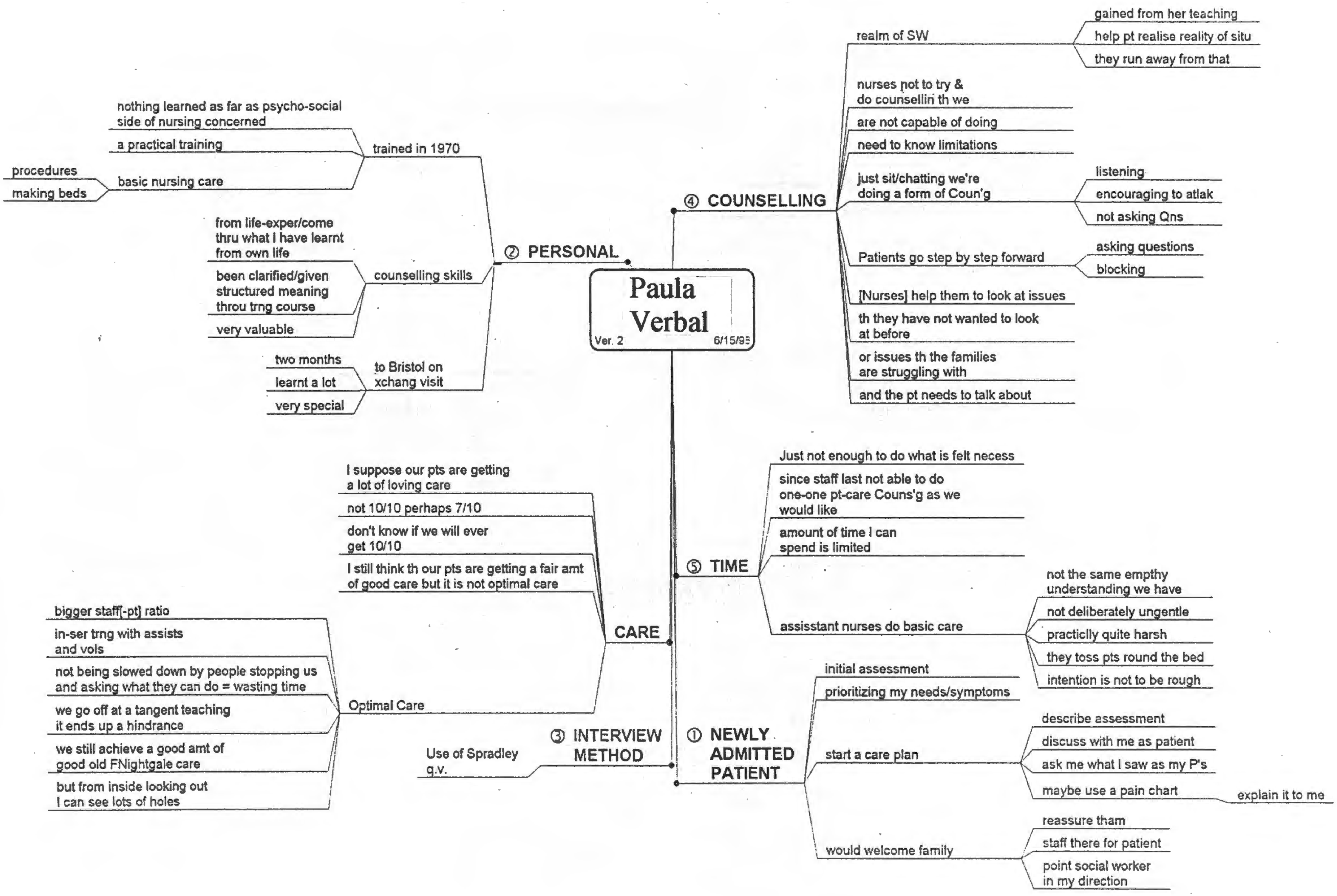
I had wanted to be a nurse for as long as I can remember .. to give to my fellow man. I am a nurturing type!.

No. 1



1 = Memory of care , 2 = Personal , 3 = Care-giving , 4 = Hospice , 5 = Fulfilled ,

No. 2



Paula Verbal
Ver. 2 6/15/98

- ④ COUNSELLING
  - realm of SW
    - gained from her teaching
    - help pt realise reality of situ
    - they run away from that
  - nurses not to try & do counsellin th we
  - are not capable of doing
  - need to know limitations
  - just sit/chatting we're doing a form of Coun'g
    - listening
    - encouraging to atlak
    - not asking Qns
  - Patients go step by step forward
    - asking questions
    - blocking
  - [Nurses] help them to look at issues
  - th they have not wanted to look at before
  - or issues th the families are struggling with
  - and the pt needs to talk about
- ② PERSONAL
  - trained in 1970
    - nothing learned as far as psycho-social side of nursing concerned
    - a practical training
    - basic nursing care
      - procedures
      - making beds
  - counselling skills
    - from life-exper/come thru what I have learnt from own life
    - been clarified/given structured meaning throu trng course
    - very valuable
  - to Bristol on xchang visit
    - two months
    - learnt a lot
    - very special
- ⑤ TIME
  - Just not enough to do what is felt necess
  - since staff last not able to do one-one pt-care Couns'g as we would like
  - amount of time I can spend is limited
  - assisstant nurses do basic care
    - not the same empthy understanding we have
    - not deliberately ungentle
    - practicly quite harsh
    - they toss pts round the bed
    - intention is not to be rough
- CARE
  - I suppose our pts are getting a lot of loving care
  - not 10/10 perhaps 7/10
  - don't know if we will ever get 10/10
  - I still think th our pts are getting a fair amt of good care but it is not optimal care
  - Optimal Care
    - bigger staff[-pt] ratio
    - in-ser trng with assists and vols
    - not being slowed down by people stopping us and asking what they can do = wasting time
    - we go off at a tangent teaching it ends up a hindrance
    - we still achieve a good amt of good old FNightgale care
    - but from inside looking out I can see lots of holes
- ① NEWLY ADMITTED PATIENT
  - initial assessment
  - prioritizing my needs/symptoms
  - start a care plan
    - describe assessment
    - discuss with me as patient
    - ask me what I saw as my P's
    - maybe use a pain chart
      - explain it to me
  - would welcome family
    - reassure tham
    - staff there for patient
    - point social worker in my direction
- ③ INTERVIEW METHOD
  - Use of Spradley q.v.

