

Spiritual Care in Clinical Nursing Practice: Myth or Reality?

Janice Lynn Hoover

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Janice Lynn Hoover

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Abstract

This study aimed to explore the experience of patients and nurses with respect to spiritual care in order to enhance the latter. A review of the literature revealed that nurses tend to either overlook this domain of their practice or poorly identify and meet patients' spiritual needs. Only one study, employing ethnography within a hospice, examined the actual process of care delivery from both nurses' and patients' perspectives. Spiritual care giving was generally found to be a myth, as the nurses, despite understanding that they should engage with patients at a deeper level, chose to cheer patients up rather than deal with their distressing emotions.

A narrative approach was adopted in order to capture the process of spiritual care giving more holistically. The researcher worked as an unqualified nurse in each of two settings, a hospice and a general medical ward, one day weekly over nine months. Data, written as stories, were generally entered in a field journal later each day. The most meaningful stories in answering the study's aim were then reflected upon and re-written to comprise the final thesis.

It was found that through suffering, there is hope and the potential for transformation. However despite an expectation that spiritual care, generally associated with dying, might be superior in a hospice, it was found to be barely evident although not necessarily nonexistent in both settings. Nurses experienced tremendous difficulty accessing their sacred space such that they might engage with patients at a deeper, spiritual level. Their working environment and educational preparation, influenced by the manner in which nursing has adopted evidence-based practice, appeared to further hamper this process. The insights gained from the study suggest that if spiritual care giving is to become more of a reality, considerable changes in these areas and within the profession itself are required.

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Chapter 1

Introduction and Orientation

1.1 Introductory narrative to my thesis

When I was writing the final chapter of my thesis, I was reminded very sharply of why I left clinical nursing practice twenty-five years ago. Indeed that story seemed to sum up so much about what I felt that I was saying in my thesis that I felt that I should employ it as a frame for the entire work, and so I will introduce it here as such.

I had been working as a junior Sister on an acute care of the elderly ward for two years. I arrived at work one morning and was surprised to see the senior Sister ('Sally') there. Her car had not been parked outside and so I had assumed that she was not on duty. I asked Sally how she had come to work and she told me that she had taken a taxi as her car was being serviced. Quite a few nurses were on duty that day and the ward was unusually very 'quiet' with fewer patients than normal and requiring less nursing care than normal. At about 11 a.m., I took several junior staff nurses and nursing students into the ward treatment room to teach them how to order the ward stock stored therein (two other nurses and Sally remained out on the ward to attend to any patients' needs). I do not believe that I had ever done this before, but as I was going to order the stock and as the ward was so quiet and the work for the morning had been completed, I decided to take the opportunity to teach others about this aspect of the qualified nurse's role.

At about 11:20 a.m., while I was still teaching, Sally poked her head around the door and asked to speak with me. She informed me that she had just received a telephone call from her sister-in-law who was very distressed. The latter had called in at her mother's home to find that her mother appeared to have had a stroke. Sally told me that she felt that she should go to be with the two of them immediately.

"Okay. I'll drive you there", I said (it was just a ten to fifteen minute drive to get there).

“No, no, you don’t need to do that. I can take a taxi”, Sally replied.

“No, honestly, Sally, I don’t mind at all. My car is parked just outside and I can get you there quicker than if you take a taxi. It’s coming up to lunch time so I can take the time as an early ‘lunch’. Besides, I’m only teaching how to order the stock. I can finish that later or another time. And ‘Dee’ is here (Dee was our most senior staff nurse). She can be in charge of the ward while I’m gone.”

When Sally had told me that she would take a taxi, I was thinking about a night when I had been seventeen years old. My father had been in a car accident and my family had been telephoned in the middle of the night to come to the hospital. We had taken a taxi because no one could drive, and while it had been a journey of approximately the same distance as Sally would be making, it had seemed such a long, lonely and frightening experience, even surreal, not helped by the fact that we had been in the presence of a complete stranger (the taxi driver). I thought that it would be so much nicer for Sally to be in the company of someone whom she knew and who cared about her, not to mention that I could get her there more quickly.

“Well, alright, then. If you’re sure”, Sally replied.

“I’m sure. I want to take you rather than you getting a taxi.” We informed Dee of what was happening (she was happy with the agreed plan), gathered our coats and left the ward.

I arrived back on the ward approximately thirty minutes later. Dee approached me and told me that while I was gone, one of the hospital’s Nursing Officers (‘Mrs. B.’) had come to the ward and asked to speak with me. Dee had informed her where Sally and I were. Dee also told me that Mrs. B. had not seemed at all happy about that. I wondered briefly what that was about and then carried on with my job.

About two days later, Sally and I were on duty together again. Mrs. B. came to the ward and asked to speak with us. We led her into the Sisters’ office whereupon Mrs. B. began to launch into a tirade about how irresponsible I had been to leave the ward to drive Sally to her mother-in-law’s home. Sally immediately stepped in, stating that if anyone was at fault, it was the *two* of us and not just me. Mrs. B. was having none of it, told Sally to “be quiet and keep out of it”, then asked her to leave the office and continued with her tirade against me. It appeared that the hospital

had a system whereby every shift a rota was drawn up listing staff to attend an airport emergency should one occur. Our hospital was the nearest to the local airport and if there was an accident, we would get the call out. My name had been on the list for the day when I had left the ward and so I should not have done so without first informing the Nursing Officer on duty and clearing it with her.

I had known that if there was an emergency involving the airport that our hospital would be asked to send staff to attend. During my induction programme two years earlier, I had been with my Nursing Officer when he had opened a large cupboard in an office to get something. The cupboard had been full of Wellington boots (about thirty pairs) in all different colours and sizes. I had asked what on earth they were all for (it is not the usual thing in an office cupboard!), and he had told me as above. I remember thinking at the time that if there was an emergency and I had to attend, I would not be terribly keen to run swiftly across muddy fields to arrive at an air crash. I had never done accident and emergency nursing and had felt that I would be relatively useless in such a crisis. I could see myself running, but I would be happy to let other people who might be more useful overtake me to arrive at the scene first! What I had not known, because I had never been told, was that there was a rota drawn up for each shift of every day, listing staff to attend an emergency call out.

As Mrs. B. continued to rant and rave at me, I remember feeling an extremely powerful urge to lie down on the floor in the office, roll around and howl uncontrollably with laughter. To this day, I do not know how I managed to remain standing upright and also to stop myself from laughing. In my entire working life (eighteen years at that point in time), I had never even been gently reprimanded for anything and here I was being screamed at for caring for my good friend and colleague, Sally. Also, how was I supposed to be responsible for something of which I had no knowledge? Instead, I had acted on the knowledge that I had of the situation and in the situation, and done what I thought was the caring thing to do. Further, if I had received a call to go to an emergency, I would have asked Dee if she would go in my place. Dee had done some accident and emergency nursing and had told me that she loved all the action and excitement. I was sure that she would have jumped at the chance to go! At any rate, Mrs. B. simply did not want to know or indeed hear anything from me (I tried to explain myself but she refused to listen). It seemed that in her mind, I was merely to stand there, accept her

judgement and authority and accept responsibility for being, in her view, utterly irresponsible. "I need to get out of this profession very soon", I thought. "It's far too dangerous for me to remain within it." I had considered myself extraordinarily lucky to have held myself together on this occasion. If something similar happened again, I might not be so lucky. It was not long thereafter before I did leave.

1.2 Introduction to the thesis

There are a number of issues in relation to the above narrative and I will be eliciting and expanding upon them throughout my thesis. First, though, in this chapter I will present the background to my research, the aim of my research, the broad process of how I conducted my research and a narrative from my personal life which demonstrates the positioning of myself as a spiritual person within my research. The latter is included so that the reader may have some understanding of how and why I have conducted my research as I have. Stemming from this and from nursing literature on spirituality, I will then set out my views on spirituality within clinical nursing practice and finally, based on these, my theoretical framework for my thesis.

1.3 Background

The role of spirituality in physical and mental health and general wellness has been examined by a vast number of studies which generally report positive correlations (for example, Levine & Targ 2003, Wink & Dillon 2003, Faull et al 2004, Kirby et al 2004, McCauley et al 2008, Anema et al 2009, Dalmida et al 2009, Ironson & Kremer 2009, Johnstone & Yoon 2009, Vallurupalli et al 2012) and support the idea that spiritual care is an important component of healthcare and spiritual well being a desirable health state.

The World Health Organisation recognized the position of spirituality with respect to health in 1993 by including it as a component of quality of life (WHO 1993). Subsequently, the Royal College of Nursing (RCN) (2003: 3) officially incorporated spirituality into nursing practice by defining nursing in the UK as

the use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to

achieve the best possible quality of life, whatever their disease or disability, until death.

Any confusion that might have surrounded the nurse's role in delivering spiritual care was eliminated by the RCN further setting out the defining characteristics of nursing. They (RCN 2003: 3) explicated 'physical, emotional and spiritual support' as modes of nursing intervention and the specific domain of nursing as

people's unique responses to and experience of health, illness, frailty, disability and health-related life events in whatever environment or circumstances they find themselves. People's responses may be physiological, psychological, social, cultural or spiritual, and are often a combination of all of these.

The focus of nursing, then, is

the whole person and the human response rather than a particular aspect of the person or a particular pathological condition (RCN 2003: 3).

The provision of spiritual care should thus be an integral part of nursing practice. Contemporary nursing philosophy acknowledges the role of spirituality in health and well being by embracing the concept of holism (for example, Rogers 1986, Dossey et al 1995 & 2009, Parse 1998 & 2007, Watson 1999 & 2005). This stresses the importance of caring for the whole person, including the spiritual aspect. The literature suggests, however, that health care providers frequently overlook the spiritual dimension of care, and when they do not, they are generally very poor at identifying and meeting patients' spiritual needs (for example, Highfield & Cason 1983, Greenstreet 1999, Lo & Brown 1999, Kuuppelomaki 2001 & 2002, Ross 2006, Koslander & Arvidsson 2007, Moss 2007, Van Dover & Pfeiffer 2007, Deal 2008, Bailey et al 2009, Tanyi et al 2009, Mok et al 2010, Murray 2010, Royal College of Nursing 2010, Williams et al 2011). Exceptions are studies with samples of nurses considered spiritually self-aware (for example, Bailey et al 2009 and Van Dover & Pfeiffer 2007). Further, virtually all of this literature examines the provision of spiritual care from the sole perspective of either patients or nurses, and

the vast majority of it does not consider the process of care delivery in any real depth. Four of these studies (Moss 2007, Van Dover & Pfeiffer 2007, Deal 2008, Tanyi et al 2009) do accomplish the latter, but as above, only from the nurses' perspective.

In order to fully appreciate how and why spiritual care giving is lacking, it would seem useful to examine the actual process of spiritual care giving, what happens *between* nurses and patients. Only one study (Vivat 2008) could be found which examined spiritual care giving in depth from both the patients' and nurses' perspectives within a hospice. Ethnography using participant observation and interviewing was employed, although for much of the study when the researcher was on the actual ward areas, non participant observation was enacted. Spiritual care by nurses (and other hospice workers) was generally found to be nonexistent, more a myth than a reality. Death and dying were never observed being discussed between the nurses (and other hospice workers) and the patients. The nurses understood that spiritual care involved engaging with patients at a deeper level than their usual chat, and dealing with their distressing emotions. However they chose not to do this, but to cheer patients up instead in an attempt to shift them from their distressing emotions. The findings suggest that the nurses were frightened of patients' distressing emotions and felt that they could not cope with them. Time was also considered to be a factor in nurses choosing not to 'get deeper' with patients.

The literature demonstrates the need to improve spiritual care giving in nursing and to investigate this topic area from the perspective that has been under-researched, specifically as the process of such care giving is experienced (inter-)subjectively by both nurses and patients. An in-depth examination of the process of spiritual care giving, incorporating both the care recipients' and care givers' experiences, might shed useful light on the status of spiritual care giving in clinical nursing practice, and if it is (more of) a myth than a reality, how nurses might improve this core domain of their practice.

This study, then, is an inquiry into the experiences of patients and nurses in relation to spiritual care in two settings, a hospice and a general medical ward at a large teaching hospital. I was intrigued to see if there would be a difference between the care delivery in the two areas, especially as it might be expected that spiritual care

might be better in the former, given its patient population, largely cancer patients, and general association with dying which is commonly linked to the concept of spirituality. As a lecturer at a university in the UK, I have had an interest in spiritual care giving in nursing since I attended the first multidisciplinary conference on spirituality in the UK in 1997. I have developed and taught post-registration modules focusing on contemporary nursing theory and especially on the concepts of holism and spirituality. I was keen to learn about the experience of spiritual care giving with a view to how it might be enhanced and it was in this vein that I approached the research.

1.4 Aim of my research

My study aims to explore the experience of patients and nurses with respect to spiritual care in order to enhance spiritual care giving in nursing.

1.5 Broad process of how I conducted my research

I obtained ethical approval to conduct my study from the Local Research Ethics Committee and additionally, in the case of the general medical ward, the Trust Research and Development Office. To collect the data for my research, I worked as an unqualified nurse for one seven and a half hour shift of duty per week for a total of nine months between October 2003 and August 2004 in each of two care settings - a hospice and a general medical ward in the UK.

In my role, I participated in and observed care giving and informally (and sometimes more formally) interviewed study participants. Nine nurses from each of the two care units (eighteen nurses in total) participated in the study. All qualified nurses involved in caring directly for patients admitted to each care unit (apart from those who worked only night shifts, because for the sake of convenience, I collected my data only on day and evening shifts) had been invited to participate. The number of patients whose nursing care I observed in my study was ninety, forty-four on the general medical ward and forty-six at the hospice. Of these ninety patients on/from whom I collected my data, I selected six for in depth analysis in my thesis. Eligible patients to participate in the study were all patients admitted to each care unit over the period of time that the researcher was collecting her data and who were able to give consent to participate themselves. (See Appendices A & B for participants' study information letters and Appendices C & D for study

participants' consent forms based thereon). I also attended nurses' 'handover' reports (when one group of nurses gives an oncoming group of nurses a verbal report on their patients' conditions, treatments and care at the end of their shift of duty) at the start and end of every shift that I worked to observe the nurses' accounts regarding my observations of the care that had been provided. Additionally in this vein, I observed the nurses' written documentation of their practice, although only when I considered it might be of especial interest to me. I also attended every weekly multidisciplinary meeting, or 'grand round', at the hospice. On the general medical ward there were no such meetings, so instead I managed to join two or three of the doctors' ward rounds (they were never scheduled in advance). Throughout my period of data collection, if there were patients or issues that I wished to pursue over time that I felt were of particular value to the study, I endeavoured to do so.

For approximately the first four months, I worked primarily at patients' bedsides, gaining an insight into their perception of spirituality and spiritual care and generally observing the ward culture from a bedside perspective. However the qualified nurses were rarely at the bedside. Therefore I felt that I needed to change my position as a researcher to explore their world. For the remaining period of my data collection, then, and with their consent, I shadowed one qualified nurse per shift, eventually shadowing all of the nurses who had consented to participate in the study two to three times each.

I kept a field journal to record all of my data (for a breakdown of its composition, see Appendix E), including that obtained from interviews and conversations with my study participants. Recording of my data generally occurred within twenty-four hours of their occurrence so that it would most accurately represent my experience. I quoted elements of people's speech as I remembered them and have included these data in my thesis to enliven the text such that the reader (and me, in the process of writing up my thesis) may experience it more directly and thus engage with it more fully. In no way are the quotes meant to represent the reality of what happened, but rather my interpretation of that reality.

In terms of writing up my thesis, I selected stories of patients and nurses that I felt contributed most meaningfully to answering the terms of reference for my work.

These are stories which captured, in the main, what I observed overall, as well as challenged me to expand my knowledge and/or consciousness (I will talk more about what I mean by the latter later in this chapter) about spirituality and spiritual care giving. I am presenting them, re-written and reflected upon, in the order that for me best tells my experience of researching spiritual care giving in clinical nursing practice, although I accept that this may have been accomplished in many different ways.

1.6 Positioning of myself as a spiritual person within my research

I employed narrative inquiry for my study (I will explicate the rationale for this later within the text) and my narrative about my experience as a researcher commences somewhat ironically at the tail end of my last shift of data collection at the hospice. I encountered the housekeeper, Meg, just outside the dayroom. She was strolling in her usual gently swaying fashion from side to side, holding the vacuum cleaner plug up to her mouth as though it was a microphone, and singing into it in her own little world. Behind her and in the distance stood the doctors and nurses at the main reception desk, going about their business in a more 'serious' manner. I burst out laughing at the irony that I perceived and which, I felt, summed up my research findings. Meg had really lifted my spirit on so many occasions at the hospice and I had witnessed her doing the same for many patients and members of staff throughout my time spent there. It was as though 'spirit uplifting' was her main purpose. Her spirit seemed 'free', unlike those of the healthcare professionals, and hence she seemed to be in a position to offer others something that they generally could not. While spiritual care giving is part of the role of healthcare professionals, I am fairly certain that it is not considered part of a housekeeper's role. There is considerable literature that extols the virtues of spiritual care giving in nursing (for example, Ross 1997, Hall 1998, Golberg 1998, Emblen & Pesut 2001, Raholm & Eriksson 2001, Cody 2007, Pesut 2010, Rumbold 2012), yet my research findings indicate that being a healthcare professional seems to militate against spiritual care giving. How is this so?

To begin to answer this question and in the vein of the notion that all interpretation is individual (Heidegger 1927/1962), I shall first position myself as a spiritual person within my narrative. The reader will thus be better able to comprehend how I have found spiritual care giving in nursing to be barely evident (although not necessarily nonexistent).

Perhaps a useful starting point in explicating what spirituality means to me was a major event in my life, the death of my first cousin, 'Aiden', which happened approximately eight years ago. Aiden was the same age as my twin sister, 'Andrea', and me. We grew up together along with his slightly older brother, 'Anthony', and in many ways, the four of us were more like brothers and sisters than just cousins. Andrea and I spent every summer at the home of my uncle 'Brendan' (Aiden's Dad) in Toronto from the age of nine to sixteen. The two families were and still are like one.

Aiden had emphysema and Brendan telephoned my sister and me in October 2004 and asked us to come to Toronto. "The doctor says that it's possibly only a matter of days." I had no idea that things had progressed that far. Only a month or so previously, Brendan had told me that Aiden was still planning on trying to find work again (he had been unemployed for about two years after being made redundant). Aiden's much younger sister, 'Charlotte', also rang Andrea from Vancouver where she lives and begged us to come to Toronto. "I simply can't face it unless you (meaning Andrea and I) are there", she told her. Charlotte had only just returned to Vancouver having spent the better part of August and September helping Brendan, who was then in his mid eighties and suffering very badly from macular degeneration and early senile dementia, move from his three-storey house into a small apartment in a seniors' residential complex.

Our plane was delayed and Andrea and I arrived in Toronto very late in the evening. The next day, we were all awakened by an early morning phone call from Aiden's doctor. "I think that you had better come to the hospital straight away." A scurrying frenzy in the tiny apartment, and the four of us (Brendan, Andrea, Charlotte and I) arrived at the intensive care unit within the hour. "Aiden has end stage emphysema", the doctor explained. "He can never come off the respirator. He is sedated. When we gave him the news, he was beside himself. As he will never recover, we'd like you to think about turning the machine off. Even if he remains on the respirator, he'll die within a year or so from complications and possibly suffer along the way. He's got yet another chest infection now. He can't keep fighting them. His death is inevitable."

We were reeling. Aiden's imminent death was bad enough, but never had I imagined being in this situation, being asked to have a hand in ending his life. We spent most of that day keeping vigil at Aiden's bedside. His tall, lanky body, almost unrecognizable in appearance, was inanimate and lying motionless in the bed save for his chest rising and falling in harmony with the ventilator, echoing the fact that Aiden and his ventilator were as one. Andrea told Charlotte stories of Aiden from our shared childhood with him – stories of Aiden standing up for himself for justice and dignity in the face of adversity and against all odds. Charlotte, in turn, shared stories of him as a big brother, teaching her life skills such as riding a bike and fending for herself physically (it was a tough neighbourhood). The stories warmed all of our hearts, representing Aiden as we knew him and giving meaning to his life.

As the four of us left the ward, we passed by Aiden's doctor. "It's a tough decision for families to have to make", he told us. "Don't worry about what we might think of you." I looked him straight in the eye and responded immediately in a polite yet firm tone of voice, "I can assure you that we don't care what you think of us." A gentle, knowing smile appeared on his face instantly and he said nothing more. His smile felt like one of acknowledged wisdom.

The next day, after a second fairly sleepless night, we got up and prepared to return to the hospital. We made it as far as the pavement outside Brendan's apartment block. Charlotte just stood there. "I can't go there. I just can't." "Well, we don't have to", Andrea replied instantly and matter-of-factly. There was a quick confab, ready agreement that we would not go (no rationale was spoken) and we all headed further into the downtown area instead. I felt slightly guilty, yet an enormous sense of relief that I would not have to spend the next few hours at Aiden's bedside. Witnessing him in such a helpless and vulnerable state was so difficult – it certainly was not the Aiden I knew. It was a bright, crisp and cold autumn day. Small, splendidly vibrant, red maple trees were everywhere, some of their leaves beginning to dust the ground.

Red maple leaves f

a

I

I

Gently to the cold, hard earth

The beauty of death

We meandered through the streets, Brendan did some banking and we ate lunch at the city's largest downtown shopping centre. We arrived back at the apartment mid afternoon. Andrea, Charlotte and I went up to the rooftop gardens for some fresh air. We shared our feelings of grief, more stories from the past that captured Aiden's essence and the pressure we were feeling. Charlotte especially was beside herself. "I just don't know what to do", she repeated several times over. "I love him and I can't bear to see him like this, but equally, I don't want to take his life."

Andrea had told Charlotte and Brendan the previous day that she did not feel that she or I should be actively involved in the decision about switching the ventilator off as we were not immediate family (in the legal sense). I had disagreed with her and later when we were on our own, argued, "we're leaving them (Charlotte and Brendan) to make this decision on their own." (Neither had seemed at all enamoured by her statement - stunned more like.) "We are like family. It will be easier for everyone if we share the responsibility of this decision. ('Everyone' included me. It felt unbearable to be suffering so much without a voice.) We've rung Anthony and there's no sign of him coming. Charlotte will be feeling so alone (as Brendan did not appear to be fully in the moment for much of the time, possibly due to his senile dementia, possibly through shock. It was hard to decipher)."

As I stood beside Charlotte on the roof in the afternoon sunshine, she began sobbing uncontrollably. I wrapped my arms around her tiny, short frame and held her. Andrea joined us and the three of us cried together for some time. We stood in a tight huddle, feeling some warmth (and not just in the physical sense) in our circle.

We all headed back to the hospital in the late afternoon and sat silently and in tremendous pain around Aiden's bed in his cubicle. Charlotte, who was positioned beside me, began sobbing uncontrollably again, even more painful to witness as she has never been given to tears, at least not in public. I rolled my chair right up to hers and put my arms around her again. Her tiny chin rested in the space between my neck and shoulder, bobbing with each and every sob. "I can't bear to see him like this. I can't bear it", she managed to get out. I began sobbing uncontrollably as well, echoing her sentiment. I wanted Aiden to be taken off the ventilator and allowed to die. Aiden had always valued dignity and I felt that he would not want to be left like this. Meanwhile, Andrea had suggested to Brendan that they leave us alone and the two of them left to go get some coffee. Alone with Charlotte and feeling desperate to have a voice and to speak the truth as I perceived it, I eventually pulled myself together enough to say, "I don't see any dignity here. I just don't see it." I felt immediately empowered. "No, neither do I", Charlotte replied starkly. Downstairs with Andrea, Brendan expressed that like Charlotte and me, he was finding the situation unbearable. Over the course of the next hour or so, we all agreed that we would ask the doctor to turn Aiden's ventilator off. We returned to the apartment and telephoned Anthony who lived several hundred miles away. He agreed as well. We then rang 'Nicky', Aiden's ex-partner of twenty years, informed her that Aiden's condition had deteriorated and suggested that she might like to visit him that evening.

We were back at Aiden's bedside by about 8 p.m. We sat silently around him as before. Nicky arrived an hour and a half later. We reminisced for about an hour together and then Nicky asked to be alone with Aiden. We waited downstairs in one of the hospital's seating areas. Nicky met us there about another hour later. She thanked us for asking her to come and we told her of our decision to ask the doctor to switch off the ventilator that night. "It should have been done a while ago", she said. "It's not right for him to be in that state." Coming from the person with whom Aiden had shared most of his adult life and who still loved Aiden deeply, I felt that Aiden, through Nicky, was endorsing our decision. We had asked Nicky directly if Aiden had ever said anything about his wishes should he be in this type of situation. She told us that he had not. We invited Nicky to accompany us back to the cubicle but she declined. We took turns hugging her goodbye and watched as she disappeared down the long corridor to the world outside.

It was just coming up to midnight. We gathered ourselves to our feet and slowly but very purposively, with me leading the way, processed back to the unit. We stopped at the reception desk and I informed the staff of our decision. We planned to stay with Aiden until after he died however long it took. "You want to stay?" the staff asked incredulously. Perhaps they thought that we would naturally prefer to distance ourselves from our decision and any further unpleasantness that we might witness in the course of Aiden's death? In my experience, nurses normally like patients to die with their families present. It is generally considered somewhat of a tragedy for people to die alone in our culture. They explained to us what we could expect to happen, including that Aiden might become very physically distressed as his body would try to breathe on its own and that it might take up to twelve hours for him to die. We calmly nodded our understanding and proceeded to Aiden's cubicle. We were barely there before three nurses arrived to administer Aiden a bolus dose of diamorphine and to turn off the ventilator. As quickly as the nurses had entered the room, they then disappeared, leaving us alone.

We drew the sliding doors to the cubicle tightly shut so that we could have privacy and sat around the bed, again in vigil. This time, Charlotte sat on the bed, her legs folded up, by Aiden's legs. I had asked (for Charlotte's sake, really) if we could light a candle that she had brought but, as expected, we were told that this would not be possible because of the oxygen points on the unit and the risk of fire. Charlotte had placed the candle in its small holder on the bedside shelf alongside the bed. It stood there proudly, as though invisibly lit, and serving the purpose for which it was intended – to represent the sacredness of the occasion. The room was completely quiet. The whole unit was completely quiet. Charlotte held one of Aiden's hands in hers and gently stroked it, Andrea the other. Tears streamed silently down Charlotte's tiny bespectacled face. After about fifteen minutes, her head held high and through her continuous tears, she began to sing several verses of a hymn-like song that she had composed. Every note was perfectly clear. I have never witnessed such dignity and poise. "I love you, Aiden. I love you so much," she called out gently after she had finished. The beauty of the moment blew me away. Time stood still. Aiden died peacefully shortly thereafter. I have never felt so privileged.

A hymn sung through tears

As a precious brother dies

of love

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The P

In the moment, when Aiden died, the power of love overwhelmed me. I remember thinking that if I had been born to be present for one moment in my life, this was it. I felt full of love, totally in tune with myself, my family and the universe.

As a young child up until the age of eight, I was not exposed to any religion. My parents, to the best of my knowledge, were not (particularly) religious and they did not attend any church. Through literature and their own teaching and example, however, they instilled in me a moral code by which I should live my life.

From the age of eight until fourteen, I attended a Protestant church Sunday school and became a confirmed member of that religion at the age of fourteen. However my attendance and subsequent confirmation were not of my own choosing and I cannot say that I was ever (particularly) religious. I viewed the teachings of Christ/the church as the foundation for a respectful community who share a code of upstanding moral values upon which, hopefully, they would base their actions (similar to and perhaps extending what my parents had taught me).

Over the course of my mid to late teenage years, I became an atheist. I do not know if it was a sign of the times (the mid to late nineteen sixties) when the age of science and technology was in its fairly steep ascendancy (or certainly, that is how it seemed to me then), but this was also a time in my life when I was introduced to the more in depth study of a number of sciences. 'Reason', of course, was the prevailing order of the day (or so it seemed to me then) and 'God', at least in the traditional sense, did not seem to fit into this schema.

I remained an atheist until my mid forties when, in the autumn of 1997, I attended the first national multidisciplinary conference on spirituality in Durham, England. I

went with a colleague to a meditation workshop there. I had never meditated before and wanted to experience something new. I was sitting in a comfortable armchair and within five to ten minutes after the session started, began to feel a force gently but firmly holding me in my chair around my groin, like a seatbelt. Its presence felt protective and reassuring. I then felt a constant, gentle lapping of fluid within the upper portion of my head (as though my head was a vessel approximately three quarters full of a fluid) followed by an experience of being part of an infinite universe comprised of what looked like a dark empty space. Everything and everyone, including me, was in this universe, but there was nothing to be seen. Yet the universe was a whole – full of love. I remember being completely stunned by the immediate certainty of what this meant to me. I had never so much as thought or heard of it before (at least not consciously), but I realized that this was the reality of everything. Everything was nothing (in form), including me. And everything was one and the same – pure love. I was in a state of what could only be called complete joy, feeling that I was totally comprised of and enveloped in this love. For days afterwards, I remained so joyful that I felt like I was walking on air. I also felt so privileged to have experienced what I had because I knew that it would have a profound impact on my life. I did not yet know how, but I knew that it would because I could never go back to perceiving things they way that I had before. I knew nothing about chakras when I had my experience as above. I later learned that they form part of an ancient spiritual system and are considered to be sacred centres within our bodies that facilitate development toward enhanced awareness and transformation, ultimately revealing the path to spiritual enlightenment. The first chakra at the base of the spine (in line with the groin area in my experience) is thought to form our foundation or grounding and to bring us a sense of security. This is how I experienced my sensation at that level, as though I was being prepared to embrace what was to come. The sixth chakra (or ‘third eye’) is at the level of the brow (the level at which I felt the fluid lapping in my head) and is meant to open our psychic faculties or enable us to ‘see the light’. It was just after my sensation at this level of my body that I had my transformational experience (Judith 2002).

I do not follow any religion (I now consider myself to be a spiritual person and will discuss more about that later) but I have found aspects of Buddhism useful in the manner in which they seem to relate to my experience and my spiritual development since (including how I developed up to and through Aiden’s death). I read about Buddhism shortly after I had finished collecting all of my research data.

In Buddhism, the experience that I had is termed the stage of perfect vision – a glimpse of the connectedness of all living things, how things really are. Buddhism proposes that everything is interdependent and interconnected, changing momentarily subject to the coming together and disintegrating of the causes and conditions. Everything exists only in one single moment. There is no permanent good or bad. We experience things when the causes and conditions are present and when they are no longer present, things cease to exist. Thus all phenomena are impermanent, interconnected and interdependent, existing in a relative state.

Buddhism proposes that the vast majority of us live our lives in a conditioned state of ignorance called samsara in which we perceive phenomena, particularly ourselves, as real, concrete or substantial. However because nothing lasts, we suffer. Seeking security, we create a delusion of solidity and intrinsic separation. We sort the world into subject and objects - 'me' (permanent solid ego-identity) and 'not me' (everything else). As a result, we become attached to ourselves and the things that we desire. We then further sort the world into things that we find pleasure in which we strive to integrate into our ego-identity to provide us with a sense of security and things we do not like which we attempt to avert and keep separate from our ego-identity at great expense because they render us with a sense of insecurity. We seek security in the intrinsically insecure, thus struggling in continual discontentment in between. In the modern technological world founded in outer material development and neurotic attachment, especially to our ego, the ultimate security we strive for cannot be found. Real security exists in learning to live in the moment with absolutely no neurotic attachments in a state in which we experience our fundamental interconnectedness with all of life. Instead of grasping some people or things and averting others, we allow things to just be as they truly are and not what we wish them to be. In this state, we are liberated to respond to all living things with loving kindness, great compassion and wisdom. It is one thing to achieve this cognitively but quite another to realize it from the depths of our being such that our behaviour may be altered by our glimpse of the perfect vision (Kulananda 2000).

At approximately the same time that I was learning a little about Buddhism, I was also reading Wilber's (2000) work which not only encompasses the Buddhist view but extends it beyond the bounds of all religions. Wilber (2000: xii), a philosopher,

attempted to credibly mesh “the many pluralistic contexts of science, morals, aesthetics, Eastern as well as Western philosophy, and the world’s great wisdom traditions”. The conclusion that he drew from this process is that “the world really is one, undivided whole, and related to itself in every way”. Human development, or the development of one’s spirituality, is a process of going further *within*, thus going further *beyond*, to embrace a *deeper identity* with a *wider perspective*. As humans transcend each stage of development or level of consciousness, they become less egocentric. At the highest level of consciousness which Wilber terms ‘nondual’ because there is no subject-object duality and which very few people ever attain yet many glimpse occasionally, the self’s identity is with and as *all* manifestation or Form – all humans, nature and the physical cosmos. Wilber calls this self-liberating, nondual state ‘transpersonal’, meaning that the soul, without persons, is grounded in God. As Wilber (2000: 289) explains, “the Witness in you transcends the isolated *person* in you” (or your empirical ego), and opens instead . . . onto a vast expanse of awareness” which is silent and empty and the light and power of the Over-Soul, or All, shine through you. The emptiness is the fundamental nature of Form. The *depths* of the self are exposed.

Spirituality is thus known and experienced subjectively and inter-subjectively through relationships. It may involve a process of self-transcendence or new relationship with self/other(s). Following my experience and well before I had read anything about Buddhism or Wilber’s work, my life began to change fairly considerably. The religious teaching that I had first encountered in my childhood, ‘love thy neighbour as thyself’, became far more meaningful. I now *knew* my neighbour, indeed all neighbours, as myself and the implication of this was that I should therefore treat my neighbour(s) as myself. Wilber (2000) expresses that this awareness is the only source of true compassion. I became generally more mindful that if I am to be who I really am (Wilber’s (2000) ‘transpersonal’), I must embody that in my relationships/dealings with myself and others. Otherwise, I will be acting against my true nature and be in conflict with myself. I also realized even more than previously that if I am to treat my neighbour(s) as myself, I must *know* my neighbour(s). I certainly endeavour to treat *myself* according to what my own thoughts and feelings are (by consciously trying to tune into them more)!

I was educated as a nurse in a Canadian degree programme which actively promoted the importance of nurses really getting to know their patients well (so that

they might meet their needs). This was considered the crux of all good nursing care. For example, we were encouraged to know what having their condition and/or receiving any treatment meant for our patients and their significant other(s). We were never part of the workforce in the way that British nurses still are despite their supposed supernumerary status and that privileged position allowed us, in the main, to care for just one patient at a time, uninfluenced by the ward culture. In this manner, the 'theory' of the classroom became reality. Buber's (1970: 173) 'I-Thou' relationship perhaps best describes the type of relationship that we were expected to develop. That is one in which two people are electively present, passively and actively at the same time, in a reciprocal relationship with their whole beings such that each does "justice with an open mind to the actuality that opens up before (them)". (Conversely, an 'I-It' relationship, according to Buber (1970) is one in which one person recognises the other as object and experiences and uses the other as such. The other is isolated such that s(he) does not feel exclusive or left devoid of feeling at one with the world.) Working to know others well was thus not new to me. It just became something that I tried to become ever more mindful of accomplishing.

Returning to my story about Aiden and my spirituality in relation thereto, when initially confronted with Aiden's imminent death, I craved his continued existence. I knew intellectually from the outset (when the doctor explained his condition) that as his death was inevitable and that he might well suffer along the way, the best thing to do would be to take him off his respirator and allow him to die. However my emotions prevented me from acting on this truth (Kulananda 2003). I was deeply, emotionally invested in Aiden's life continuing for a number of reasons. I will not go into all of them here but rather, to illustrate the point that I am making, merely present some. Aiden was part of my family and I did not want my family to change. Also, he had been a severe alcoholic for most of his adult life yet had begun to overcome this about two years before his death (although he had relapsed badly over his last year as his emphysema worsened considerably). I have a strong sense of justice and it seemed horrendously unjust that just as he was getting his life back in order, he should develop severe and ultimately fatal emphysema (even Aiden had expressed earlier in his life that it was his drinking which he thought would kill him). I also did not want him to die because while I loved him so much, I felt guilty that I had spent so little time with him as an adult. It was easier and far more pleasant not to be around him and not to have to tolerate (in his own words) his 'boorish behaviour' caused by his drinking. All of these reasons for me to want

Aiden to continue to live were about *me* and my sense of security, including my not wanting to suffer because of what I considered an injustice and my not wanting to suffer through having feelings of guilt.

At the same time, I remember the doctor's words, "when we gave him the news, he (Aiden) was beside himself", really standing out for me. At a deeper level, the instant that I heard those words (what I understood to be an expression of *Aiden's* feelings about his forevermore existence on a respirator (at least in this lifetime)), I knew that Aiden had to die fairly imminently, one way or another. His wishes *had* to be respected. It also registered with me that the doctor had most probably been the instigator in summoning my sister and me all the way from the UK to Toronto to help that happen. Apparently, various doctors had been asking Brendan to consider switching off Aiden's respirator for some time and Brendan had remained resolute in his refusal to allow that to happen.

At the end of our first visit to Aiden in hospital, when I assured the doctor that we did not care what he thought of us (if we had a hand in Aiden's death or not), I was employing the royal 'we'. I was, in effect, telling him that I was my own person - in the vein of Wilber's (2000) 'transpersonal'. I knew that I would be the embodiment of who I really am and 'do the right thing' (respect what it seemed that Aiden would have wanted) if I had to. Spirituality means being connected and true to your true (spiritual) self regardless of the consequences, for example, what others may think of you. I felt like the doctor and I were kindred spirits, having travelled the same spiritual path, when he smiled back at me gently and knowingly. I believe that he said nothing more quite possibly and simply because he felt the same way and hence nothing more needed to be said. As time went on, it seemed to me that the rest of my family were quite possibly not going to reach the point of taking the decision to end Aiden's life as soon as I would. Charlotte sought aversion to her suffering by refusing to go to the hospital the next morning and then later said that she did not want to take Aiden's life. Andrea was happy to take a back seat regarding involvement in any decision about what should happen with respect to Aiden. I bided my time.

As time continued to pass, the conflict within me grew. I felt an increasing urgency to 'do the right thing' by Aiden and end his life; I was not being true to myself. I

seized the opportunity when alone with Charlotte at Aiden's bedside to 'lay my cards down', so to speak, by asserting, "I don't see any dignity here. I just don't see it." It seems that Charlotte was ready to hear and accept what I was saying. Additionally, it seems that Andrea, meanwhile, had by this time also decided that enough was enough and encouraged Brendan to reach the same conclusion. When we met with Nicky later that evening, I took the opportunity of checking whether Aiden had ever expressly made his wishes known to her should he be in such a situation. Her response in the negative and subsequent expressed view that it was not right for Aiden to be in his current state were a further 'green light' indication that it was okay for us to proceed, that we *were* doing 'the right thing'. Thus after Nicky finished saying goodbye to Aiden, I led the way back up to the unit where he lay and informed the nursing staff of our decision. Aiden's death was beautiful as I had envisaged that it could be because we, his family, felt true compassion for him. Aiden's death was not about our sorrow but about him being released from his suffering.

It is impossible to say how things might have turned out differently had I not had my spiritual 'experience'. Aiden's death at such a relatively young age was, I think, what most people would consider (somewhat) tragic (although, of course, we all must die at some time and time is nonexistent in reality, as I have described). I still love and miss Aiden tremendously, but I have never felt that we did the wrong thing by ending his life as we did. In comparison, approximately twenty-five years ago, when two of my work colleagues died in their twenties, one by suicide and the other killed by a drunk driver, I was unable to deal with their deaths. I felt angry and insecure for over six months, maybe even up to a year. I do not think that I ever really came to terms with their deaths at that point in my life, more like the painful suffering just wore off gradually. As I have described, though, it would seem that a degree of mindfulness and awareness in relation to my glimpse of reality has enabled me to embody that reality in the case of Aiden's situation; I was able to let go of my various attachments in relation to Aiden, connect with myself as a spiritual person and embody the love or compassion of the universe by enabling Aiden to die. Of course, as Wilber (2000) points out and my narrative about Aiden attests, my mere glimpse of reality renders it virtually impossible to always embody that reality. I am on a never ending spiritual journey, hopefully of increasing levels of consciousness of reality. Foremost for me (and others) on my journey is that I endeavour to embody that reality as much as possible. I believe that spirituality is

something that should not serve the purpose of self indulgence but be practised for the benefit of humankind.

My spirituality, as I have attempted to illustrate through my narrative about Aiden's death, is about a life long journey of self-transcendence toward the embodiment of the reality of myself and the universe as I have experienced it. This means endeavouring to embrace myself and others with true compassion (I include myself as I believe, as the saying goes, that one must feel true compassion or love for oneself before one may feel the same for (an)other(s)). Thus spirituality for me concerns itself with relationship (with myself and others) and as my narrative above also demonstrates, self-awareness, mindfulness, critical reflection and finding meaning in what happens in my life. I further believe that the ultimate meaning for me may always be in the embodiment of my true (compassionate) self as that is what I have experienced in my life thus far. However, as any individual person, I have experienced but a relatively small range of the possibilities that may unfold in life. I am therefore open to other possibilities in terms of finding (ultimate) meaning.

1.7 My views on spirituality within clinical nursing practice

In the nursing and healthcare literature, spirituality is very conceptually diverse (Clarke 2009, Swinton & Pattison 2010). Fairly recently, it has been conceptually separated from religion. Religion is now considered a component of spirituality rather than defining it (Swinton & Pattison 2010). Spirituality is frequently associated with matters of meaning, purpose, love and hope (Murray & Zentner 1989, McSherry & Draper 1998, Sellers 2001, Tanyi 2002, Raingruber & Milstein 2007, Creel & Tillman 2008, Mok et al 2010). (For example, my family and I tried to find meaning in Aiden's life and hope for a good death for him.) Foremost, though, the literature suggests that while spirituality is a matter of individual interpretation, it concerns itself with connecting with self, others or a dynamic, transcendent being and/or self transformation (Reed 1992, Hawks et al 1995, Golberg 1998, Mahoney & Graci 1999, Humphreys 2000, White 2000, Logan et al 2006, Creel & Tillman 2008, Mok et al 2010, Rykkje et al 2011). Thus it matches reasonably well (at least in a broad sense) with my own understanding and experience of spirituality. (In my personal experience with my family concerning Aiden's death, I connected with my true (spiritual) self and as a result, transformed to being able to end Aiden's life, as

it seemed he would have wished. I feel that my family and I also connected with the love of the universe when Aiden died.)

So from my perspective, what does all of this mean for nursing practice? What might good spiritual care giving entail? What are my indicators of good spiritual care giving that determine my research gaze?

In their article examining how spirituality may be employed practically in nursing practice such that it is *useful* to patients, Swinton and Pattison (2010) stress that spirituality is individually determined and that for any individual this may differ in different contexts. Further, they argue that spirituality is about patients engaging in what they term as different 'quests', for example, for meaning, purpose, connectedness, and/or self transcendence (patients may be engaging in more than one quest at a time). Their point is that spirituality is a *process*, and that nurses should assist patients in that process, whatever it might be and however possible. The nursing role, therefore, may take many varied forms. Swinton and Pattison's (2010) views resonate with me and my experience (albeit in the case of Aiden, both he *and* my family and I might be perceived as having been in a process of questing and his quest was taken up by us as he was unable to actively engage in it himself. My own quest was to alleviate my suffering caused by not being connected to my true (spiritual self) and thus not being able to live in the moment as I have outlined above).

Of course, in order to help patients with their quests, nurses must become familiar with what these are. They need to get to know their patients well enough to determine this. Furthermore, they need to work in partnership with their patients as they engage in the process of questing, wherever this may lead (as I tried to do with the other members of my family in relation to Aiden's death). Being open to different possibilities and able to embrace uncertainty would therefore seem vital attributes for nurses to possess. (I tried to be open to the possibility of playing a role in ending Aiden's life (previously I had never even contemplated the possibility of doing such a thing), but I struggled initially with the uncertainty of what his death would mean for me in my life.) The ability to take risks, be self aware, mindful and critically reflect on their practice would further seem extremely useful. (I engaged in all of these activities in relation to Aiden's death, and they assisted me in the

eventual alleviation of my suffering. The risk that I took was in relation to telling Charlotte how I felt when we were alone at Aiden's bedside. I did not know if she was ready to hear such a thing, and therefore risked alienating her.) Also, Buber's (1970) I-Thou relationship would seem an appropriate relationship for nurses to engage in with their patients in this whole process. (I believe that I engaged in such relationships with my family, being present with them throughout their suffering in coming to the decision to terminate Aiden's life. Similarly, we all had an I-Thou relationship with Aiden, doing justice with an open mind (in the end) to the circumstance in which he was, by allowing him to die.)