1 = Newly Admitted Patient , 2 = Personal, 3 = Interview method , 4 = Counselling , 5 = Time ,

The transcript written as narrative

`c:\int\pipker2.wpw` 15.1.98

As I re-read the transcript [and I have done so many times], but whilst re-typing and having worked on the other data chronologically I realized many things.

1. Using Spradley's questions had given me factual 'ethnographic' data more than data that came from memories of experiences. The answers to the questions were extremely useful. They validated my observations. From this interview I saw things so much clearer and that was so useful.
But, if I wanted 'lived experiences' I would need to use questions that produced memories of such experiences of being caring. My original ones may not have been so bad.
2. the questionnaire took all the innuendoes away - there was so much else to ask, things just hung as bald written statements. I had to go back and ask the questions verbally to get to the feeling of the person involved. Maybe a questionnaire is useful to allow interviewees to understand what they will be questioned on and to reflect [especially in phenomenological interviewing] but otherwise I had doubts on its usefulness if one did not combine it with a verbal interview as well. I learned this from the SS situation, an interviewee expects one to have read the replies before they are interviewed, which of course is no bad thing, circumstances allowing. But if one can then interview face to face one can then dig deeper into what has been written. A questionnaire alone was inappropriate for this kind of research.
3. Working through all previous data [background and interviews: FD, HS, EP, SS, CC, Bekkare, & the B'fast] and now on this one made me realise that what I had picked up from my observations were the very things that were frustrating PW and others. The skill-mix, the lack of in-service training for the volunteers and aides, and their type of nursing; the shortage of registered nurses, the administrative work: recording drugs, phones, reports, etc. all acted against continuity of care on the part of the sisters.

PW was enjoyable as an interviewee. She made time. Later on one sees that this is part of PW's character. She wanted to make time with and for patients. Her approach was not the fussing about that I had experienced before. She sought for quietness, and obtained it, in her favourite place, the garden. This was a soul thing. The stillness of the interview place had a calming effect. She herself was calm and working with such calmness was noticeable and a pleasure. She also struck me as being reflective and this was, I believe, because she drew on her own life experiences and sense of being [which she refers to in the interview as spiritual]. She called herself a 'nurturing type' one who gave to her fellow man.
I felt that if she were to assess and prioritize my needs as a newly admitted cancer patient that I would feel comfortable with her, and that she would be listening and interested in my 'trivia'. And if I or a friend became anxious or upset she would be there for me or mine. She gave that impression. But also exuded a professionalism of the type that HD talked about in the B'fast interview [q.v.] - involved enough to understand my pain whether spiritual-emotional or physical [rather than that of the HS type]. She was also professional about her role and that of the SW, yet fluid enough to be there ready to counsel [spiritually] from her life experiences if that were necessary at that time. She would assess this situation as well. She was knowledgeable about symptoms and symptom control which would give the confidence that was imperative to quality caring.
She had memories of being caring and she gave of them willingly even though the caring was of the 'hands-off' type, helping someone gain independence.
She was willing to learn from experience: from patients and others; so that she was not saying that she knew 'it all' even after nine years of experience. She showed that she had learned patience and professionalism through nursing a patient who stayed for two years and who made 'gruelling demands'. She showed love and caring for her in spite of her ways. Through this 'very incredibly stretching experience' she was taught 'a great deal about suffering and caring' and was volitionally motivated to do so. PW was aware that people could 'grow' spiritually through caring and unconditional love.

PW had her own intrinsic standard of care. She called it 'optimal care'. It implied having empathy and understanding for patients. Spending time talking to them, doing basic care: nails, hair; and listening. It meant being gentle with patients and going at a slower pace. This kind of care was special [for both herself and her patients, she implied]. The opposite of this for her was having no time, being rushed. And she itemised rough handling, being 'practically quite harsh' and 'ungentle'. She was aware that the caring being given at this time was below the standard set previously. She felt it to be at the level of a State Hospital where one would never feel that one had finished off the day properly.
She had deep concerns, even fears, about caring because of the way she felt the hospice to be going due to financial constraints. That this would mean that the hospice would 'lose some of this very special care in the process'. Yet she was unsure as to how things could be changed. She understood about the staffing level from the financial point of view but felt that they could not 'possibly continue the kind of care they used to give' when they had a high registered nurse to patient ratio. She felt that improvements could be made if there were more in-service training. This would at least stop time wasting and take off a work-load.

I would like to ask her
Why she wrote "Loving" in inverted commas [under best memories of caring].
Who D is/was.
What she understands by the terms 'professionalism', 'spiritual' and 'inspiration' in the context of caring.