My own understanding and experience of spirituality suggests that foremost, nurses should aim to embody the highest level of consciousness of reality possible with their patients (as I have described above in the story about my family). Swinton and Pattison (2010) make the point that patients quest for a reason – namely, they are looking for something that they do not have and are trying to obtain. Compassion would therefore seem most appropriate to offer such patients and especially as their quest(s) may be long, difficult and painful (and that is if their quest(s) is/are successful in the end. It/they may not be).

As mentioned above, Wilber (2000) determined that there are different levels of consciousness of reality and that these may expand over time. This means that in any practice setting, nurses may have different levels of consciousness of reality. (This may have also been the case with me and my family in my narrative about Aiden and, for example, my behaviour may have given (an)other member(s) of my family a glimpse of a higher level of consciousness. This, in turn, may have contributed to raising their level(s) of consciousness.) Is this not what Christ's (main) purpose on earth was? Is this not also what we hope to achieve (consciously or not) when we expose our children to fables as was done to me by my parents? Good spiritual care giving practice might usefully entail the employment of a similar strategy in the attempt to expand nurses' existing levels of consciousness. This might be achieved by the modelling, discussion and/or critical reflection of good nursing spiritual care giving within the practice setting. In other words, a good spiritual care giving environment seems important. (In terms of my family's situation regarding Aiden, the doctor and unit staff provided us with space to consider our decision which allowed us to connect to our true (spiritual) selves

and 'do the right thing', and the doctor made a point of telling us that they would be nonjudgemental of us.)

A final indicator of good spiritual care giving might be that nurses *make* time for spiritual care giving and/or for engaging in its various components as I have indicated above. Time may be finite but what is done with it is not. Again, the care giving environment might usefully allow for this, for example in terms of ensuring adequate staffing levels. (My family and I took the time that we needed to reach our decision.)

1.8 Theoretical framework

It has been argued (Paley 2008a & 2008b) that in an attempt to render spirituality universal to health care providers and those receiving healthcare and not just to those individuals who associate it with religion, the concept has been stretched within the nursing literature such that it may mean all things to all people. I have therefore attempted above to explicate what spirituality means to me with a view to providing the lens through which I view spirituality and through which I conducted my research such that the reader may understand my interpretation of my data. In order to focus that lens further, I will employ a theoretical framework comprised of the key elements of the meaning of spirituality for me to present my research findings. These key elements which underpin my narrative above and which are also widely prevalent in the literature on spirituality within healthcare and spirituality in general (as I have previously indicated) are as follows:

- connection/relationship with other(s) (for example, Kulananda 2000, Wilber 2000, Cohen 2002);
- sacred space (the space where we may embrace our deeper identity with a wider perspective in line with our level of consciousness, or connect with our higher self) (for example, Walsch 1998 & 1999, Wilber 2000, Cohen 2002);
- forces (internal and/or external) which influence sacred space (for example, Tolle 1999, Kulananda 2000, Wilber 2000, Cohen 2002);
- possibility of expanding consciousness/self transcendence (for example, Kulananda 2000, Wilber 2000, Cohen 2002).

Each chapter in the main body of my thesis employs my theoretical framework and thus examines the possibility of my expanding consciousness or self transcendence. As the latter does in fact occur, my narrative is one of ever increasing transformatory learning. The chapters have been written such that they reflect my journey in becoming a more spiritually caring researcher. As a result, in the earlier chapters of my thesis, I am depicted more often in 'I-It' relationships than in subsequent chapters.

Additionally, in writing my thesis, each time that I returned to re-write and reflect on a chapter, further transformatory learning occurred. I stated previously that I am presenting my thesis (its chapters) in the order that for me best tells my experience of researching spiritual care giving in clinical nursing practice, accepting that this may have been accomplished in many different ways. As my transformatory learning has been nonlinear and in the vein of nondualism, everything is connected to everything else, it has been somewhat challenging to determine the most logical ordering of the chapters and there is a certain amount of repetition within the text. I would therefore ask that the reader exercise a degree of patience in his/her reading thereof and especially if the reader's expanding consciousness is more advanced than my own at various stages. It is hoped that we will meet together at the end and that you may appreciate and follow my journey of expanding consciousness.

1.9 Summary

In this chapter, I have provided a broad picture of what my research is about and how I conducted it, why it is important for nursing practice, my views of what spirituality and spiritual care giving are from both a personal and professional perspective and based on the latter, my theoretical framework for my thesis. All of this is to contextualize my thesis for the reader.

Foremost, I believe that in line with Wilber's (2000) concept of nonduality and varying levels of consciousness in relation thereto, spirituality and spiritual care giving concern a potential for expanding consciousness/self transcendence (the generation of new knowledge), spirituality and hence spiritual care giving are of an individual nature and may vary in different contexts, and spiritual care giving should entail nurses embodying the highest level of consciousness of reality that they are able. In the practice of spiritual care giving and in order to facilitate the potential for

expanding consciousness/self transcendence, Buber's (1970) I-Thou relationship and critical reflection might usefully be adopted by nurses and patients.

In Chapter Two I will begin to explore how these beliefs about spirituality and spiritual care giving translate into the reality of clinical nursing practice, focusing on the chief, ongoing issue that I experienced as a researcher in clinical nursing practice – the instability of my field boundary.

Chapter Two

Researching Spirituality: Instability of the Field Boundary

2.1 Introduction

Chapter Two begins to examine the main, ongoing issue that I experienced as a researcher observing clinical nursing practice – the instability of my field boundary. My examination, employing my theoretical framework, is centred on my experiences involving first a patient on the medical ward, John, and then two nurses also on the medical ward, Betsy and Bethan. The instability of my field boundary raises issues concerning spirituality and spiritual care giving which I will begin to explore in this chapter and continue to explore throughout my thesis. These issues, in turn, have implications for what it means to be a researcher of spirituality and I will explore these likewise.

2.2 John

My first day of data collection was on the medical ward. After the morning handover report, I met John, a patient, at about 8 a.m. when I was standing at his bedside with Joe (the nurse in charge of the nine-bedder) and a nursing student who were giving him his medication. I was observing their practice. John looked absolutely worn out.

“I haven’t slept all night”, he announced, shrugging his shoulders in a resigned manner and looking directly over at a gentleman who had been shouting all night. “And I don’t feel well at all. There’s just no point in going on.”

Neither of the nurses looked to him when he said this. Instead they seem to purposely focus their gaze on the medications. There was what felt like a very uncomfortable silence for about thirty seconds in which you could hear a pin drop. Seemingly realizing that neither nurse was going to pick up on what he had said, John merely sunk back a little further in his bed, again in a somewhat resigned fashion and stopped talking. I had the distinct impression that he had ‘baited’ the staff to engage with him and had now resigned to pulling up his line from the empty water.

Just before the shift ended, John asked me to escort him to the toilet.

“Hurry and put my slippers on for me”, he said. I walked alongside him and he got there in time. “I’m feeling a little bit dizzy.”

“I’ll wait right outside the door”, I replied. “I won’t be far and I’ll take you back when you’re ready.”

After we walked back and he sat down in his chair, John thanked me for my help. He told me that he just wanted to rest.

“Is there anything else that I can do for you?” I asked.

“You can fold those two blankets across the end of the bed.”

I did so and he thanked me again. I felt a tiny bit like I had taken a ‘test’ and passed as being willing and able to meet at least some of his needs. He seemed a little happier than he had been earlier. I was aware, though, that perhaps my having been present when John was ‘baiting’ the staff earlier and having remained silent had led him to class me along with them in not wishing or being willing to enter his ‘life world’. Further, my ‘hanging back’ afterwards to see what the staff did in terms of approaching him rather than going in to speak with him may have exacerbated such an impression. I wrote at the time, “This poses a bit of a dilemma for me in relation to my research versus clinical role and presumably will continue to do so”.

2.3 Analysis of my story about John, employing my theoretical framework

When I commenced my research, I set out to observe clinical nursing practice in an objective manner associated with the positivist tradition of research which views people as objects and considers that social life may be known as facts (Topping 2006). From my very first period of observation above, however, my field boundary became unstable: should I be observing practice as a non-participant observer or as a participant observer? I will reflect upon this issue in relation to John, employing my theoretical framework.

2.3.1. Connection/relationship with other(s)

My relationship with John at the beginning of the above scenario was one of a passive observer. It was an I-It relationship. Similarly, the relationship that John had with Joe and the student nurse was a ‘We’-It relationship. John was on his

own, trying to connect and speak with others regarding how he was feeling, but not succeeding. Hence he sank back a little further in his bed and resigned from his effort to connect with (any of) us.

2.3.2 Sacred space

I was focused on maintaining my passive, observer role in the situation and on the details of what was happening so that I could write my data up later to represent the most complete and accurate picture of events possible. I was also in a state of conflict as I will explain below. The nurses appeared to be focusing on giving John his correct medication. None of us was in a space where we were able to embrace our deeper identity and connect with John.

2.3.3 Forces (internal and/or external) which influence sacred space

As stated above, my understanding of my role as a researcher was to observe nursing practice in as much of an 'objective' manner as possible. My intention was to observe practice as it is 'normally', i.e. without my presence. Throughout the course of my thirteen years working as a nurse in clinical practice, I had attempted as much as possible to engage in I-Thou relationships with my patients and had, on the whole, provided what I considered very good spiritual care. For example, in the above scenario, I would have picked up on John's comments about how he was feeling at the time and encouraged him to express his feelings further. Also, if I had considered myself to be too busy to spend much time with him then, I would have explained this to him and offered to return later to continue the conversation with him. If I had taken this course of action, however, I would have felt that I was researching my own experience of spiritual care giving and not that of the patients and nurses (I considered myself a researcher rather than a nurse), the aim of my study. In gaining approval to conduct my study from the Trust Research and Development Office, I had been told that I must be objective in my research approach; one of the reviewers had even commented that there was no place in my study for my own definition or thoughts about spirituality because research results should be reproducible. Having had to obtain their approval to conduct my study, I had felt that I had to abide by their stipulations in relation to my study and maintain my 'objectivity'. In this same vein and as I indicated above, I had felt pressure to maintain my 'objective' stance so that I could focus on the details of what was

happening for when I later wrote up my data, such that it would be as accurate as possible.

2.3.4 Possibility of expanding consciousness/self transcendence

After John had expressed himself and no one responded to him, I wrote, "There was what felt like a very uncomfortable silence for about thirty seconds in which you could hear a pin drop". I was feeling that discomfort. As above, as a nurse (and as a person), I would normally have attempted to connect with John in the moment, but instead I chose not to do so. My behaviour was in direct conflict with who I am (or at least, who I *think* I am), a spiritual person who endeavours to connect with others at a deeper level and be compassionate. Later, after I accompanied John to the toilet and folded his blankets as he requested, I wrote, "I felt a tiny bit like I had taken a 'test' and passed as being willing and able to meet at least some of his needs". In essence, though, I felt that I had failed the test posed to me earlier; throughout the shift I had maintained my 'objective' stance and failed to respond to John's initial comments. When I wrote, "This poses a bit of a dilemma for me in relation to my research versus clinical role and presumably will continue to do so", I knew that as long as I continued to maintain my 'objective', non-participant stance, I would continue to experience my inner conflict as above. I was also concerned that if I wished to question other patients whom I would encounter in the course of conducting my research regarding anything that I observed, or if I wished to interview them regarding spirituality and spiritual care, that they might refuse, thinking that, based on their prior experience of me, I would not be willing to connect with them and/or be compassionate in hearing their stories. For these same reasons, I felt that it might also be awkward and/or difficult providing care to them, let alone experiencing meaningful, personal encounters with them in the process. At the same time, the forces influencing my sacred space were so strong that I envisaged maintaining my 'objective', non-participant stance.

2.4 Factors affecting my reflexivity

While I claim to have been reflexive above, it is important to note that my ability to be reflexive from the beginning and throughout my period of data collection and initial writing up of my narrative was fairly, if not very limited for the following reasons:

- I had a very limited amount of time to collect my data whilst working full-time and it was all that I could do to physically collect it and write my initial stories up having done so;
- It was difficult to be reflexive in the moment in the field because I was constantly thinking about or experiencing whatever situation I was in which was more often than not harrowing or causing me to experience tensions or conflicts, for example, as above. I was also constantly being bombarded with stimuli (because I was in a busy work environment and because I was constantly thinking about where I wanted to be and who I wanted to be with (in terms of chasing certain threads of previous stories and knowing that in chasing certain ones, I would have to leave certain others. I constantly had to prioritize));
- In both settings the ward managers were “very stressed” about my being there and conducting my research. It was difficult not to worry about that, especially as I felt that I had to try to keep them on my side, so to speak, so that I could complete my data collection;
- Some of my study participants did not clearly understand what my role was and wanted me to provide answers for them in terms of various dilemmas that they faced. This conflicted with my perception of my role as a non-participant observer of their practice (as I explained above). This was also fairly stressful because often I did not have any answers with which to provide them, even if I had wished to do so or felt it to be part of my role and yet often I wanted their practice to be more caring or spiritual.

Of course, these same tensions and conflicts also had an impact on my sacred space. My ‘space’ was often filled with these, making it difficult for me to find that quiet, peaceful space within me where I could embrace my deeper identity or connect with my higher self.

My ability to be reflexive was further hampered during my initial data analysis for the following reasons:

- I commenced my studies at another university. I struggled throughout my experience there to present my data holistically, such that it represented the whole of my experience as a researcher of spiritual care giving and did not reduce what I understood of the study participants’ experiences. I knew that none of my thoughts and/or efforts to attempt to accomplish this was

successful and in my view, I was not given the tools or support to assist me in this process. This created tension for me as I felt morally obligated to present my data holistically for the study participants who had embraced me and shared so much of themselves and their experiences with me;

- For me, being a successful student means such things as being free to be who you are, to express yourself, to be vulnerable and to take risks and make mistakes. These, in my view, are all part of a successful growing or learning process. I also feel that a student should be free to produce their own work (as opposed to being told to produce someone else's vision of the work) and to be treated respectfully. I did not feel free in any of these areas, but rather a tremendous amount of tension and conflict as a student at my previous university.

For the above reasons, in 2008 I transferred my studies to the University of Leeds, bringing my research data with me.

2.5 Introduction to Betsy and Bethan

Having made the decision at the end of my first day of data collection to continue to observe practice as a non-participant as opposed to a participant observer, it was not long thereafter that I realized that adopting such a research approach was difficult if not impossible, primarily because first and foremost I am a human being and not a researcher. Throughout both parts of my data collection (primarily listening to patients' stories in the first part and nurses' stories in the second part), I engaged in (more) intimate, often therapeutic relationships, especially with patients (such as Lydia whom I will discuss in my next chapter), but also frequently with nurses (such as Betsy whom I will discuss below) and therefore I strove to achieve I-Thou relationships. Additionally, I interviewed many patients (including Lydia) and nurses about spirituality and spiritual care giving which, in and of itself, comprised being in an I-Thou relationship or 'therapeutic listener' (giving back) role (Oakley 1981) with them as they shared their innermost thoughts and feelings with me.

In this process, I gained (increasing) empathy which induced what I consider to be a human need to *respond* compassionately or in a caring manner. In other words, at times I felt morally *compelled* to respond, and thus be a participant within the data (for example, when a patient or a nurse asked me to help them with regard to

their suffering, when a nurse, in my view, was unable to be compassionate in engaging with a patient and I felt that she might be in danger of the patient making a formal complaint against her as a result, or responding to a patient when his/her story of suffering was such that (s)he was not in a position to relieve his/her suffering yet I was in such a position).

As the following story (which took place approximately three quarters of the way through my data collection period) demonstrates, at times, therefore, my field boundary changed and I adopted a (more) participant observer role. However, this also created tensions or conflicts for me, albeit different ones, and as a result, my field boundary continued to remain unstable for the duration of my period of data collection.

2.6 Betsy and Bethan

Betsy and Bethan were two qualified nurses who worked on the general medical ward where I collected my data. On a shift during which I shadowed Bethan, a staff nurse who had been qualified for eight or nine months, Betsy, a mature nurse with two years' experience and whom I had shadowed twice previously, was also on duty. Bethan had been assigned to care for the female patients in the nine-bedded area and Betsy, the patients in the adjacent cubicles (single, side rooms) on the same half of the ward. Two healthcare assistants, Lara and Nadia, had been assigned to assist them.

At approximately 9 a.m., I observed one of the patients, Mrs. Foster, as she approached Bethan at the nurses' station.

"I need to make an appointment to attend the eye clinic today", Mrs. Foster said. "I don't want to wait to go until after I have gone home (she was due to be discharged the next day). Then it will be so difficult to get here and such. It's so much easier to get it done while I'm here. Can I use the phone and ring the clinic?"

"Certainly", replied Bethan, handing her the phone. Mrs. Foster arranged the appointment and then approached Bethan again.

"I've managed to get an appointment for 11a.m. I'll need to go down in a wheelchair and I'll need some oxygen."

“You haven’t been using your oxygen much lately and your SATs (oxygen saturation levels) are okay. Do you really need oxygen?”

“Yes. I’ve been down to the clinic before. It’s so hot and stuffy (it was twenty-eight degrees centigrade and sunny outside). Last time, I was put in the corridor there and waited for over four hours. It was awful. I felt that I couldn’t breathe. I’ve got a heart condition . . . Oh, and I’d like to see the cardiologist before I go home tomorrow . . . *If I go tomorrow, that is . . .* My heart starts fibrillating . . . and then I feel that I can’t breathe. Besides, if I go down with the oxygen, they might see me quicker (Mrs. Foster flashed us a slightly “cheeky” glance, as though she knew how to get around the ‘system’.) . . . I need the oxygen.”

I appreciated what Mrs. Foster was saying about feeling that she needed oxygen, especially given the heat of the day. It must be very frightening to feel that you cannot breathe.

“Well, okay then. I’ll sort it out for you”, Bethan replied, agreeing with my thinking, and she arranged oxygen for the visit. This involved ordering a new, small portable tank for the ward. It arrived about an hour later and I watched Bethan unwrap it to get it ready.

It was 10:45 a.m. when a porter arrived at the nurses’ station with a wheelchair to take Mrs. Foster to the clinic. We were all sat at the station, Lara and Nadia having just sat down. Bethan and Betsy had been writing in their patients’ notes for five to ten minutes. I watched as Bethan turned to Lara and Nadia on one side of her. Betsy was on her other side.

“Can one of you escort Mrs. Foster to the eye clinic, please?” she asked. “She has an appointment for 11 a.m. and is going down with oxygen.” (It was hospital policy for a nurse to escort a patient when oxygen was in use.)

“She doesn’t need to have oxygen”, stated Lara very assertively, leaning a little towards Bethan. “Her SATs are fine, and she’s going home tomorrow. She’s not having oxygen at home, so she doesn’t need it now. I’m not taking her down. No way. Besides, there’s too much work to be done in terms of feeding when the lunches come.” (The lunches would arrive in about one hour, although Mrs. Foster might not have returned to the ward by then. Three or four patients in the nine-bedder alone had difficulty feeding themselves and needed assistance.) Nadia was nodding in the background.

I appreciated what Lara was saying but felt quite uncomfortable, especially as I agreed with Bethan that Mrs. Foster should go to the clinic with oxygen. I also felt somewhat uncomfortable about Lara's assertiveness in challenging Bethan; it was not a dialogical approach, but more like a "semi-ultimatum". I questioned myself what was behind it. Was Lara so meticulous about her approach to work that she really felt that she could not leave the ward and thus not be available to help feed patients or did she have another motive? My past nursing experience is that escorting a patient off the ward is not always considered a welcome undertaking; the nurse may become unexpectedly stuck in unpleasant or uncomfortable conditions for a considerable length of time (for example, if the patient's condition changes for the worse or if no porter is available to accompany them back to the ward), and may even have to miss his/her lunch break or be late to go home at the end of the shift as a result. Or perhaps, as Lara had just sat down after having been on her feet for over three hours, she just wanted to continue to rest for a bit – not an unreasonable desire and especially on such a hot day.

Bethan looked severely taken aback and sank back a little in her chair, a nervous grin on her face, as though she did not agree with Lara's stance, was feeling extremely uncomfortable and did not know what to do next. I wondered for a minute why she just did not insist that Lara do as she had been asked. After all, Bethan was the qualified nurse in charge of caring for Mrs. Foster. I then remembered how dependent qualified nurses are on healthcare assistants to do their job. Perhaps Bethan feared that she might risk losing that vital support. Betsy then stepped in.

"No, you're right", she stated assertively, looking at Lara. "She doesn't need the oxygen. Her SATs are fine. She's constantly arranging things and telling us what to do, but there's a limit to what is reasonable. We're busy and there are other patients to care for. We haven't got enough staff. If we did, it wouldn't be an issue. But no, we haven't got anyone to spare. She'll have to go without the oxygen."

I appreciated Betsy's point about there being other patients to care for, but I felt that it was a little strange that she was objecting to being told what to do by Mrs. Foster but seemed happy to be told similarly by Lara.

Bethan was sat looking at Betsy. She spoke softly and almost "apologetically",

“I guess I’m just too soft . . .” I was slightly taken aback. I could not really understand why Bethan was backing down so readily. If she really felt that Mrs. Foster should have oxygen, why did she not even attempt to convince Betsy of her case, especially as if the two of them agreed, their strength in number might persuade Lara to back down?

“Well, I’ll go and tell her then”, Betsy asserted. “That’s no problem. I’ll go and do it.” She rose to her feet purposively and headed for the nine-bedder. I felt that she was on a mission and nothing was going to stop her. Bethan followed swiftly behind and I ran after Bethan. My heart was beating quickly. Betsy had such an air of “slightly aggressive determination” about her that I began to worry what would happen. Betsy reached Mrs. Foster’s bedside and stood beside her. Mrs. Foster was sitting on top of her bed, facing the opposite direction. She twisted her torso around to face Betsy. Bethan and I were stood on the other side of the bed, me behind Bethan.

“Mrs. Foster, you don’t need oxygen to go down for your clinic appointment”, Betsy stated assertively. “Your SATs have been fine. Besides, you’re going home tomorrow and the doctors haven’t ordered any oxygen.”

“I’m very sorry”, piped in Bethan gently but firmly. “But we haven’t got the staff to cover the lunches.”

“I need the oxygen. And I *am* having oxygen when I go home . . . *If* I go tomorrow . . . We’ll see if I do go then . . .”

Clearly, Mrs. Foster seemed threatened. I began to worry even more. I felt like this was turning into a duel; pistols seemed to have been drawn.

“No, your SATs are fine and we can’t spare the staff”, continued Betsy. “We’ve got other patients to care for as well. If you need oxygen while you’re down there, you can have it. They’ve got oxygen down there.”

“No. I need the oxygen. I’ve got a heart condition and my heart can fibrillate. I need the oxygen. I’m not going without it and I need to go for my appointment. I’ve had an operation on my eye. It’s a follow up appointment. You’ve got the staff if you’ve got time for lunches.”

“I take great offence to that”, Betsy stated very firmly and loudly. It was not quite a shout, but very nearly. Betsy was turning quite red in the face with “anger”. “The qualified staff members don’t even have time to take a break during their shift on this ward, let alone go for lunch! I really take offence to that!”

Betsy's assertiveness had turned into "outright aggression". This now seemed to be a proper duel and I felt equally really stunned and frightened. I felt like I was watching a runaway train (Betsy) derailling, catapulting down from a very high bridge into a deep gorge. The outcome would be catastrophic. Mrs. Foster had misunderstood what Bethan had said about covering the lunches and Betsy was too "angry" to begin to appreciate this. All she could see was red.

"Your SATs are fine and you're not going down with oxygen", Betsy continued. "If you don't want to go, then you don't have to, but you're not going down with oxygen."

Bethan was looking embarrassed and "completely out of her depth". I was feeling sick for everyone – Mrs. Foster for having been treated so "disrespectfully" (in a manner that I feel no patient should ever be treated), Betsy for having "lost her temper", Bethan for having "lost control of the situation and having been unable to take control and turn it around", and the other patients in the room for having been exposed to such a display of "uncontrolled aggression". The room was otherwise so quiet that you could hear a pin drop; it seemed that I was not alone in being stunned. Mrs. Foster rose to her feet and faced Betsy directly. She was "upset" and shaking a little with a combination of "fear" and "anger".

"I must go for my appointment. Mr. Jones (the ophthalmic Consultant) always says that staff members on the wards don't appreciate the need for treatment for eyes. You can say that my SATs are fine. *Your* SATs are fine, but that doesn't mean that *mine* are. I'm going for my appointment with the oxygen."

"I wouldn't tell you that your SATs were fine if they weren't. They're fine and they've been fine for a while. You don't need the oxygen. My job is to make this kind of assessment and I've been trained to do my job well. I know what I'm doing and I wouldn't do anything that would put your health at risk. I wouldn't say that you didn't need the oxygen unless I was absolutely certain. I know what I'm doing. You're not going down with the oxygen."

"I must keep my appointment, but I'm not going without the oxygen."

"No, I've made my assessment and you're not going down with the oxygen. Other than that, the choice is yours as to what you do. You don't have to go to the clinic today. Nobody's forcing you to go."

Nobody was forcing Mrs. Foster to go to the clinic, yet I could not help thinking that force was in operation here. Mrs. Foster was being “forced” to go to the clinic without oxygen if she chose to attend, which made me feel very uncomfortable. Betsy was exercising ‘power over’ Mrs. Foster; this was “an issue of control”.

“I do have to go”, asserted Mrs. Foster. “I told you that it’s very important. My eyesight is at risk. If anything happens to me while I’m down there, you’ll hear from my solicitor and there will be trouble.” Mrs. Foster’s response was “confrontational”, “threatening” Betsy. However she seemed to know that Betsy was not going to change her mind and sat down in the wheelchair to be taken away by the porter who had come into the room at some point.

“I’ll ring the clinic and let them know that you’re coming and that you might need oxygen while you’re down there,” called Bethan after them as the porter started to wheel Mrs. Foster out of the room.

Betsy, Bethan and I followed them down the corridor to the nurses’ station. Bethan picked up the phone immediately, telephoned the eye clinic and alerted them to Mrs. Foster coming and the need to have oxygen ready for her.

In the immediate aftermath of all of the above, I spoke with Bethan and Betsy. I encouraged Bethan to reflect on her behaviour, for instance in relation to her not having insisted that Mrs. Foster be escorted to the clinic by one of the healthcare assistants. Betsy asked me if I thought that her behaviour was “right” or whether I thought that she had “just been assy”. I responded that I did not think that she had been “assy”. However I did not specifically answer her question as I felt too uncomfortable to do so. When Betsy then asked me, “But there are right ways and wrong ways to behave?”, once again, I did not specifically answer her question. I could not do so.

2.7 Relevant background to my story about Betsy and Bethan

As I stated above, I had shadowed Betsy for two shifts previously. A prevalent issue that I had observed was “conscious or unconscious disrespect” shown to her by other healthcare professionals which had been ongoing throughout both shifts. There had been considerable “miscommunication” between Betsy and other

healthcare professionals. Betsy had “not been informed of appropriate information in relation to her patients”, and “her professional judgement, advice and requests had often been questioned, not heeded or acted upon or even usurped”. Such “miscommunication” had generally resulted in more physical work and/or stress for Betsy. Additionally, Betsy had been “humiliated” by the ward’s Senior Registrar in front of other members of the ward medical team for not having taken a patient’s temperature before their ward round. I had adopted a (more) participant observation role in my research by talking to Betsy about both of these issues. I had wanted to know how she felt about these issues. I had also felt a need to care for her by acknowledging what I felt was her difficult reality and challenging her somewhat to reflect thereon with a view to perhaps altering things in the future. I had told Betsy that I would find it de-motivating in doing my job, having to run after members of other disciplines to chase up on things about which they had not communicated with me and I had asked her if she felt that way. Betsy had replied that she had not really thought about it. I had also talked to her about how “disrespectful” I had found the Senior Registrar’s behaviour. Betsy had said that she felt that it was a matter of him having “bad manners”. I had challenged her interpretation of his behaviour, stating, “Perhaps it’s not a question of manners. I would guess that he knows what good manners are.” Betsy had replied, “Yes, I suppose you’re right . . . I don’t have to take that. No one should have to take that. I’m not a walkover.”

Betsy’s “stress” had been further compounded by feeling that she had to be perfect. On one occasion, she had accidentally left the key to the drugs cabinet hanging in the door and as a result, told me that she had not slept that night for fear of her error being reported by (an)other nurse(s) to the ward manager and his subsequent and undoubted severe reprisal (at least, in her mind). Betsy had also told me that she felt that she experienced ageism from her nursing colleagues (she had said that as a mature or older nurse, she would not live down her forgetfulness in relation to having left the key to the drugs cabinet hanging in the door).

When these things were occurring, I had felt frustrated if not angry, as I had felt that such behaviour towards Betsy and expectations of her were “inappropriate” and “unnecessary” and I had told Betsy this. However these had not been the only things that I had observed about which I had felt this way. Betsy’s job, like that of all of the qualified nurses in both settings of my data collection, had been made

more difficult to undertake as a result of more 'physical' or environmental factors. The nurses were regularly if not constantly "bombarded" by people (other healthcare professionals, including other nurses) and information on some shifts. The result of this was that the nurses were generally required to remember considerable amounts of information, continually re-prioritize what they needed to do and try to meet a growing number of demands on their time. Additionally, the general medical ward was usually very noisy, frequently with music also blasting from the kitchen area (played by the kitchen staff). This rendered mental concentration somewhat if not very difficult much of the time. Further, the vast majority of the time, no coffee or lunch breaks (or even rest breaks) were taken by the qualified nurses on the general medical ward as they had so much to do that they never stopped working for the duration of their shifts. This had been the case even on an exceptionally hot day as above and could affect the nurses' well being (for instance, I had developed a severe headache when I arrived home after working the above shift, quite probably due to dehydration as I had not had a drink for eight and a half hours). (In contrast, coffee and lunch breaks were virtually always taken by the nurses at the hospice as they usually just managed to accomplish their workload within the shift's time frame minus the time allocated for such breaks. Also, taking appropriate, scheduled breaks seemed to be considered an organizational priority there.)

2.8 Analysis of my story about Betsy and Bethan, employing my theoretical framework

As before, I will examine my adoption of a (more) participant observation role in relation to the events that transpired involving Betsy, Bethan and me, employing reflection in relation to my theoretical framework.

2.8.1 Connection/relationship with other(s)

As I had done when working alongside or shadowing all the nurses in my study, I endeavoured to have an I-Thou relationship with Betsy and Bethan. I feel that I did so in part only however. Specifically, I feel that I had an I-Thou relationship with Betsy whilst I was working alongside her, bonding with her on the two shifts prior to the shift involving Mrs. Foster. I also feel that I had (more of) such a relationship with each of them when I was engaged in dialogue with them about events that had happened, encouraging them to reflect on their situation or practice. When I was

encouraging them to reflect, I did so with a view to facilitating them to embrace what was happening and consider how to enhance their practice or the situation in the vein of being open with them to new possibilities for the future. This, I feel, is very much in line with Buber's (1970) definition of an I-Thou relationship.

With regard to Mrs. Foster, I was back in my role as non-participant observer whilst at her bedside. We had an I-It relationship.

Betsy and Bethan also had I-It relationships with Mrs. Foster (although Bethan not at first). Bethan was also largely a passive observer and Betsy treated Mrs. Foster "as an object upon which to vent her anger" (I will discuss this latter point further below).

2.8.2 Sacred space

I have mentioned some feelings of tension that I was experiencing prior to Betsy confronting Mrs. Foster. Most specifically, these were in relation to decisions that were being taken by Betsy and Bethan concerning how to handle the situation regarding whether or not Mrs. Foster should go down to the eye clinic with oxygen. My 'space' was somewhat occupied by these tensions during that time. From the moment Betsy took the decision to go to speak with Mrs. Foster, my 'space' was almost if not completely filled with so much tension that I felt like I was in a state of chaos. This state is perhaps best reflected in the initial manner that I wrote about the incident (in the present tense) from that moment onward as follows:

"Well, I'll go and tell her then. That's no problem. I'll go and do it." Betsy gets to her feet purposively and heads for the nine-bedder. Bethan follows swiftly behind and I run after Bethan. Betsy reaches Mrs. Foster's bedside and stands beside her. Mrs. Foster is sitting on top of her bed, facing the opposite direction. She twists her torso around to face Betsy. Bethan and I are stood on the other side of the bed, me behind Bethan.

"Mrs. Foster, you don't need oxygen to go down for your clinic appointment", Betsy states assertively. "Your SATs have been fine. Besides, you're going home tomorrow and the doctors haven't ordered any oxygen."

"I'm very sorry", pipes in Bethan gently but firmly. "But we haven't got the staff to cover the lunches."

“I need the oxygen. And I *am* having oxygen when I go home . . . *If* I go tomorrow . . . We’ll see if I do go then . . .”

“No, your SATs are fine and we can’t spare the staff”, continues Betsy. We’ve got other patients to care for as well. If you need oxygen while you’re down there, you can have it. They’ve got oxygen down there.”

“No. I need the oxygen. I’ve got a heart condition and my heart can fibrillate. I need the oxygen. I’m not going without it and I need to go for my appointment. I’ve had an operation on my eye. It’s a follow up appointment. You’ve got the staff if you’ve got time for lunches.”

“I take great offence to that,” Betsy states very firmly and loudly. It’s not quite a shout, but very nearly. Betsy is turning quite red in the face with “anger”. “The qualified staff members don’t even have time to take a break during their shift on this ward, let alone go for lunch! I really take offence to that!” Betsy’s assertiveness has turned into “outright aggression”. Mrs. Foster has misunderstood what Bethan has said about covering the lunches and Betsy is too “angry” to begin to appreciate this. All she can see is red. “Your SATs are fine and you’re not going down with oxygen. If you don’t want to go, then you don’t have to, but you’re not going down with oxygen.”

Bethan is looking embarrassed and “completely out of her depth”. I am feeling sick for everyone – Mrs. Foster for being treated so “disrespectfully”, Betsy for “losing her temper”, Bethan for having “lost control of the situation and being unable to take control and turn it around” and the other patients in the room for being exposed to such a display of “uncontrolled, negative emotion”. The room is otherwise so quiet that you could hear a pin drop. Mrs. Foster rises to her feet and faces Betsy directly. She is “upset” and shaking a little with a combination of “fear” and “anger”.

“I must go for my appointment. Mr. Jones (the ophthalmic Consultant) always says that staff members on the wards don’t appreciate the need for treatment for eyes. You can say that my SATs are fine. *Your* SATs are fine, but that doesn’t mean that *mine* are. I’m going for my appointment with the oxygen.”

“I wouldn’t tell you that your SATs were fine if they weren’t. They’re fine and they’ve been fine for a while. You don’t need the oxygen. My job is to make this kind of assessment and I’ve been trained to do my job well. I know what I’m doing and I wouldn’t do anything that would put your health at risk. I wouldn’t say that

you didn't need the oxygen unless I was absolutely certain. I know what I'm doing. You're not going down with the oxygen."

"I must keep my appointment, but I'm not going without the oxygen."

"No, I've made my assessment and you're not going down with the oxygen. Other than that, the choice is yours as to what you do. You don't have to go to the clinic today. Nobody's forcing you to go."

"I do have to go. I told you that it's very important. My eyesight is at risk. If anything happens to me while I'm down there, you'll hear from my solicitor and there will be trouble." Mrs. Foster sits down in the wheelchair to be taken away by the porter who has come into the room at some point.

"I'll ring the clinic and let them know that you're coming and that you might need oxygen while you're down there," calls Bethan after them as the porter starts to wheel Mrs. Foster out of the room.

Betsy and Bethan follow them down the corridor to the nurses' station. Bethan picks up the phone immediately, telephones the eye clinic and alerts them to Mrs. Foster coming and the need to have oxygen ready for her.

While I have a natural propensity for writing in fairly lengthy sentences, it is very noteworthy that this is not at all the case in my initial written text. The vast majority of sentences are quite if not very short and thus each follows the preceding sentence swiftly. Also, the entire text is written in one paragraph. One of my supervisors commented at one of my supervisory meetings that when he read the above, initial text, he felt short of breath in the process and became consciously aware of the fact. When I re-wrote the text, having reflected upon it (and this is the version that I presented above initially), I wrote that Betsy was like "a runaway train, derailing", and that "my heart was beating quickly". My initial text races, reading like a runaway train (as the situation and my state of tension escalate out of control) and shortness of breath and an increased heart rate are symptoms of stress and anxiety. I also wrote of worrying, suggesting that I felt fear ("I began to worry what would happen", and then later, "I began to worry even more").

After the event with Mrs. Foster, when I spoke with Bethan, my 'space' was somewhat cleared, at least to the extent that I was able to engage with her to encourage her to reflect a little on the situation. When I spoke with Betsy,

however, my 'space' was still full of tension. As a result, I was unable to encourage her to reflect.

Whilst at Mrs. Foster's bedside, it would seem that Betsy's and Mrs. Foster's 'spaces' were filled with tensions, Bethan's perhaps somewhat less so.

2.8.3 Forces (*internal and/or external*) which influence sacred space

There were several tensions or conflicts which filled my sacred space:

- As mentioned above, as a result of having shadowed Betsy and observed what I considered to be "disrespectful" behaviour towards her along with 'physical' or environmental factors that hampered her ability to do her job well, I had felt a need to care for her. I had especially felt this need due to having bonded with her in the course of our giving care together previously and our discussions of a more personal nature in which she had spoken to me about a number of the above difficulties that she faced at work on a regular basis. When the above scenario that unfolded at Mrs. Foster's bedside occurred, therefore, I had felt a demand to care for Betsy. I had also heard Mrs. Foster's story both before and during the incident regarding why she felt that her appointment at the eye clinic and her need to attend with oxygen were so important to her. As a result, I had also felt a demand to care for Mrs. Foster. At the time, I remember thinking that additionally I felt a demand to care for myself and my study. As I stood there watching the event unfold, I remember having thought that I could step in and escort Mrs. Foster to the clinic. I had not offered, however, as I had told myself that I had approached my data collection with the view that I needed to observe clinical nursing practice objectively (as discussed previously). I had tried, therefore, to do this; I had felt that stepping in to act as an escort would have compromised my 'objective' stance and the duty that I felt to honour the Trust's Research and Development Committee's request. Thus I had experienced three major competing demands to care – for Betsy and Mrs. Foster (and had I acted on these two demands, I might have stepped in and tried to halt or change the situation) and for myself and my study. I acted upon the latter demand, but not without feeling constantly torn between the opposing demands;

- At the time of the Senior Registrar “humiliating” Betsy, she had not shown any emotion. As the situation with Mrs. Foster had escalated and Betsy had become increasingly “angry”, I remember having thought that perhaps Betsy was projecting her “anger” about the Registrar “humiliating” her onto Mrs. Foster. I had felt extremely guilty as I had challenged Betsy’s initial interpretation of the event with the Senior Registrar (at least as she had expressed verbally to me), thus having encouraged her to reflect and having raised her consciousness about what had happened. Indeed, in a conversation with Betsy and Bethan in the immediate aftermath of the incident with Mrs. Foster, Betsy had said the following, supporting my above suspicion that a projection of her “anger” had been at play regarding the incident with Mrs. Foster:

We also can't have the patients telling us how to do our jobs. We have to take a lot in this job, but we don't have to take that! Patients have got choices about some things and they should, but they can't choose to tell us how to do our jobs!

Betsy’s statement, “We have to take a lot in this job”, may have been referring to the “humiliation” that she had endured at the hands of the Senior Registrar, especially as she had employed the exact same phrase (“I don’t have to take that”) in relation to both instances. The various other elements of “disrespect” that Betsy had been subjected to by other healthcare colleagues as well as the ‘physical’ or environmental factors that rendered her job more difficult, as I have described above, may also have contributed to her “projection of anger” onto Mrs. Foster. When these had occurred, Betsy had not shown any emotion either and I had also tried to raise her consciousness somewhat in relation to them, as I have described above. Hence my feelings of guilt were further compounded;

- A psychodynamic approach to counselling involves clients “working through defences and resistance”, ultimately connected with their upbringing, that prevent them from responding differently in situations (Jacobs 1998: 1). My feelings of guilt were so powerfully influencing me in the situation regarding Betsy that on the advice of one of my supervisors, I considered at a deeper level of consciousness (as often these processes are unconscious) why I did not behave differently and enact I-Thou relationships. The following is an explanation of why my defences or resistance may have arisen:

My mother died very suddenly of a cerebral aneurysm when I was seven years old. Just before my mother's death, or at least within half a year beforehand, she used to prepare the family a cooked breakfast, including fried eggs, sunny side up, every weekday morning. She considered this a good, healthy start to the day (it was a very different era in time!) and my sister and I were expected to eat this breakfast.

At some point during the time that this breakfast was being regularly served up to me, one of the children in the neighbourhood told me that eggs were baby chicks that had not yet been born. Upon hearing this, I was no longer able to eat eggs. Every weekday morning my mother continued to present a plate in front of me with an egg on it and all I could envisage was an unborn baby chick on my plate. I literally could not even contemplate eating the egg without feeling really physically sick to my stomach.

I knew that my mother was trying to do what she thought was best for me in terms of eating an egg for breakfast, but still I could not eat an egg. All I remember about any dialogue between my mother and me regarding the issue is that every weekday morning my mother insisted that I eat the egg, telling me that I would not be allowed to go to school until I did. I was always unable to do so. I also remember that my mother made me sit at the kitchen table with my plate in front of me until there was just enough time for me to run as fast as I could to get to school on time. This, then, was what happened every weekday morning.

As time progressed, I think that my mother thought that she would be able to 'break' me in terms of breaking what she may have considered to be my stubborn will (as though this was what was behind my not eating eggs. In those days, not many people were vegetarians on moral grounds as they are today). I did and still have what many people might consider a 'stubborn will' in that I generally 'know my own mind' and I guess that that is why she may have thought this. We lived in a close knit neighbourhood where many of the mothers knew each other and were good if not best

friends. As a result, I think that some if not all of them had heard about the issue of my not eating my eggs.

A while after my mother died, my grandmother came to live with us to help raise my sister and me. She was in her mid to late sixties and my sister and I were still fairly young children. Having long since raised a family of three children, then become a widow, nursed her mother-in-law and two sisters to their deaths from cancer, remarried and divorced, subsequently become an independent career woman twice over and then just recently retired, raising two still fairly young children was not always easy for her and especially as I 'knew my own mind'. On fairly rare occasions, my grandmother would get very angry with me (I do not remember why exactly, although I think that those occasions must have had something to do with me 'knowing my own mind'). When she did, she would shout at me that I had killed my mother. I know that she used to say on occasion that I had a 'will of solid steel' and I think that the two statements were made together.

After my mother died, my father discovered that she had gone to see numerous doctors over the course of about a year beforehand, complaining of severe headaches. Presumably she had a leaking aneurysm which eventually ruptured, killing her.

My grandmother had obviously been told about the issue of my not eating my eggs (presumably by (a) neighbour(s) or maybe by my father) and somehow linked this information with my mother's severe headaches. She came to the conclusion that the two were tied together - that my refusal to eat eggs had caused my mother's headaches and subsequent death.

When my grandmother used to say this to me, I do not think that I ever believed it, but it certainly was extremely hurtful, especially coming from a member of my own family and my new primary carer. As a child, it struck me as really 'nasty'.

The years went by and my grandmother and I never spoke about this. When she was in her early eighties, my grandmother was admitted to hospital at death's door. She was living in another city and I rushed to see her. I arrived at the hospital early in the evening. My grandmother was being wheeled on a stretcher in a corridor and I had only a brief minute or so with her at the side of the stretcher. She was extremely weak, small and frail (she had been a fairly large, strong woman). She looked straight at me and asked very urgently if I could forgive her. I said, "Yes". That was the sum total of our conversation. She was then wheeled away. I never saw my grandmother again; she died the next morning.

I am now much older and I understand and appreciate the many reasons why my grandmother may have behaved as she did. I also appreciate that I will never know exactly what was behind her behaviour. I always knew that my grandmother loved me and I loved her, but it still strikes me as exceedingly sad that she lived for so many years carrying the weight of what she said to me with her and that she was therefore seemingly so desperate for my forgiveness before she died. It also still strikes me as exceedingly sad that she waited until she was dying to ask for my forgiveness. The legacy of all of this is that I have tried to live my life never having to say that I am sorry. I do my best not to hurt or harm others in any way so that I will have nothing to feel sorry for or about.

As stated above, when Betsy was "venting her anger" at Mrs. Foster, I felt extremely guilty. I felt that my having raised her consciousness had triggered Betsy's "anger" and the situation that unfolded and, in turn, "caused considerable suffering" to so many people – Mrs. Foster, Betsy, Bethan and the other patients in the nine-bedded area. As I have also already explained, it had been with a caring intent that I had raised Betsy's consciousness in the first place, yet it had all gone so horribly wrong! I found it extremely difficult to live with myself – as though I was my grandmother. I just wanted the ground to swallow me up!

2.8.4 Possibility of expanding consciousness/self transcendence

The process of reflection has enabled me to appreciate that the demand to care for myself, as discussed above, had probably *not* been (so much) in relation to my research (my need to maintain 'objectivity') but (more) in relation to my overwhelming feelings of guilt. I had, after all, already moved from my non-participant observer stance, certainly in terms of my previous experiences with Betsy, and at the time, I had seriously considered stepping in to escort Mrs. Foster to the clinic.

A further noteworthy point about my initial text in relation to the situation is that other than one statement, 'I am feeling sick for everyone – Mrs. Foster for being treated so "disrespectfully", Betsy for "losing her temper", Bethan for having "lost control of the situation and being unable to take control and turn it around" and the other patients in the room for being exposed to such a display of "uncontrolled, negative emotion"', I do not overtly express my feelings or thoughts. Further, even in this one statement I mention how I am feeling about 'everyone', but this does not include how I am feeling about myself.

As I have already stated, I was extremely stretched for time when I wrote my initial narrative. Also as I have stated, I generally wrote up my data for each shift of duty that I worked within twenty-four hours at most of having worked each shift so that I would have as accurate a record as possible of what had happened. At times, in order to save time, I made a conscious decision to edit myself out of the data. I did this when I felt that I would be able to remember what happened with respect to me at a later date because I felt that what had happened concerning me was so memorable. I do not remember whether in this instance I took such a decision to edit myself out. Having said this, even if I did, it is still fairly astonishing how overtly absent I am from my initial text. My emotions (anxiety and fear), however, are expressed throughout the text in its form and such that the reader (one of my supervisors, for instance) may experience them, with the exception of my feelings of guilt. Although having said this, my supervisor experienced such stress that he may have thought that I too had been experiencing more stress than I appeared to have been experiencing (and, as demonstrated above, indeed I had). A common means of coping with anxiety is to distance oneself from the source of anxiety (Menziez 1970) and a common means of dealing with negative emotions is to control them (Smith 1992, Theodosius 2008). Perhaps, then, my emotions and especially my feelings of guilt were so powerful and so threatening to me that I

made a decision (conscious or not) to distance myself from them by not writing about them. This may have been the case, especially because I had felt that to *not* mention anything to Betsy about how I felt she had been “disrespected” by others would have been *uncaring*, and all the more so because I had been present with her when such behaviour occurred. At any rate, my emotions leaked out in the text’s form.

Smith (1992) and Theodosius (2008) state that nurses are taught to control their negative emotions and remain ‘professional’ such that patients feel cared for (they term this, ‘emotional labour’). Theodosius (2008) says that by doing so, however, nurses create false selves and this then creates stress as they are disconnected from their true selves. I had thus been disconnected from my true or higher self - I was certainly not in touch with my sacred space.

Theodosius (2008) advises that nurses need to process their emotions rather than ignore them and she advocates reflection as a means of doing so. As stated above, the incident at Mrs. Foster’s bedside had happened so quickly and I had been so upset at the time that I had been unable to reflect in the moment(s). Thus demands on me to care for others in the situation had been negated; the demand to care for myself because I had not yet processed my overwhelming feelings of guilt had been greater. In this same vein, it was my overwhelming feelings of guilt that prevented me from being able to engage in meaningful dialogue or reflection about the situation with Betsy afterwards. I felt so awful that I could barely stand to look at her! As I stated above, it is only now, having stood back from the situation and reflected thereupon, that I might behave differently in the same or a similar situation.

My foray into shifting my field boundary from non-participant to participant observer had started off well but ended up being a very unpleasant experience for me. Further, I carried the legacy of the experience with me for a considerable length of time afterwards, as while I continued my fieldwork, for the reasons mentioned above, I still had not had the opportunity to reflect (more) fully on the situation. Guilt does not just disappear on its own. It was very difficult for me to contemplate being a participant observer again and I felt that should I be in circumstances

where I felt it might be appropriate to adopt that stance again, I would certainly need to try to weigh up the situational risks most carefully beforehand.

Finally, reflecting on the above situation has caused my consciousness to expand further in another direction. By engaging in some degree of participant observation in my research, I have experienced the benefit of so doing. I now realize that this presents a most important opportunity for researchers to facilitate practitioners to take their practice forward in a manner that may enhance patient care (for example, my encouraging Bethan to reflect in relation to her not having insisted that Mrs. Foster be escorted to the clinic by one of the healthcare assistants). Further, because such reflection is based on actual nursing practice, the traditional theory-practice divide may be reduced if not eliminated. Research thus serves a useful, relevant role in a practice discipline (Rolfe, Freshwater and Jasper, 2001).

Similarly, a most important opportunity is also presented to raise nurses' consciousness about issues which affect them in a negative manner. They are then in a position to consider meaningfully how to address such issues satisfactorily (which may be facilitated by the researcher). For example, I had attempted to raise Betsy's consciousness about the Senior Registrar "humiliating" her. In this regard and in light of Theodosius' (2008) recommendation concerning how nurses should deal with emotional labour, it appears that Betsy did reflect on her behaviour and altered it as a result. About an hour later, the same Senior Registrar who had "humiliated" Betsy previously in relation to the taking of a patient's temperature had announced to Betsy that one of her patients' observations had not been recorded that day. Betsy had been walking down the corridor away from him as he had said this. She had continued walking, but had turned her head around and stated firmly and politely, "We haven't been able to take her observations because she has been outside all morning." The Senior Registrar had said nothing in return. Betsy had taken assertive control of the situation and did not appear to have *allowed* herself to be or feel "humiliated". By having done so, unlike previously, it appeared that she had not acquired any "negative emotion" from the experience and therefore, unlike in the incident concerning Mrs. Foster, none might have been inadvertently passed on to a patient.

2.9 Implications of the instability of my field boundary

The issue concerning the instability of my field boundary arose initially because I blindly accepted that I had to conduct my research in an 'objective' manner. This was what I had been told by the Trust Research and Development Office and I feared possible reprisal from them if I did not. As I described in relation to John, however, this produced conflict within me from the very outset of my data collection, rendering me what I considered to be an uncaring nurse and researcher. While I knew this and that if I did not alter my behaviour I might continue to be uncaring in nature and that this might even affect my gaining access to participants for my research (as I have described previously), my continued fear and lack of reflection led to no immediate change in my behaviour.

In working closely alongside Betsy in an I-Thou relationship (before the incident with Mrs. Foster), I developed empathy for her difficult situation in caring for her patients and herself. I developed a demand to care for her. As a result, I relinquished my 'objective' research stance and responded to that demand, encouraging her to reflect on her difficult situation. Unfortunately, then, Betsy seemingly became angry and projected her anger onto Mrs. Foster. Meanwhile, I had developed empathy for Mrs. Foster's situation and developed a demand to care for her as well. When Betsy was "uncaring" towards Mrs. Foster, I wanted to care for them both, but the situation evoked unresolved feelings of guilt in me, stemming from my childhood, which created a greater demand for me to care for myself by distancing myself from the situation.

Upon reflecting on the situation afterwards, I appreciate that if I had reflected upon it earlier and dealt with my feelings of unresolved guilt, I may have been better able to access my sacred space and care for both Betsy and Mrs. Foster while the aforementioned incident was occurring. Having said this, having relinquished my 'objective' stance after the incident at Mrs. Foster's bedside, I was able to assist both Betsy and Bethan to some extent by encouraging them to reflect on their practice and enable them to move it forward as a result. This appeared to make a difference to Betsy's practice in terms of her response on the second occasion when the Senior Registrar appeared to challenge her about a patient's observations having not been recorded.

In terms of spirituality and spiritual care giving, I have learned that it is important to listen to and act upon one's own voice rather than the voice of others. This may enable one to be connected with oneself and to access one's sacred space such that one is able to care for others. Of course, in order to do this, one needs to not be afraid. Spiritual care giving, then, would seem more likely to occur in an environment in which nurses may practise without fear. I have also learned that working with others in I-Thou relationships seems to foster empathy for them which, in turn, seems to induce a demand to care for others. However, critical reflection would also seem to be required, perhaps even of a psychodynamic nature, such that unresolved negative feelings do not interfere with this demand to care. Thus the teaching of nurses to control their negative emotions and remain 'professional' so that their patients feel cared for, as described by Smith (1992) and Theodosius (2008) and as I mentioned above, would appear to be erroneous. It would seem rather that nurses *should* process their emotions rather than ignore them, as advocated by Theodosius (2008) above.

In terms of researching spiritual care, I have learned that one should be an active participant in the research process. This may enable others to see one as caring and may assist with gaining their participation in the research. It may also enable one to influence practice for the better and to facilitate others to do likewise.

2.10 Summary

This chapter has begun to examine a chief difficulty that I experienced in researching spirituality – the instability of my field boundary. Through examining two clinical nursing experiences, I have revealed several implications for spirituality and spiritual care giving as well as for researching spirituality. Chiefly, it seems important to:

- listen to one's own voice and employ this as an important source of knowledge in influencing one's behaviour as this will enable one to remain 'true' to oneself and one's innately caring nature (as we are all One as 'love');
- engage in I-Thou relationships with others as this will induce a demand to care for others which will then lead to caring practices;

- engage in critical reflection, perhaps even of a psychodynamic nature, as this will reveal important knowledge about oneself and others which might usefully influence one's behaviour;
- actively participate as a researcher in the research process as this will enable one to take practice forward and to facilitate others to do likewise.

As I have stated, the issue of the instability of my field boundary remained with me virtually throughout my period of data collection and as such, it will be discussed in subsequent chapters of my thesis. In Chapter Three, I will explore another broadly related difficulty that I experienced as a researcher – my narrative itself.

Chapter Three

Researching Spirituality: My Narrative Itself as a Difficulty

3.1 Introduction

The instability of my field boundary was not the only difficulty that I had to face with my narrative as a researcher. Additionally, my narrative itself poses a difficulty. The two difficulties are broadly related to each other and I shall begin to explore the latter in relationship to the former, focusing on my experience with Lydia, a patient at the hospice. My discussion will be informed by human caring theory (Watson 1999) which forms part of the caring-healing paradigm (Watson 1999), narrative inquiry (Clandinin & Connelly 2000) and critical social theory (Lather 1992), the latter such that what is learned from my examination may be taken forward to enhance future spiritual care giving in clinical nursing practice.

3.2 Lydia

Lydia was a patient whom I knew over a three week period over the course of two of her admissions to the hospice with Christmas in between (approximately a third of the way through my data collection period). Her second admission was because her symptoms had worsened and she had come in for further palliative treatment. Lydia was one of a handful of patients whom I encountered during my data collection who very obviously embraced her spirituality and was eager to share her experience with me. I met Lydia one morning after one of the nurses at the hospice, Jill, had reported her to me as “very anxious”, and knowing that I was researching spirituality and keen to speak with patients who were willing and able to speak with me about their spirituality, suggested that Lydia would be “a good one” for me. Throughout my relationship with Lydia I inquired out of genuine interest how she was feeling, listened to her empathetically when she explained how difficult her symptoms were to live with, left her to rest when she was feeling tired, gladly assisted her with activities for which she requested my help and shared her joy with her when, at times, her symptoms were less distressing for her. At other times when she was feeling somewhat better and was happy to chat at greater length with me, I asked her if her life had changed a lot since she had been

diagnosed with cancer (she was initially diagnosed with cancer of the right breast and had received chemotherapy and radiotherapy for this). She told me,

“Oh yes. I just don’t have the energy that I used to have . . . I used to be on the go and doing things all the time . . . I can’t now . . . And it makes you think about death more. You realize that death is just around the corner for everyone and that makes you think more about the way that you live your life. Muslims (Lydia had told me that she had recently adopted this religion) believe that you should live every day as if it was your last. I try to do that. You appreciate all the simple things . . . like that (she pointed with her chin to the gorgeous panoramic scenery outside the windows which formed the greater part of a wall in the room) . . . I find myself looking at a sunset or a flower and thinking how beautiful they are. How wonderful it is that I can see things . . . I’ve learned to live differently because it is so very precious. We spend our lives running around, being constantly busy with things . . . forgetting how precious life is . . .”

Lydia was very contemplative in her manner in speaking with me about such things as the above and I sensed that she was also sad. I too felt sad – sad that she was having to suffer so much in the way of her physical symptoms and sad that she may not get to experience this precious life much longer. She told me that she was always thinking about things and had been that way all her life. She also mentioned that her father-in-law had been telling her to stop thinking. At the end of nearly every conversation that I had with her, Lydia said, “I hope that I haven’t bored you” and told me that she had enjoyed talking with me. I always responded that I too had enjoyed our talks.

One day when I was with Lydia, she asked me if she might die suddenly. She had heard that another patient, May, whom she had known previously at the hospice, had died. As Lydia expressed:

“She (May) had been fine. She was up, walking around the ward and talking all the time . . . She looked quite well . . . and then suddenly she was no longer here . . . Can it happen that quickly? . . . It’s hard to believe . . . I mean, I look at myself in the mirror and I don’t look great, but I think that I look okay My father-in-law says that he’s heard that older people die more quickly . . . because they’re old . . . Is that true? . . . Is that what you’ve seen in your experience?” May had been a fairly elderly woman and I sensed that Lydia wished to be reassured that she would not die as quickly as May.

“No”, I answered. “I don’t think so. Older people may have more chronic illnesses and so sometimes that may contribute to say, them getting pneumonia on top of another illness and then they may die more quickly than they might have done otherwise . . . But no, not necessarily.” I did not want to give Lydia false hope. The end of her life might come swiftly. I sensed that she knew this already at some level and was perhaps ‘testing’ me. At any rate, I felt that I had to tell her the truth. There had been a silence lasting about thirty seconds during which time Lydia looked contemplative (as she almost always did) but not uncomfortable.

On the last day that I was with Lydia, she called me over to her bedside to request that I be present when she removed her wound dressing so that she could shower. Her wound (caused by radiotherapy) covered her entire chest and sides at chest level. Together we headed for the shower room. Lydia’s dressings came off very easily. We stood side by side looking in the mirror. Lydia’s entire chest and sides were blood raw and oozing serous fluid. She had undergone a right mastectomy but the left side of her chest was also completely flat with just a nipple in the centre. “It’s awful what cancer treatment can do to the human body”, she told me, half sorrowfully, half matter-of-factly. “I had my left breast after my initial surgery for cancer but all of the radiotherapy has done this. It’s almost unbelievable isn’t it? Who would have thought that I’d be left like this?” Who indeed? Lydia did not seem self-conscious in the least. It was as though she just wanted me to bear witness to how ravaging cancer and its treatment can be. I thought to myself how much, as a society, we cloister ourselves off from the ravages of life that may be hard to bear; the general population, I am fairly sure (as per Lydia’s experience), have no idea that treatment for cancer can result in such bodily devastation. Surely this must make experiencing such devastation all the more difficult for people like Lydia. We both just stared at her chest for a minute or two. I felt tremendously humbled to be with Lydia in that intimate moment and very privileged that she had shared it with me. I also felt extraordinarily lucky not to be as ill as she was or to have undergone body mutilation to anywhere near the extent that she had. I fleetingly thought of the problems that I had in my life – they paled in comparison. I also felt, as I had for several decades but more powerfully than I had experienced for some time, how incredibly precious life is and how neither my health nor the health of those whom I love can ever be taken for granted. Every single, tiniest thing in life *is* a wondrous gift and the greatest gift of all is connecting at a deep level with people as I just had with Lydia. I felt that my bearing witness to her

suffering helped her to bear her burden of suffering. I know that it additionally fostered my own spiritual (re-)growth as I have described.

Also on the last day that I was with Lydia, her abdominal symptoms were causing her considerable distress, and her Consultant, the junior doctor on the ward and the ward Sister came on their ward round to see her about this at her bedside. I arrived in the room after they had approached Lydia and stood in the background observing. Lydia carefully explained all of her symptoms to them in great detail, stating that she was unable to hold herself comfortably because of her pain. The Consultant explained that he thought that her movement was restricted because her skin was so tight across her chest and abdomen due to the radiotherapy which she had received. Together, he and Lydia discussed the medication that Lydia was receiving for her pain as well as her other symptoms. They considered what changes in this treatment might still control all of her symptoms yet alleviate her discomfort in relation to this particular problem as well. I marvelled to myself at how well the Consultant enacted his problem solving approach, working hard to attain a finely tuned balance of the various elements in the presenting equation that was agreeable to both him and Lydia. The only adverse thing was that the Consultant felt that the change in treatment would necessitate Lydia having to stay a few more days at the hospice for medical monitoring. Lydia was not very pleased about this.

“Okay, then”, Lydia agreed reluctantly. I’ve got to get sorted before I have any more radiotherapy. I’m due to see the doctor at the other hospital again soon to discuss that option.”

“It may be that more radiotherapy will make things worse”, the Consultant replied. “Your skin may not have healed and if they give you more radiotherapy you’ll then be in a really bad way. It might not be a good idea at all.”

“I never realized that”, replied Lydia. . . . “The treatment will stop me having more treatment”

I do not know who was more stunned – Lydia or me. I was looking directly at Lydia when she said this and the expression on her face mirrored exactly what I was experiencing – it was like watching a pinball machine in action as the ball rolls swiftly downward through the various twists and turns and then slots abruptly into its final resting place. The ball had slotted into place at the same moment for both

of us. Oh, my God, I thought. This is one hell of a bombshell of information. You are probably going to die considerably sooner than you had expected without further radiotherapy! I was sure that Lydia was thinking the exact same thing. Very calmly, though, and looking directly at the Consultant, Lydia said, "Should I keep the appointment, then? What do you think?"

"I wouldn't . . . I think that might be best."

Lydia then simply responded, "Whatever you say", after which the Consultant very calmly briefly recapped the agreed plan of action regarding Lydia's medication treatment and the group left.

I then moved immediately to sit beside Lydia on her bed. Still reeling from the bombshell that the Consultant had dropped, I felt catapulted into another space altogether as I listened attentively and with the utmost of respect for Lydia as a fellow human being as she continued, still very calmly,

"I never realized that. I guess that I should have realized . . . I'm not afraid to die. We're all going to die. I've lived a good life. I am afraid, though, as I think most people are, about how I might die. I don't want to suffer too much . . . I could take suffering . . . severe suffering for about a week, I guess, if I knew that I was going to die at the end of it. I don't want to suffer for weeks and weeks or even months and months, though, when you know that there will be nothing at the end of it. I'm suffering a bit now but at least I can sleep for reasonable periods of time. Some people whom I've met here have it far worse than that. They suffer a great deal of pain constantly with no relief whatsoever. I'm lucky compared to them. I do think that we've got it all wrong, though, in the world today. People are so afraid to die. We pretend that we can live forever and fight death. But it's a natural process. You've got to relax and go with the flow. There's just no point fighting it. I realized this when my mother died. I stood around at the end, waiting for her to die. It was just like when my daughter was born. All the waiting and people standing around. We pass into life when we are born and then we pass out again when we die. They are both such natural processes . . . part of the same process . . . going in and out of a spiritual world . . . the world where we really belong . . . forever . . . We're just visiting this world . . . We should realize that and just go with it. That's what my religion tells me and that really helps me. It really helps when I pray. You have to make some decisions along the way, though, when you die. Inside, you know what the right decisions are for you . . . You need to go with those . . . and everything will be okay . . . You have to trust that the decisions that you make are

right for you and just go with that . . . I'm going with the Consultant's decision not to see the other doctor about more radiotherapy. I know that that's the right decision for me. I think that these things are decided before you are born. I think that it was decided that I would get cancer and so I've just got to go with that."

Lydia then drew a big breath as though she had said everything that she had liked. She then turned to me and told me as always that she must be boring me stupid with all her talk. As always I replied, "Not at all". Then again as always, Lydia thanked me and told me that she had enjoyed talking to me. I then left to hand out the lunches.

While I sat listening to Lydia, I felt in honour of her. Through all the suffering that she had been through with her cancer and in the face of the bombshell that the Consultant had dropped on her, she remained calm, philosophical and accepting of her probable imminent death (or at least more imminent than she had previously thought). I do not know if she had experienced the thoughts that she expressed about the seamlessness of life and death before, or whether, in the moment, and probably facing her death more directly than ever before, that further self transcendence occurred. I just know that she felt good speaking her thoughts to me at that time and I felt equally good, indeed privileged, hearing them. It had brought our relationship to yet another level and I felt completely connected to her. This was partly because she was expressing such a similar view of life and death as I hold, partly because her response to the situation that she was in was exactly what I hope my own would be in similar circumstances, but mostly because we were connected, sharing the vulnerability of what it means to be human together. And as before with her, I felt sad - that this is the reality of what it means to be human for us all. Again, this was not a new 'place' for me, but my experience with Lydia brought it to the forefront of my consciousness in a way that made me focus my thinking and try to live my life more 'in the moment' (Tolle 1999).

Afterwards I reflected on what had happened. I had felt as stunned when the team moved on after the Consultant delivered his bombshell and then quickly recapped the agreed plan of action as I had concerning the actual bombshell itself. Even though I am a nurse, it had never occurred to me that Lydia's physical state of being regarding her chest, sides and abdomen would compromise further treatment for her, especially as I had not known that she was due for consideration of receipt of such treatment. I could hardly believe that no one had asked Lydia how she was

or that Deirdre, the ward Sister, had not stayed with Lydia to be with her and check that she was okay, having received such literally life changing news. I also could hardly believe that at the very least, if Deirdre felt it necessary to continue on the ward round, she had not told Lydia that she would be back later to see how she was doing or sent someone else to be with Lydia in the meantime. Of course, it might be argued that as I was standing in the room at the time, they all felt that they did not need to do anything – that I would do whatever was required. (Of course, for *me* and according to Jean Watson (1999), caring is primarily a way of *being* as opposed to doing (I will talk more about this later in this chapter.)) I watched and neither Deirdre nor any other nurse came (back) to see Lydia that morning to see how she was coping with the news and I did not pass on any information to the nurses on the ward regarding how Lydia was coping. Also, Deirdre did not pass on any information regarding what Lydia had been told by the Consultant to the other nursing staff at the handover report at the end of that shift of duty nor did she tell anyone else to pass the information on; I listened to the handover report and nothing was said. I also felt sad because I felt that Lydia, like all patients, deserved to be cared for and the way that the team moved on did not strike me as “remotely caring in nature”. Where had any I-Thou relationship with the team gone or indeed any relationship at all? I do not think that they could have known how Lydia would react to the news that was delivered to her and even in the event that she reacted well (as she did), I feel that Lydia would have felt more cared for if someone had been with her at that pivotal time in her life. Of course, physical presence alone does not equate with caring (Liehr 1989) or being in an I-Thou relationship; Lydia seemed to have felt cared for with my being truly present in an I-Thou relationship with her. I also know from a relatively recent experience as a student at another university what it is like to feel “uncared for” – “isolating and absolutely soul destroying” in my case. I felt that I was in such a “hostile environment” that I was completely unable to accomplish any work even over a year afterwards, as what I perceived as the “uncaring environment” remained with me, transcending place and time. Such feelings of being “uncared for”, of feeling as though one is being “treated as an ‘It’” and such effects thereof, are not conducive to anyone’s health or healing.

3.3 Analysis of my story about Lydia, employing my theoretical framework

3.3.1 Connection/relationship with other(s)

Contemporary nurse theorists such as Jean Watson embrace Wilber's (2000) philosophy in relation to spirituality, as I outlined in Chapter One, and have developed holistic nursing theories in relation thereto. Their theories concern the role of the nurse in caring for patients and in the case of Jean Watson, caring for patients' spiritual needs. More precisely, Watson (1999) believes that people are embodied spirits and that the highest form of health is a state of harmony among mind, body and soul and achieving this, therefore, should be the goal of nursing care. She professes that a caring relationship and environment promote spiritual growth or new relationship with self/other(s) for the carer and the person being cared for as well as self-healing processes and possibilities. Caring, she believes, is a way of being, holding an intentional consciousness of caring which is communicated as healing energy to the person being cared for. The nurse engages in authentic presencing with the person being cared for in a caring relationship of connectedness which preserves human dignity, wholeness and integrity. An important aspect of Watson's theory (1999) is what she terms 'the transpersonal caring moment'. This refers to a given moment encompassing two people that simultaneously transcends them both, connecting them to other dimensions of being and a deeper or higher consciousness. It is this moment in which space, time and physicality are transcended which promotes growth and healing, more in a spiritual sense than an eradication of disease. The transpersonal caring moment facilitates access to one's inner healer, at the same time transcending self to access a wider universe. Self-knowledge and deep wisdom are gained as a result of connecting with the universal human experience. Watson's theory thus also embraces the principles of feminist theory (Oakley 1981) in that the carer and the person being cared for are equal partners in an I-Thou relationship (Buber 1970) on a journey of mutual (spiritual) growth and healing.

In caring for Lydia, I endeavoured to embrace the theories of Ken Wilber (2000) and Jean Watson (1999) as well as feminist theory (Oakley 1981). As a result, I feel that I offered her spiritual care that made a positive difference to her. I feel that my care provided her with a sense of connectedness with me through our relationship and a greater connectedness or relationship with herself and the universe and self healing as a result (I know that I certainly felt a more connected relationship with myself and the universe as a result). I feel that we had two transpersonal caring moments - the first in the shower room after I bore witness to the devastation of her body as a result of her cancer treatment (I think that this helped Lydia to bear the burden of her suffering as I shared her suffering) and the

second when she spoke to me after the Consultant had informed her that her death was (more) imminent.

When Lydia questioned me about how sudden her death might be, I answered her honestly. I did not want to give her any false hope, but instead I wanted her to be fully informed of the possibility of a sudden death. I felt that this was not only respectful of her as a person, but it was affirming of her in her situation; she would be able to choose how to live each moment of the remainder of her life in the knowledge that it could be her last. As I sit here writing this, I find myself crying unexpectedly. I loved Lydia and I imagine that she may well have died already. I feel sad that she will have died so young, but at the same time I am happy that I may have facilitated her self-actualization as above. My tears are of sorrow and of joy for both of us.

In Lydia's circumstances, I feel that our connection or relationship was very important in that, to the best of my knowledge, neither her family (certainly her father-in-law who tried to suppress her 'thinking') nor the nursing staff at the hospice connected with her in relationship at such a deep, meaningful level regarding her spirituality. Having said this, I accept that as spirituality is by nature a (more) private matter, any such connecting with Lydia may have occurred in private without my knowledge. The fact that Lydia always told me that she enjoyed talking with me and hoped that she had not bored me at the end of every 'deep' conversation that I had with her suggested to me that it was possible that she felt that such conversations would or did bore others.

Sadly, though, not everyone in my study employed the above theories in their practice. The Consultant and Lydia, in my view, had an I-Thou relationship of expert partnership in action when they were engaged in discussion about how best to manage Lydia's distressing abdominal symptoms. However this appeared to transform into an I-It relationship when the Consultant informed Lydia that her death would be (more) imminent, after which he merely recapped this news and left her bedside. During this latter time, it seems that the other multidisciplinary team members accompanying him on the ward round also had I-It relationships with Lydia.

3.3.2 Sacred space

As stated above, caring is considered to be a way of being, holding an intentional consciousness of caring (Watson 1999). In line with Wilber's (2000) theory, Roach (1992), another theorist of human caring, holds that caring is our natural way of being. Thus we are connected with our true selves when we are caring. My understanding of this is that it is because everything and everyone is one – true compassion, or love. When we love, we embody our true selves or the reality of our being and this brings us great joy (this is the joy, for example, that I felt in my relationship with Lydia as described above). This joy forms a part of Watson's (1999) transpersonal caring moment. I have described sacred space earlier as the space where we may embrace our deeper identity with a wider perspective in line with our level of consciousness, or connect with our higher self. This is the space where our true selves are embodied. When we are filled with tensions, we are connected consciously or unconsciously to these; we are connected to negative energy rather than to the positive energy of love. In this sense, it is difficult if not impossible for us to access our sacred space. It is also difficult if not impossible to hold our conscious intent to care, as we are distracted or even otherwise absorbed, consciously or unconsciously.

In the situation with Lydia, unlike that at Mrs. Foster's bedside or afterwards with Betsy, I was for the most part free to access my sacred space. As a researcher, all I had on my mind during (most of) the time that I was with Lydia was a conscious intent to care for her, to engage with her, to hear her story, to 'be' or presence myself with or connect with her. I viewed my role as a researcher to enter her world with her in (an I-Thou) relationship. This is, after all, how spirituality is lived and therefore accessed, as supported by the literature as above. Having said this, I was distracted from my conscious intent to care momentarily on several occasions: when I first saw Lydia's chest wound (and thought of myself), when I was knocked sideways by the Consultant's news of Lydia's (more) imminent death (I just wasn't expecting it) and when the Consultant and remainder of the multidisciplinary team exited quite swiftly after the delivery of the aforementioned news.

When the Consultant was working with Lydia to treat her abdominal symptoms, he too appeared to have accessed his sacred space. My experience of the situation was that he and Lydia were connected in a perfect, expert, problem solving

partnership of caring or love. Love is a most beautiful and wondrous thing to experience, even by proxy, and it was for this reason that I remember being in awe and feeling privileged to witness them in that relationship at the time.

When the Consultant and accompanying members of the multidisciplinary team exited the room fairly swiftly after delivering the bad news to Lydia, I felt that they were not merely fleeing the room and Lydia, but perhaps themselves as well. I am reminded of the long running television commercial in which a 'sharp exit' is made. I did not speak with any of them later about how they were feeling at the time. I do not know why not, perhaps because I was too upset by what I considered to be their "uncaring behaviour" at the time (in this sense, I was (more) focused on Lydia and myself rather than (any of) them). I can only surmise that they were experiencing tensions (and hence were unable to access their sacred space) from which they wished to make a 'sharp exit'.

3.3.3 Forces (*internal and/or external*) which influence sacred space

In relation to Lydia and as I have described above, my tensions chiefly involved the staff members, as at the time and in the heat of the moment, I perceived their 'sharp exit' from Lydia as "uncaring". I was upset for Lydia that she had received such bad news and was then left by the bearers of that news to face it alone. As I described, my relationship with Lydia resulted in me having developed great empathy, even love for her and I felt that she (like all people) deserved to be cared for. I may have also had an expectation that Lydia *would* be cared for by so called *caring* professionals and was perhaps disappointed that this was not the case.

A further tension was in relation to my bearing witness to Lydia's horrific chest wound. As Lawton (2000) expresses, 'leaky boundaries' with respect to the human body (meaning bodily fluids and such leaking from places that they generally do not) are widely considered abhorrent and frightening; we perceive having leaky boundaries as being less than human. Lydia's chest was leaking somewhat and my fear in this regard kicked in briefly. I was also quite taken aback as I was not expecting to see what I saw. Similarly, I experienced tension briefly when the Consultant dropped the bombshell of Lydia's (more) imminent death. As I stated above, I just was not expecting it.

With respect to the Consultant and accompanying members of the multidisciplinary team exiting the room fairly swiftly after delivering the bad news to Lydia, as stated above, I can only surmise that their behaviour stemmed from experiencing tensions in that regard. Possibly they needed to distance themselves from Lydia and the situation as a means of coping with anxiety (Menzies 1970). In their line of work, I am fairly sure that they have to inform many people of their imminent death and this may well be stressful as Western society, on the whole, fears death (Mellor 1993). Indeed, quite a few of the nurses on the ward described Lydia as primarily “very anxious”, yet I never experienced her as such, suggesting that perhaps they were projecting their own anxieties or vulnerability about her situation onto her, thus treating her as an ‘It’.

3.3.4 Possibility of expanding consciousness/self transcendence

3.3.4.1 Introduction

I stated in my introduction to this chapter that my narrative poses a problem and that the problem is broadly related to the difficulty that I experienced in relation to the instability of my field boundary. The problem as I have identified above with respect to Deirdre (and in the previous chapter, especially with respect to Betsy) is that nurses (and other healthcare professionals, such as the medical staff in relation to Lydia) may be “*uncaring*”. This is a problem in that nurses have long been generally regarded as synonymous with angels, that is, innocent, selfless and caring (Salvage 1985). The same holds true today. Indeed this is *why* the public are so outraged when nurses’ behaviour is exposed as other than angelic and caring (for example, The Mid Staffordshire NHS Foundation Trust Inquiry 2010a, The Mid Staffordshire NHS Foundation Trust Inquiry 2010b, Care Quality Commission 2011, Parliamentary and Health Service Ombudsman 2011). How then can they be so “*uncaring*”? I shall begin to examine this question first by examining narrative inquiry (Clandinin & Connelly 2000) and my role in relation thereto as a researcher. I will then examine how critical social theory (Lather 1992) may inform the discussion such that future spiritual care giving may be enhanced. Human caring theory (Watson 1999) as discussed above and which is underscored by the caring-healing paradigm (Watson 1999) will also be applied to my discussion.

3.3.4.2 Narrative inquiry

Narrative inquiry, collecting events and happenings as its data (Polkinghorne 1995) in oral or written form and derived from fieldwork, interviews or conversations that happen naturally (Chase 2005) is employed to understand experience (Clandinin & Connelly 2000). I wanted to study nurses' experience of spiritual care giving and I chose narrative inquiry as my research method primarily because it is designed specifically for such purposes. Also, its underpinning philosophy, embracing the constructivism and participatory paradigms (Guba & Lincoln 2005), are in keeping with my own personal philosophy.

Clandinin and Connelly (2000: 50) explicate that experiencing an experience or conducting research into an experience is to do so within “a metaphorical *three-dimensional narrative inquiry space*, with temporality along one dimension, the personal and social (interaction) along a second dimension, and place along a third”. Based on their theory of experience, they (2000: 20) offer an initial working concept of narrative inquiry as follows:

It is collaboration between researcher and participants, over time, in a place or series of places, and in social interaction with milieus. An inquirer enters this matrix in the midst and progresses in this same spirit (to understand the experience), concluding the inquiry still in the midst of living and telling, reliving and retelling, the stories of the experiences that make up people's lives, both individual and social. Simply stated, . . . narrative inquiry is stories lived and told.

Clandinin and Connelly (2000: 189) further elaborate that at the heart of narrative inquiry is relationship (a fundamental element of spirituality) and based thereon, offer the following definition:

Narrative inquiry is the study of experience, and experience . . . is a matter of people in relation contextually and temporally. Participants are in relation, and we as researchers are in relation to participants. Narrative inquiry is an experience of the experience. It is people in relation studying with people in relation.

Chase (2005: 671) states that narrative inquiry's strengths are its ability to demonstrate “(a) the creativity, complexity, and variability of individuals' (or groups') self and reality constructions and (b) the power of historical, social, cultural,

organizational, discursive, interactional, and/or psychological circumstances in shaping the range of possibilities for self and reality construction in any particular time and place”.

In studying nurses’ experiences of spiritual care giving, I had felt that it was vital to examine nurses’ (inter-)subjective experience (because spirituality is a subjective/inter-subjective experience), their social interactions and influencing macro-issues regarding their experience. Narrative inquiry would allow me to do so. I had also felt it vital to represent nurses’ experiences as holistically as possible. Again, narrative inquiry enables this to be achieved (Holloway & Freshwater 2007).

Putting theory into practice, however, is another matter altogether as a segment of my initial attempt at writing up my narrative about Lydia on the last day that we shared together demonstrates below. Afterwards, I will analyze the difference between my initial narrative and my re-written narrative as above in relation to their content and form with a view to understanding how nurses may be “uncaring”. In my discussion, I will include elements of Betsy and Bethan’s story for the purpose of further informing my analysis.

3.3.4.2.1 Lydia – part of my initial narrative

It is mid morning in no time and Lydia calls me over to her bedside. She would like a shower because she has not had a “proper” wash for two days. Her entire chest and sides at chest level are bandaged from sores incurred through radiotherapy. She would like to take her dressings off, shower and have fresh bandages applied. She is reluctant, though, to take the dressings off herself. She does not say why – perhaps she is frightened of what she might see or worried that something awful will happen. Perhaps she just does not want to be alone. I offer to be present while she takes them off and we head for the shower room. The dressings come off very easily. Her entire chest and sides are blood raw and oozing serous fluid. She has undergone a right mastectomy but the left side of her chest is also completely flat with just a nipple in the centre.

“It’s awful what cancer treatment can do to the human body”, she tells me half sorrowfully, half matter-of-factly. I had my left breast after my initial surgery for

cancer but all the radiotherapy has done this. It's almost unbelievable isn't it? Who would have thought that I'd be left like this?" We both stare at her chest for a minute or two. Lydia does not seem self-conscious in the least. It is as though she just wants me to bear witness to how ravaging cancer and its treatment can be. I feel tremendously humbled to be with her in this intimate moment and so extraordinarily lucky not to be as ill as she is or to have undergone body mutilation to anywhere near this extent. I fleetingly think of the problems that I have at this moment in my life – they pale in comparison. I reach for the bag with her dirty dressings inside and gather it up to take with me as I leave the tiny shower room. "Oh, you're going to take it away, are you?" she asks incredulously.

"Yes. I'm happy to help." I sense that she did not expect me to touch her body's waste products. She possibly expected that no one would willingly. I smile at her as I leave, telling her that I hope that she enjoys her shower.

I return from my break at about 11:30 a.m. Lydia's Consultant, the junior doctor and Deirdre, the ward Sister, are standing around Lydia's bed. I approach and stand in the background, listening in. Lydia is explaining her symptoms to them in great detail.

"I just can't eat hardly anything . . . and I worry about eating . . . whether it will make the griping pains in my stomach worse. And I know that if I take more medication for the pain, I'll probably get more constipated which will cause me even more pain . . . It's so difficult to know what to do for the best . . ." (Such a delicate balance.)

"And I can't get comfortable. It's so tiring holding myself like this (she emphasizes holding herself so rigidly with her body). Why do you think that I need to hold myself like this? What's causing that?"

"Well, I think that your stomach as well as your chest may be affected by the radiotherapy", says the Consultant. "The skin is so tight . . . It's restricting your movement. And it's restricting the actual movement in your gut most likely and that's partly why you find it so difficult to eat."

"But this griping pain . . . I find it so difficult to sleep at night. I have my last pain killer at about 11 p.m. and then nothing until the morning. I've been waking up at about 2 a.m. I just don't know what to do."

"Well, perhaps the laxative that you've been taking since you've been here with us this time is causing that griping pain. It's very strong and it can do that. Now that your constipation is fairly well sorted out, perhaps we can take you off it and just

give you a stool softener. Hopefully that will keep you from becoming constipated again, now that your bowel seems to be working better. That might help. Perhaps you could also take another drug for the pain that you get in the night. We'd have to see how the two work together, though, before we send you home again."

(Another finely tuned balance to try to establish.) "Are you happy to try that and see how it goes for the next few days?"

"Not really . . . I mean, I was due to go home on Friday (tomorrow) but I guess I'll have to stay a bit longer now and see how this goes I don't really have a choice, do I?"

"Well, we would like to monitor how you go on the new treatment before we send you home again."

"Okay, then", Lydia agrees reluctantly. "I've got to get sorted before I have any more radiotherapy. I'm due to see the doctor at the other hospital again soon to discuss that option."

"It may be that more radiotherapy will make things worse. Your skin may not be healed and if they give you more radiotherapy, you'll then be in a really bad way. It might not be a good idea at all."

"I never realized that the treatment will stop me having more treatment"

Lydia looks genuinely surprised, as though a major penny has dropped. I am very surprised as well – that no one has mentioned this possibility to her before.

Perhaps, like telling white lies, healthcare professionals parcel out small grains of truth to patients such as Lydia so as not to overload them (or themselves, in terms of the potential patient emotional or spiritual fallout)? There is always another corner to turn, another hurdle to jump, and/or another cruel reality to try to absorb. So ravaging indeed. "Should I keep that appointment, then? What do you think?"

"I wouldn't I think that might be best."

"Whatever you say." The Consultant briefly recaps the plan of action and the group leave.

I am fairly amazed at how calmly Lydia has taken this news about no further radiotherapy, at least not in the foreseeable future. I move to sit beside her on her bed.

"I never realized that", she remarks, still very calmly. "I guess that I should have realized . . . I'm not afraid to die. We're all going to die. I've lived a good life. I am

afraid, though, as I think most people are, about how I might die. I don't want to suffer too much . . . I could take suffering . . . severe suffering for about a week, I guess, if I knew that I was going to die at the end of it. I don't want to suffer for weeks and weeks or even months and months, though, when you know that there will be nothing at the end of it. I'm suffering a bit now but at least I can sleep for reasonable periods of time. Some people whom I've met here have it far worse than that. They suffer a great deal of pain constantly with no relief whatsoever. I'm lucky compared to them. I do think that we've got it all wrong, though, in the world today. People are so afraid to die. We pretend that we can live forever and fight death. But it's a natural process. You've got to relax and go with the flow. There's just no point fighting it. I realized this when my mother died. I stood around at the end, waiting for her to die. It was just like when my daughter was born. All the waiting and people standing around. We pass into life when we are born and then we pass out again when we die. They are both such natural processes . . . part of the same process . . . going in and out of a spiritual world . . . the world where we really belong . . . forever . . . We're just visiting this world . . . We should realize that and just go with it. That's what my religion tells me and that really helps me. It really helps when I pray. You have to make some decisions along the way, though, when you die. Inside, you know what the right decisions are for you . . . You need to go with those . . . and everything will be okay . . . You have to trust that the decisions that you make are right for you and just go with that . . . I'm going with the Consultant's decision not to see the other doctor about more radiotherapy. I know that that's the right decision for me. I think that these things are decided before you are born. I think that it was decided that I would get cancer and so I've just got to go with that." Lydia draws a big breath, as though she has said everything that she would like. She then turns to me and tells me that she must be boring me stupid with all her talk. "Not at all", I reply. "I want to know what it is like for someone in your situation and you are telling me. I am very grateful." She thanks me and tells me that she has enjoyed talking to me. I leave to hand out the lunches.

3.3.4.2.2 Nurses as "uncaring" in relation to my initial and re-written narratives concerning Lydia

There is a vast difference between my initial and re-written narratives concerning Lydia with respect to connection and relationship. One of my supervisors at Leeds challenged me to reflect on where *I* was in my narrative in my initial narrative and

why he could read it in a fairly detached way in spite of the harrowing experience that was being described. He said that he felt that he was reading a *commentary* on the situation. Another supervisor expressed that she felt that what was happening was that he was engaging and disengaging with it, which was actually saying something about the way that it is written and about the process and about what it is like to be in an environment as a nurse caring for such patients and thinking, "I'm getting too close. I need to step back". She continued that I was writing *about* the third person and this was what was putting both my other supervisor and me at a distance. It was further expressed that what is coming over very powerfully is not my *human contact* with patients (although it was felt that I do connect with patients very strongly in ways that other people do not), but the extent to which I am embedded in the *system*. My text is conveying the realities, not so much the patient's reality, but the nurse's reality of the need for detachment in order to cope. I was then challenged to re-write my narrative about Lydia (as I have done above) with a view to bringing *myself* into the narrative in a much more *engaged* way. A major focus of the re-written text is now my connection or relationship with Lydia as well as my connection or relationship with myself and the universe. As a result, in reading my re-written narrative above, it is hoped that the reader will have felt thoroughly engaged with the text throughout. Similarly as a result, in reading the application of relevant theory to the re-written text (another difference between the two narratives), it is hoped that that text will have resonated deeply with the reader because I have successfully explicated my connections or relationships as above.

Narrative inquiry, as I have indicated above, is about people in relation studying people in relation. As the researcher, I was in relation with my study participants (whether I was consciously aware of this or not). Therefore I was part of the study's field of inquiry. Expanding on my argument concerning my field boundary in the previous chapter, then, this is another reason why I should have been a (fully) participant observer. Further, and also as stated previously, spirituality concerns connection or relationship with self, other(s) and the wider universe (indeed everything is connected to everything else). My research is an exploration of spirituality. Therefore I need to be included in my study and as a researcher I should write my narrative such that it includes all aspects of me. My initial narrative about Lydia above includes primarily what I was doing and thinking when I was with her and very little about what I was feeling. Conversely, as it should, my re-written

narrative includes all of these aspects and both I and the experience are represented more holistically.

After writing my entire initial narrative, as stated previously, my main concern was how to present my narrative holistically so as not to reduce the participants' experience and such that the whole of my experience of spiritual care giving was captured and conveyed to the reader. I felt that this had not been fully achieved. From reflecting with my supervisors at Leeds as above, I realized that I had been (largely) missing from my narrative and that this was part of the problem, as I have explained above.

In relation to this concern, I also felt that it was difficult if not impossible to analyze my initial data as I did not necessarily know what was influencing the nurses' behaviour; behaviour may be conscious or unconscious. How therefore could I better understand the nurses' behaviour (notwithstanding the notion that one may never fully understand others)?

Participating in my study, not just by engaging with my study participants but also by examining various aspects of myself (for example, my experience, my feelings, my deeper level of consciousness, my writing of my text), enables me to address these concerns. Merely examining my participants' experience does not or may not facilitate an holistic understanding of spiritual care giving as their holistic experience may not be known (as much) by me. For example, when I came to discuss the sacred space and especially the forces (internal and/or external) which influence that space above in relation to the Consultant and his accompanying members of the multidisciplinary team (and similarly with both John's and Betsy and Bethan's stories previously), I was having to surmise to some extent what these might be. (Also in the case of John's and Betsy and Bethan's stories, I was unable to comment on the latter for anyone bar myself). I might have asked my participants what these might be, but I would then be relying on their ability, willingness and honesty to tell me. However sometimes denial may serve as a protection from the truth, thus militating against honesty. (Also, as I described in relation to Betsy after the incident with Mrs. Foster, for example, I was not always in a position to engage with them.) Of course, in examining my own self, my ability, willingness and honesty to do so may also serve as restraining factors, as they may

for anyone. As the researcher, though, I know that I am willing and trying my hardest to be as honest as I can with myself, which is the best that I can do. As for my ability, it is what it is and I can but try my best to respond to the guidance from my supervisors, which I am doing.

My reflections stemming from all of the above have resulted in the employment of narrative as my research method having new meaning for me. As “narrative refers to the (retrospective) making of meaning through personal experience by way of a process of reflection in which storytelling is a key element” (Connelly & Clandinin 1988: 16), by bringing me into the narrative, I am now retelling it, having reflected on it myself, and having participated in guided reflection with my supervisory team at Leeds University. The change in my storytelling involves a number of issues. First, and further bringing me into the narrative, I am now the main character rather than a storyteller narrating in the third person. (When I wrote my entire initial narrative, there was no main character, but rather a number of key characters - patients and nurses, such as Lydia, Mrs. Foster, Bethan and Betsy. These key characters were the people whom I felt contributed meaningfully to some degree of an understanding of spiritual care giving in nursing, although almost inevitably as above, this understanding was incomplete and possibly, also to some degree, erroneous (not, of course, that my re-written narrative is potentially any less erroneous, as it is still my interpretation of what happened, albeit from a different perspective).)

Regarding narrative, Polkinghorne (1995: 17) claims, “The story is about the central character and movement toward an outcome . . . The protagonist is not merely a pawn buffeted by the setting, but an actor who alters the scene”. The plot’s rising action, the climax or any conflict, falling action and any resolution of the story is thus driven by the central character’s issue(s) or problem(s), focusing on the inner conflict of the central character. The latter, then, should be positioned in the foreground and should not be discussed solely in relation to my role as a researcher, for as Rolfe (2002: 181) states, in non-positivist research that concerns in-depth study of “unique phenomena in particular cases”, of which my data comprise, it is vital that the researcher be written into the study as a whole person. He (2002: 179) argues that clinical nursing research such as mine, which concerns itself with nursing practice, “a series of *individual encounters* between individual people”, is formed by a “a series of ongoing I-thou relationships, constantly

formulated and reformulated, either serendipitously or as part of a deliberate research strategy” (2002: 181). Thus he (2002) advocates that the researcher involved in such a study must adopt a reflective research approach of exploring aspects of herself, or as Greene (1998: 390) specifies, her “perceptual frames, histories and values” inevitably impact upon the study.

. . . the study of self must become the *focus* of the research rather than simply part of the *process*. In other words, the focus of the study must be turned from the outer to the inner, from the thoughts, feelings, beliefs, attitudes and practices of the thou to those of the I, that is, of the researcher herself. Under these conditions, the researcher and the researched become one and the same person (Rolfe 2002: 185).

Such a process of a deep and personal dwelling with the phenomenon of inquiry, otherwise known as ‘heuristic research’, and involving “self-search, self-dialogue, and self-discovery” is considered to result in a real understanding of that phenomenon (Moustakas 1990: 11). As Pinar (1981: 183) elaborates, “efforts to understand properly arise in the midst of a *felt* problematic” and feeling is only experienced subjectively. Using and presenting myself in this way, including that of autobiography (another means of bringing myself into the equation), further enhances understanding, as it facilitates the reader to appreciate me as a full human being (Gergen & Gergen 2002) and as such, someone to whom s(he) may relate. Of course, all of these ideas are in line with the caring-healing paradigm of which spirituality and spiritual care giving form a part (Holloway & Freshwater 2007), making them all the more appropriate to incorporate in my research. I will elaborate on this further later in this chapter.

Concerning the virtual absence of *me* from my initial narrative about Lydia, I have previously discussed how at times and in the interest of time, I edited myself out of my data. This might explain (some of) my absence from my initial narrative. Having said this, perhaps an expectation on my part that the staff would be caring also contributed to the virtual absence of me in my initial narrative. Perhaps this was a means of distancing myself from what I perceived as the *other* “*uncaring*” professionals. I like to think of myself as a caring person but perhaps the reflective mirror was a little too close for my comfort. I know that like all people, I am not always caring. I know this cognitively but it is not so easy to swallow otherwise. Earlier in my text, I wrote that while it is one thing to respond to others with great

compassion cognitively, it *is* quite another for our behaviour to realize this (Kulananda 2000). I hold very high standards for my behaviour and am often my worst critic. Accepting myself as human, or at times “*uncaring*”, is not always easy. Further, perhaps as my supervisor suggested, I needed to distance myself from the other “*uncaring*” professionals because I knew subconsciously when I was with Lydia and exposed to all of her suffering that I wanted to distance myself from that suffering in order to cope with it all (I had no conscious awareness of this however).

From the outset and throughout my period of data collection and as I have already demonstrated to some extent, I experienced considerable inner conflict or tensions. Primarily, these tensions or conflict concerned the issue of I-Thou relationships which according to feminist methodology, must be reciprocal in nature (Oakley 1981). In my intimate relationships with people in all aspects of my life, I endeavour to have I-Thou relationships. I value this form of relationship tremendously and feel that it is the only appropriate form for such relationships to take. My inner conflict, as I mentioned in the previous chapter, stemmed from having initially adopted a fairly traditional, reductionist stance to my research - one in which things are known ‘objectively’ and there is no place whatsoever for the subjective and inter-subjective. (My traditional science academic background may have further contributed to this.) Thus to one extent or another, whilst positioning myself such that I vicariously lived the patients’ (such as John’s, Lydia’s and Mrs. Foster’s) and nurses’ (such as Betsy’s) experiences, often of suffering, I was engaging in I-It rather than I-Thou relationships with my study participants (Rolfe 2002). (Indeed, in a sense, my I-It relationships might possibly be more aptly described as It-It relationships, as I was not bringing my entire self or the best of myself to those relationships.) In other words, I was “*uncaring*” because I was not engaged in subjective and inter-subjective knowing and processing my emotions in relation thereto.

Similarly, my experience of researching other peoples’ stories regarding spirituality and spiritual care giving was one of primarily bearing witness to missed opportunities for meaningful or personal nurse-patient encounters entailing I-Thou relationships (such as between Betsy and Mrs. Foster and Lydia and the Consultant and his accompanying members of the multidisciplinary team). These many missed spiritual care giving opportunities suggest that the nurses were engaged in the same struggle as I was, unable to deliver care embracing and

knowing their subjective and/or inter-subjective selves. In other words, they too were “*uncaring*” (for example Betsy and perhaps Deirdre) because they were not engaged in subjective and inter-subjective knowing and processing their emotions in relation thereto.

Through critical reflection however, as indicated to some extent in this and the previous chapter, my narrative is one of empowering myself to conduct my research in a more caring manner. It is further one of facilitating others to practise nursing likewise, through embracing subjective and inter-subjective knowledge and processing their emotions in relation thereto.

3.3.4.2.3 Nurses as “*uncaring*” in relation to critical social theory

The intent of critical social theory is “to interrupt particular historical, situated systems of oppression” (Lather 1992: 121). As per my previous attempt to theorize with respect to my data in relation to Betsy and Bethan’s story, I was aware that (a) system(s) of oppression was/were in operation (although I have not previously explicitly described them as such), influencing my study participants. In my research, I was not a practitioner within the culture that I was studying, yet as I have stated, my view was and still is to enable my vision for change within it. Critical social theory, therefore, is an important epistemology worth exploring as I am attempting to understand how and why society is constructed unequally and governed by dominant ideologies that suppress other understandings (Manias & Street 2001) as the basis for potential future change. In relation to my behaviour in Lydia’s story (another way of bringing me into my narrative, in terms of my relationships with self and others), then, critical social theory might be applied as follows:

- With respect to the team moving on after the Consultant had made it clear to Lydia that her death might be more imminent than she had thought, I never spoke with or challenged Deirdre regarding this. For example, I never brought it to her attention that perhaps this behaviour did not match her beliefs about spiritual care giving. Deirdre had told me on another occasion that spirituality is what matters most to a patient. However she made no effort to come back to Lydia and find out how she was after having been told such potentially life changing news, or even say that she would come

back to talk with her after the ward round or later that day or indeed any time;

- With respect to myself as a researcher regarding the above, from a feminist research perspective, I should have been engaged in 'right' (I-Thou) relationships with all of the staff and patients with whom I interacted. It might be argued, therefore, that I should have spoken with Deirdre as I have discussed above. It might also be argued that I should have shared Lydia's reaction to the news and her concern about a painful death with the staff (although I did not do the latter because both Lydia and I knew that painful deaths occur regardless of attempts to relieve pain). Also, I held myself back because at the time I considered that I was supposed to be conducting my research in a more traditional, 'objective' manner (indicative of I-It relationships);
- With respect to my relationship with Lydia, as above, it might be argued that I let my 'right' relationship with her down by not following through and speaking with Deirdre regarding what happened. This might have enhanced the care that Lydia received, not just from Deirdre but potentially from the other nurses on the unit as well.

Nurses *can* be "uncaring", as evidenced by my story about Betsy and Bethan and again in my story about Lydia. My overall research findings mirror these stories, although there were glimpses of some excellent spiritual care giving by nurses in both settings.

My findings are not new. In a seminal paper employing phenomenology and examining care between healthcare professionals (including nurses) and cancer patients from the latter's perspective, Halldorsdottir and Hamrin (1997) found that patients experienced both caring *and* uncaring encounters along a caring-uncaring continuum. Six major categories emerged from their analysis, three of which each formed the basis of essentially caring and uncaring encounters: the perception of the nurse by the patient as caring or uncaring, the connection or disconnection between the two parties and the perceived effect of the caring or uncaring encounter on the patient.

In caring encounters, the nurse was perceived as both competent and compassionate. The two parties connected in a relationship of mutual trust with the nurse being genuinely concerned for and respectful of the patient. As a result, the patient experienced “a sense of solidarity, empowerment, well-being, and healing” (Halldorsdottir & Hamrin 1997: 122). Contrastingly, in uncaring encounters, the nurse was perceived as somehow incompetent and worse, not caring about this or its effect on the patient. Additionally the nurse was seen as being indifferent to the patient, both as a patient and a person, someone either not able or willing to connect with patients. This resulted in a negative effect on the patient in terms of his/her well being and healing, of “distrust, disconnection, uneasiness, discouragement, and a sense of being broken down” (Halldorsdottir & Hamrin 1997: 124).

Halldorsdottir and Hamrin’s (1997) findings would appear to support human caring theory (Watson 1999) and its application to practice in terms of the findings of my study as above, particularly with regard to the importance of the nurse-patient connection and relationship and its positive effect on the patient. They further support the notion that caring should not be an ‘add-on’ to more technical or practical aspects of care giving (the latter in the broad vein of what Halldorsdottir and Hamrin (1997) class as ‘competence’), as patients’ perception is that competence without compassion is not ‘caring’. Sadly, though, caring is commonly viewed as an ‘add-on’ by nurses (Hoover & van Ooijen 1995), including a number of nurses in my study who told me as much. Halldorsdottir and Hamrin’s (1997) findings clearly demonstrate that without a connected, compassionate, I-Thou relationship between the nurse and patient, the patient may experience a devastating effect which may affect their health and well being.

In recent years, nurses have been shown repeatedly to be ‘uncaring’ (for example, Department of Health 2010a, NHS Future Forum 2011) and the public have been outraged (Brindle & Curtis 2011). It seems that ‘angels’ (Salvage 1985) have transformed into demons in whose care the public are not safe physically, psychologically and/or spiritually. What may account for this?

Nursing was once considered a vocation (Salvage 1985), then an occupation and is now widely considered to be a profession (Rolfe, Jasper & Freshwater 2011). Nurses in Britain are now increasingly educated to degree level and that education is underpinned chiefly by the dominant discourse of evidence-based practice. All of the nurses in my study told me that they wanted to give patients good spiritual care and the vast majority of them told me that such care meant meeting the patient's most pressing need, whatever that may be from the patient's perspective. However many of the nurses also told me that they did not always feel they were able to deliver that care. One nurse even begged me to explain her 'uncaring' behaviour (which I witnessed and she verbalised as such to me) to her so that she might try to rectify it. (She kept getting angry/impatient with the patients in her care who did not behave as she thought that they should (for example, they did not do as much as she thought that they could do physically in terms of washing themselves) or who expressed anger (for example, when their dinner arrived 'cold')). She told me that while she *knew* that she was behaving in an 'uncaring' fashion, she just could not help herself. An examination of the difference between the evidence-based paradigm and the caring-healing paradigm (as embraced by Watson's (1999) transpersonal caring-healing model concerned with human caring theory which I have described previously within this chapter) may shed useful light on this conundrum.

The caring-healing paradigm is explicated by Watson (1999) as being underpinned philosophically and morally by sacred feminine principles. Thus deeper, subjective meanings and feelings about life, living, natural inner processes and choices are honoured. Relational, intuitive and receptive ways of knowing and being are considered and art, beauty and aesthetics are honoured every bit as much as science and technology. Everything we do from living our lives to researching and practising our profession derives from a call which is motivated by a love of everything (in the vein of Wilber's (2000) concept of nonduality which I have described previously). Forms of inquiry involve discovering ourselves. In all aspects of our lives, inter-subjectivity, feeling, things that we do not know, transcendence, mystery and chaos are incorporated. In all our relations with everything and everyone, including ourselves, we strive to accomplish nurturing, cooperation, relatedness and harmony whilst embracing manifold variety. And finally, our vision of wholeness and healing is both inner and outer.

According to Watson (1999: 102), then, within the caring-healing paradigm (Watson 1999), “caring is based on an ontology and ethic of relationship and connectedness and of relationship and consciousness”, and “caring consciousness, in-relation, becomes primary”.

Evidence-based practice is a systematic process of reviewing, appraising and employing existing research findings as the foundation for clinical decision making (Rosenberg & Donald 1995, Kitson 1997). Nursing practice should be contextually determined within the individual experience of nurses and patients (as I have expressed in relation to spiritual care giving) and ideally, nurses should employ all four of Carper’s (1978) ways of knowing (empirics, aesthetics, personal knowledge and ethical knowledge) in their decision making. Thus evidence-based practice should additionally embrace these elements of decision making and embrace a caring philosophy of nursing (Holloway & Freshwater 2007).

In reality, though, this is very largely not the case. The hierarchy of evidence model of evidence-based practice has been widely adopted within nursing. This emphasizes the value of hard, ‘scientific’ evidence and positivist research associated with empirical (and some ethical) ways of knowing and de-emphasizes propositional knowledge stemming from an understanding of individual nursing situations. Thus unlike in the caring-healing paradigm (Watson 1999) where all four of Carper’s (1978) ways of knowing and propositional knowledge are valued and promoted, personal and aesthetic ways of knowing are largely devalued and dismissed in the evidence-based paradigm (Holloway & Freshwater 2007). In essence, then, students taught nursing within the evidence-based paradigm are taught to embrace a more technical approach to nursing (Rolfe, Jasper & Freshwater 2011). They are taught to value hard, ‘scientific’, ‘objective’ evidence (what Carper (1978) broadly terms empirics or empirical knowledge) over propositional knowledge and ‘subjective’ (or inter-subjective) knowing (what Carper (1978) broadly terms aesthetic and personal knowledge). Thus they are taught to perform technical tasks or activities and to be technically competent. They are not taught to engage in understanding their patients as individuals or to facilitate their potential for expanding consciousness or self transformation (as well as this same potential with respect to themselves). Nor are they taught to be compassionate, the latter as promoted within the caring-healing paradigm. It is no wonder, then, that nurses in my study were found to not engage in meaningful or personal nurse-

patient encounters entailing I-Thou relationships, and thus to be “*uncaring*”. As I indicated above, to be seen as ‘caring’ by patients, nurses are required to be technically competent *and* compassionate.

Feeling that they do not have time to care for their patients as they would wish and/or experiencing their own behaviour as “uncaring” (for example, Betsy and Bethan both conveyed these notions to me as did the nurse mentioned above in this section of my thesis) may therefore be a source of cognitive dissonance or a form of tension for nurses. The dissonance may be between the thoughts, “I am a caring person” and “My behaviour as a nurse is uncaring”. This is (part of) the tension that Betsy, Bethan and I all felt to one extent or another during and after the “uncaring” episode of care at Mrs. Foster’s bedside. This tension may also have been present in the healthcare team who made a sharp exit from Lydia’s bedside, as I have described above. Such tension, as I have previously argued, renders it difficult to access one’s sacred space and hold a conscious intent to care, which may have a knock-on effect of leading to further “uncaring” behaviour. This was the case with Betsy who had experienced tension as a result of having been “humiliated” by the Senior Registrar (in essence, having been told that she was not a “good” (“caring”) nurse) before she became involved with Mrs. Foster.

It is perhaps worth noting that the tension that nurses experience as I have described above may also be considered as a result of them having been taught to value ‘objective’ knowing over ‘subjective’ knowing. As persons, we are both ‘objective’ and ‘subjective’ by nature. By teaching nurses to devalue their ‘subjectivity’ or ‘subjective selves’, are we fostering them to feel divorced from their ‘subjective selves’? It is common knowledge that the fallout from what is understood as a ‘normal’ divorce, meaning a marital divorce, may be huge. Why would this fallout within our subjective selves not be equally huge if not even greater? It strikes me that I may have experienced such a fallout when I decided to leave clinical nursing as I have described in my introductory narrative to my thesis in Chapter One. That fallout, just in the practical sense, was one nurse leaving the clinical profession.

Sadly, though, this is not the full picture of why nurses may be “*uncaring*” in their practice or the difficulties this presents for them, as it does not account for

environmental or cultural influences. A number of such influences were indicated in my discussion about Betsy and Bethan's story. On a wider basis, the nurses in my study generally encountered the following issues to which critical social theory may be further applied:

- In the same way that I was pushed for time to collect my data and write up my initial narrative, the nurses in my study were almost constantly pushed for time to complete their work within their shift of duty. Therefore, they too would most likely have experienced difficulty being reflective in their practice. Also, reflectivity in relation to spiritual care giving, as I have described above, concerns subjectivity and intersubjectivity. As nurses are taught to devalue 'subjective' ways of knowing, they might find it somewhat difficult to practise reflection;
- Just as I was constantly thinking about or experiencing situations which were more often than not harrowing, being bombarded by stimuli and having to prioritize with regard to my role, so too were the nurses. This, then, is another reason why the nurses would undoubtedly have found it difficult to reflect on their practice, both in and on action, and this would have militated against spiritual care giving;
- Similarly to my having to worry constantly about keeping the ward managers on my side in order to complete my data collection, many of the nurses in my study in both settings felt, as one nurse expressed, that they were 'ruled with a stick', having to worry about minding their behaviour as a result. A number of nurses in both settings even told me "horror stories" about how they and/or their colleagues had been, in their view, severely badly treated by their ward managers or higher management within their organisation, causing tremendous long standing suffering. Again, this renders the potential for reflection in the workplace difficult, as it is difficult for the nurses to be relaxed and 'in the moment' (Tolle 1999). This would also make the process of spiritual care giving difficult as it too requires being 'in the moment'. (Of course, somewhat ironically, I too was 'ruled with a stick', except that it was me "beating myself up", in terms of trying to conduct qualitative, 'holistic' research within a techno-rational framework.) Also, being 'ruled with a stick' is suggestive of I-It rather than I-Thou relationships between ward managers and staff. It may be (more) difficult for nurses to engage in I-Thou relationships with patients when they are engaged in I-It relationships with their managers, particularly when they are the 'Its'.

Similarly, in terms of “beating myself up” as above, perhaps I was not enacting an I-Thou relationship with myself in the process, affecting my relationships with others. Self love (as in ‘love thy self’) and respect are surely forerunners to loving and respecting others.

A further aspect of the nurses’ treatment by their managers above is that it may lead to them feeling very vulnerable in their employment. Once again, the nurses’ sacred space may be filled to some extent with tensions and fears or anxieties in relation to their feelings of vulnerability, making it (very) difficult, if not impossible for them to exercise a conscious intent to care. Also, feeling vulnerable is not a good position from which to embrace concepts such as mystery, uncertainty, self discovery and the unknown – concepts associated with spirituality and the caring-healing paradigm. Fear, for example, breeds a need for certainty, not *uncertainty*. It may also be argued that the nurses’ feelings of vulnerability at the hands of their managers may lead to increased feelings of vulnerability with respect to their cognitive dissonance in relation to wanting to care but feeling unable to do so, and vice versa. Thus the nurses may be caught in a vicious circle of vulnerability;

- As I had worried that I did not have answers for the nurses with respect to various dilemmas that they brought to my attention (for example, in the case of the nurse above who wanted to know why she behaved in an ‘uncaring’ fashion), being or feeling unable to respond to patients’ questions (adequately) (or to doctors’ questions, as in the case of Betsy) caused the nurses concern. For example, there was one particular nurse in my study (of only one or two other nurses) who, in my view, was highly skilled at encouraging patients to speak with her regarding personal matters of importance to them. I watched her in only one situation in which she enacted this skill and just as the patient was about to actually express his concern to her she fled from the room in a fairly distressed state. I encouraged her to reflect on the situation afterwards and she told me that she had been afraid that she would have been asked a question that she could not answer; she felt that she needed to know everything. Spirituality, as indicated above, has ineffable, mysterious qualities. It is not about predictable, knowable (at least not in the traditional, ‘scientific’ sense) certainties, and spiritual care is (more) about the art rather than the science of nursing. In the Western

world where the techno-rational paradigm is dominant and certainty and predictability are sought, however, there is little or no place for the spiritual and spiritual care giving. Sadly, this nurse was in considerable distress as she wanted desperately to provide good care to her patients, yet was unable to always do so because she thought it meant having all the answers. Our stresses (and oppression) were of the same origin – trying to operate in a caring-healing paradigm while unwittingly being a servant to the techno-rational paradigm.

I will discuss the first three points above further in Chapter Seven.

Caring theory (Watson 1999) espouses that caring is foremost about holding a conscious intent to care in relationship. Nurses want to care but they need to be freed up of the tensions on their sacred space so that they are *able* to care. Teaching them about the theory of caring, all of Carper's (1978) ways of knowing in relation thereto and in relation to spirituality and spiritual care giving (and teaching them to value *all* ways of knowing equally), and relevant, applied critical social theory (Lather 1992) might help the current situation so that they are empowered to know what caring is and how and why it does not occur to the extent that it might. In this manner (by expanding their consciousness), nurses may be assisted to transcend their "*uncaring*" selves. However, a way of being and subjective and inter-subjective knowing cannot just be learned cognitively (by traditional classroom methods). They should be learned via reflective practice (Freshwater 2000, Johns 2002, Johns 2004a, Johns 2006). The latter, though, is not generally valued within nursing as it is based on all ways of knowing in nursing and like caring theory, does not 'fit' the evidence-based paradigm. Also, it would be most helpful if the environment or culture within which nurses work changed such that it might facilitate caring practice rather than impede if not destroy it. This will certainly not happen overnight!

3.4 Summary

Chapter Three has explicitly made known and examined a second difficulty with my narrative – that despite the longstanding public image of nurses as caring, nurses (and other healthcare professionals) may be "*uncaring*". Indeed, my thesis has revealed that spirituality and spiritual care giving are barely evident, although not necessarily nonexistent in clinical nursing practice. Human caring theory (Watson

1999) underpinned by the caring-healing paradigm (Watson 1999), narrative inquiry (Clandinin & Connelly 2000) (what it is and how my misapplication thereof was instrumental in producing the instability of my field boundary) and critical social theory (Lather 1992) all contribute to an understanding of how this finding was produced and what might be done to turn the myth of spiritual care giving in clinical nursing practice into a reality.

Foremost, nurses' "uncaring" behaviour may stem from how evidence-based practice has generally been adopted by the profession; subjective and intersubjective knowing in line with the caring-healing paradigm have been devalued in favour of objective, empirical knowing in line with the evidence-based paradigm. Nurses are thus generally taught to be technically competent as opposed to both technically competent and compassionate. As being seen as 'caring' by patients requires that nurses be both, nurses may therefore be seen as "uncaring". The environment in which nurses practice additionally contributes to the difficulty, and this will be explored further in Chapter Seven.

In Chapter Four I will continue to explore the implications of the evidence-based paradigm having been adopted by the nursing profession in the way that it has by examining my struggle with the research process.

Chapter Four

Researching Spirituality:

My Struggle with the Research Process

4.1 Introduction

Throughout my period of data collection and most of my period of data analysis, I struggled with the research process. My struggle, which I have touched on in previous chapters, concerned my struggle with what a professional nurse should do. I struggled with it because I did not want to do that. I wanted to develop a different sort of relationship with the phenomena that I was observing, namely the experience with the patient. In this chapter, I will examine my story about Raymond, a patient at the hospice, with a view to understanding my struggle. My struggle is in relation to the evidence-based paradigm having been adopted by the nursing profession in the way that it has, and I will explicate this along with implications thereof for researching spirituality and providing spiritual care.

Researching the care that Raymond received was perhaps the most challenging experience for me in conducting my research, creating a huge amount of tension. In my struggle to understand my experience, and unlike my analysis in relation to the other chapters of my thesis, I have examined it previously (after my initial writing of it and before I began to employ my theoretical framework in this regard) and this is the narrative that I will present below. I will then re-analyze my narrative, employing my theoretical framework.

4.2 Raymond

Raymond was a gentleman in his early seventies who was a patient at the hospice. I observed the care that he received on a weekly basis over the course of just over one month. I first encountered Raymond on my third visit to the hospice, approximately only two weeks after I commenced my data collection. Raymond was admitted to the hospice for symptom control for his prostate cancer and because his neighbour was no longer able to care for him at home. He also suffered from depression (he had been depressed since his mother had died four

years previously) and was taking prescribed antidepressants. Raymond had been informed by the doctors at the hospice that his prognosis was not very good and he had told various members of the nursing staff that he wanted to die. As Raymond explained to me on one occasion when I asked him how he felt when one of the nurses had repeatedly asked him to smile while she and I were assisting him with a bath:

“I can’t smile. I wish that I could smile but I just can’t. I’m a Zombie.”

“What does that mean exactly, that you’re a Zombie?”

“Everyone wants to be autonomous, to be able to do things for themselves. But I have cancer and I’m not autonomous any more. I can’t smile and I can’t cry. I’m a Zombie.”

“When did you last cry?”

“Four years ago when I had my kidney out.” There was a short silence lasting about a minute.

“Was that when you were first diagnosed with cancer?” I inquired tentatively.

“Yes. I wish I had died then. Then I wouldn’t have to be a Zombie.”

“It must be awful, feeling like you’re a Zombie.”

“Yes. I just want to die. I want it to be over.”

Raymond remained emotionless. I sensed that he was trying his very best to cope with his illness and condition and to explain to me how he was feeling. From his explanation, I had no difficulty understanding Raymond’s wish to die; his condition was terminal and he would never be autonomous again. However it emerged that Raymond also had a desire to talk about death and dying and this seemed to pose great difficulty for the nurses on the ward as evidenced by the following conversation during the morning handover report which took place one week after I first met Raymond:

“It’s unacceptable that he (Raymond) goes round telling other patients, particularly when they’ve just arrived, that he’s seen so many people die here. They don’t need to know that. That’s the last thing that they want to hear”, stated Jill, one of the staff nurses, emphatically. The other nurses nodded and/or made utterances in agreement. Apparently, Raymond had witnessed a number of deaths on the unit over the week since his admission both in his room and others. Jill elaborated,

“Just because he’s obsessed with death and wants to die himself. We’ve been intercepting him before he has a chance to speak to the other patients. He goes out into the corridor and talks to everyone. We’ve had to restrict him to his own bay.”

I felt uncomfortable hearing the above conversation. Jill expressed that the nursing staff ‘*had*’ to take the action of restricting Raymond to his own bay, as though they had no other choice regarding how to respond to the situation. There are always choices regarding behaviour (and interpretation of behaviour). The nurses could have let things be and if Raymond approached other patients and those patients did not want to engage in a conversation about death with him, they could have just told him so. After all, all the patients were adults. In my initial writing up of this portion of my data, I wrote, “Raymond is being ‘policed’ for ‘breaking the rules’. While he can think of little (or nothing) else but dying, he must keep it to himself”. On reflection, the term ‘policed’ is perhaps somewhat harsh with respect to describing the nurses’ behaviour, indicative of some anger on my part. Clearly, Raymond wanted to talk about death and his dying which I considered reasonable if not natural and was being impeded by the nurses in his endeavour to do so.

Jill had expressed that the other patients did not want to hear anything about death and dying and had been supported by her colleagues in stating this. However an incident that I had observed the previous (first) week when I had met Raymond and which involved Deirdre, the ward Sister, had not borne this out.

It was about 10:30 a.m. and Alf, an elderly patient, was sat in his chair, overlooking a stunning, sunny panoramic view. He was all decked out in his flannel trousers and woollen cardigan, his feet swollen like tree trunks resting up on a stool. Alf had originally come in for symptom control of his cancer and had been waiting for weeks and weeks to be transferred to a residential home. He was no longer physically able to remain in his own home. He had waited longer than any other patient had ever done (according to the staff on the ward) because no one in any of the three homes that were on his list had died to create a place for him. This was very unusual. Another gentleman who shared his four-bed bay had only recently died in there. Several other men had also died either in the room or been moved to private rooms just beforehand over the past few weeks. Tom, the gentleman who

was currently beside Alf, had been going fairly steadily downhill for the previous week or so. Two days previously, Alf had apparently told the staff that he was 'bored' (and this had been written in his notes from the grand round). Deirdre, the ward Sister, was kneeling alongside Alf.

"Can I interest you in going to the dayroom? There's a telly and video there and lots of films."

"No. I'm fine here, thank you", Alf replied politely.

"Do you like westerns? There are lots of those. Would you like to watch a western?" Deirdre was still kneeling beside Alf, staring into his face with considerable concern.

"No, thank you", Alf politely re-declined. Deirdre remained kneeling, continuing to look at him with concern. She remained thus for several minutes in mutual silence.

"Are you sure?"

"Yes, thanks."

"What about cards? Do you play cards?" she asked, chivvying him along. "What games do you know? Gin? Perhaps Susan here (an unqualified bank nurse) can play with you for a while. I think that we have some cards on the ward somewhere. I'll ask Gloria (the receptionist) when she gets back. She's just gone to another ward for a minute."

Alf did not say anything. Susan, meanwhile, had piped up that the only game she knew was snap.

Deirdre was still in her knelt position, gently stroking the back of Alf's hand. Neither of them spoke as she continued to do so for several minutes. The look of concern was still etched on her face. Alf looked rather nonplussed. Deirdre then rose to her feet to leave the room.

"I'll go and see if Gloria's back yet. She knows where everything is. I'm sure we'll come up with a pack of cards for you".

Alf looked at her as she left. He still appeared to be fairly nonplussed.

After about five minutes, I approached Alf. I had worked in his bay previously and had begun to get to know him a little. He was generally a man of few words. I was curious to know what the previous conversation with Deirdre had been all about

from Alf's perspective. I was also keen to know how he was in light of the recent death and Tom's obvious deterioration.

"How are you doing today?" I asked, pulling up a stool beside him.

"I'm okay. *He's* not well, though", he whispered, tilting his head knowingly and discretely in Tom's direction. "He's getting worse by the day. I don't think he'll be here too much longer."

"How does that make *you* feel?"

"Okay. These things happen. We've all got to die sometime. *He's* (tilting his head toward Raymond across the way) been talking to me, saying that he might as well be dead *now*. Oh, well. The Sister's been in here, trying to get me to go to the dayroom. She's gone to get some cards."

"And how do you feel about that?"

"I don't want to leave the room."

"Why not?"

"I don't like being by myself. I like the company of the other people in the room. I like having people around me. And I've really enjoyed talking to Raymond since he came in. I don't want to play cards. She'll be back with some, but I don't want to play", he said, rolling his eyes gently as if to suggest that he had led her to believe that he would go along with her wishes (I sensed that he felt that her intent was good), but that he had no intention whatsoever of doing so. I gave him a look in return and shrugged my shoulders as if to suggest that his response to the Sister was fine - perhaps the only thing that he *could* have done in response to her persistence. Ultimately, though, if he did not want to leave the room or play cards, he did not have to. I sensed that Alf would come up with some way of politely 'doing his own thing' if the Sister returned. He was gazing at the gorgeous view out the window looking totally relaxed.

"I'll leave you to enjoy the view. Is there anything that I can do for you before I go?"

"No, thanks."

"I'll see you later, then."

Alf had remained in his room for the rest of the shift. The Sister had not been able to find any cards. When she had returned to the ward after looking for some elsewhere, she had announced this to me. I had asked her why she had been so

keen for Alf to go to the dayroom and/or play cards. She had said that when he had come into the ward, he had been such a happy man. "He's changed so much. He used to talk all the time."

At the afternoon handover, the nursing staff had spoken about Alf's situation in his room:

"It's not good for him in there with Raymond. He's seen too much death already. It's not good for him. The last thing that he needs is Raymond going around telling everyone that he wants to die. Nobody needs that."

Clearly, it seemed that the nurses had not been speaking on Alf's behalf. Further, by employing the word 'nobody' in the sentence 'Nobody needs that', they were including themselves. Indeed, it seemed that they had been projecting their own "anxiety about death and dying" onto the patients with Deirdre's behaviour toward Alf forming part of this. This had upset me, as reflected by the rhetorical question that I had written at the time: "If you can't talk about death in a hospice, where can you?"

The nurses generally felt that death should neither be mentioned nor seen at the hospice. I had noticed in the few weeks that I had been there that when a patient's death had been imminent, (s)he had been put on 'the care of the dying pathway' (a standardized care plan for patients whose death is imminent) and moved into a private 'family room' whenever one had been available.

Very shortly after Jill had expressed that the other patients did not want to hear anything about death and dying (above), of her own volition, she had taken me aside to explain what happens at the hospice regarding imminent deaths and why as follows:

"When they (patients) are about to die, we like to move them into the private, single rooms. There, families can have privacy to grieve. In our experience, we've found that this helps them to get through the process better. We don't force them to go into a single room. We ask them and let them decide."

There are two issues concerning Jill's explanation which indicate that what she had been telling me was not the case in reality. First, despite emphasizing at the end of

her explanation that the *patients* decide whether or not to be moved into a private, single room, Jill had previously stated, “*we like to move them*”, indicating that the nurses had a clear preference about what should happen. Second, she included the statement, “We don’t force them to go into a single room”. This had been a totally unsolicited statement to make; she and I had not been talking about anyone forcing anyone else to do something or not. There was no need for her to have included this statement unless, of course, there was some truth in it. It would seem, then, that moving dying patients into private, single rooms was employed to help the *nurses* get through the process better (although it may have assisted the families as well, as Jill had stated). Jill’s continued explanation to me appeared to support this:

“We get quite a few young women dying of cancer. Unlike male patients, they tend to be very expressive with their emotions. That’s very hard on the nurses. They’re about the same age as many of us, with young children.” Jill then told me that the unit had experienced a particularly bad spate of such deaths the previous Christmas. “It was terrible. I can remember it very well. We can all remember them, even their names. I hope this year will be better. We try to make this a nice place to work and it is most of the time.”

I took it that ‘a nice place to work . . . most of the time’ meant for the nurses, when (negative) emotions and death were kept contained. Indeed, the practice of moving imminently dying patients into private, single rooms had seemed to be the ‘norm’ as evidenced at the afternoon handover report the previous week when a number of patients had been deteriorating rapidly. “There’s going to be a race on”, the nursing staff had agreed, referring to the prospective competition for a limited number of single rooms. No one, however, had mentioned anything about having asked the patients in question about a decision to move rooms or not.

There had also been an incident on the ward two weeks later at the hospice that was indicative of the extent to which death and dying were sequestered by the nurses and the need for that to be case. The grand round had just ended (it had been approximately 2:30 p.m.), and I had just been about to prepare to leave to go home when I had seen all the nurses gathered around the nurses’ station. Deirdre had been there, talking with some of the staff about something that had been taking place at the front of the building. They had all been watching the live video camera of the front entrance. There had been a small boy wearing a parka,

playing just outside the entrance. One of the male staff nurses from another ward had been there. After about a minute, a Sister from another ward at the hospice had been seen going outside. The receptionist had then switched the camera off.

“What’s going on?” I had inquired.

“Nothing that you need to know about”, Deirdre had replied, flashing me a look as if to say, “I don’t want you to see this.”

“I’m intrigued now”, I had answered, half jokingly. My curiosity had peaked, especially as I had seen several nurses becoming quite “anxious” - Lorraine, one of the healthcare support workers in particular.

“She’s asking them to leave. They’re going to take the body out now”, Deirdre had stated.

“They can’t do that”, Lorraine had replied. “We only take bodies out when there’s no one around, either at seven o’clock in the morning or eight o’clock at night, when it’s dark. They can’t do that. I’m not working at a place where they do that.” Lorraine had become “very upset”. Some of the other nurses, including Margaret, one of the staff nurses, had also been saying that they did not think that it should be done.

Several minutes later, the Sister from another ward had arrived at the desk.

“We’ve done it”, she had said. “It had to be done.” I had heard one of the nurses say that the Sister had not been prepared to keep a body on her ward for six hours and so had taken the decision to send it to an outside morgue in the middle of the afternoon. On hearing this information, Lorraine had screamed, “No, I can’t believe it!”, and had run to the linen cupboard across the hall (some of the nurses kept their cardigans and coats there behind the door). She had reached behind the door and then raced off the ward toward the front entrance. One or two of the other nurses had noticed this as well, although neither of the ward Sisters.

“I wonder if she’s coming back”, I had heard one of the nurses say, as though she meant *ever* coming back. The “norm of sequestration of death and dying at the hospice” had been broken, and Lorraine had fled the scene, unable to cope with the situation.

As established above, the “sequestration of death and dying on the ward” was one means of the nurses coping with their “anxiety about death and dying”. Another

means of coping was to “project their anxiety”, as illustrated by the following mealtime scenarios that occurred during the fourth week that Raymond was on the ward:

It was eight o'clock in the morning and the breakfast trolley was parked in the corridor just outside Raymond's room. I was working with Lorraine and Margaret, two healthcare support workers on the ward. Our job was to ascertain what the patients wanted for breakfast, serve it up from the trolley and take it to them. I went into Raymond's room to take his order. He was in bed with his bedside table beside him. I returned with his breakfast and set it down on the bedside table.

“There you are, Raymond”, I announced. “Do you want to get up for breakfast and sit in the chair?”

“No, I want to stay in bed”, he replied. I nodded and left. As I exited the room, Margaret was standing at the trolley just outside the door. She had apparently witnessed the above and told me,

“Raymond's another one. He can do far more for himself than he does. He's depressed and just doesn't want to do anything.” Lorraine had joined us. Margaret continued, “He can walk perfectly well when no one is looking at him, but the minute he sees you looking at him he won't do it. He's depressed. I could never work in mental health, that's for sure. It would drive me crazy.”

“He doesn't belong here”, added Lorraine assertively. “We don't know how to treat him. He needs to be in a place where they know how to treat him. No, I could never work in mental health either.”

Midday arrived and it was time to hand out the meals again. I did so once again with Lorraine and Margaret and as before, the trolley was parked outside Raymond's bay. Margaret entered Raymond's room. He was lying in bed, the covers partly up over his head.

“Come on, Raymond. Sit up in the chair for your lunch.”

“No. I want to stay in bed. I'll eat my lunch in bed.”

“No, I'd like you to get up to eat your lunch”, responded Margaret.

“I told you, I'll eat my lunch in bed”, Raymond repeated.

“You're not going to eat your lunch in bed. You can get up in the chair.”

“I don’t want any lunch”, Raymond muttered, his head still partially obscured by the bedclothes.

“Okay then, if that’s what you want.” Margaret came back to the trolley. Lorraine and I were standing there. We had both witnessed the above scene. Margaret assumed her serving position at the trolley as she and Lorraine exchanged a glance of mutual “disgust” at Raymond’s behaviour. “Well, we’d better leave him some anyway”, she told Lorraine. She served up Raymond’s dinner and handed it to Lorraine to take into the room. Lorraine placed the dinner on Raymond’s bedside table at the foot of his bed.

“I told you, I don’t want it!” shouted Raymond loudly, his physical position unchanged. Margaret, still at the trolley, jumped a little as though recoiling from his ‘wholly inappropriate’ behaviour. Lorraine said nothing and turned and exited the room, leaving the lunch there.

Margaret rolled her eyes in “disgust” at both me and Lorraine. Lorraine justified their behaviour to me on a wider basis:

“There’s just no need for it. He can get up for his lunch. He can walk when he wants to, but when you’re watching him, he’s a fine actor. He did it again this morning, just draped himself over his zimmer frame (a frame to aid walking) and refused to walk any further when he knew that people were watching. His neighbour, Sheila (Raymond’s carer before his admission) said that he was like that before he came in here, a real actor. She went away on holiday and he just decided that he would play helpless and get himself admitted here to get back at her for going.” It seemed that Lorraine was attempting to accrue further support for her behaviour by implicating the neighbour as agreeing with her perspective.

Margaret added, “It’s not easy to get in here. Not just anybody can get in here, but he managed to get himself in here. He wanted to die and he thought that he would die in a few days. When they told him that he wasn’t going to die (in the immediate future), he was so disappointed! Most of our patients don’t react like that when they hear that they’re not going to die just yet! He doesn’t belong here. We’re not equipped to deal with patients like him. He belongs on a psychiatric ward. Oh, I could never work in a place like that. It would drive me nuts!” It struck me that she painted Raymond as “severely abnormal” or “mentally ill” because he wanted to die. She also ‘moved’ him in her mind’s eye to another speciality, one that she was not trained to work in and so “absolved herself of responsibility to care for Raymond adequately”. This was certainly an easier option than admitting to herself that she

was “unable to deal with patients like Raymond who are terminally ill and want to die as a result”.

Lorraine continued, “He goes about talking about dying all the time, telling the other patients about all the people he’s seen dying here. We’re not like that here. We like to keep those things private to protect the patients who don’t want to know.”

Margaret stepped in: “Not everybody wants to know about things like that. Not everybody who comes in here comes to die. We have the private (family) rooms and when people are about to die, we put them in there (I noted that Margaret did not qualify this statement in relation to patients being offered a choice of whether to be moved or not) so that things are kept private, to protect them and the other patients. Dying patients and their families don’t want the other patients watching them and the other patients don’t want to know.”

Lorraine added, “People only want to know what’s affecting them. They don’t want to know what’s going on with the other patients, but Raymond’s got to run around telling everybody. He even asks the new patients what their diagnosis is! We like things private here. He doesn’t follow our rules. He’s bang out of order! He doesn’t belong here!”

I was conscious that all of this was being said just outside Raymond’s bay and it was quite possible that he and his fellow patients had heard. I was also conscious that as with Jill last week (as per the conversation that I had with her above), I felt like I was being ‘sold’ the ‘party line’ regarding the reason why patients are moved to private, single rooms when their death is imminent. Having accounted for their behaviour to me, Margaret and Lorraine continued to hand out the rest of the dinners.

One half hour later, Margaret, Lorraine and I were standing at the ward desk in the middle of the unit. We could see Raymond coming slowly out of his room with his zimmer frame. He stopped for about thirty seconds and looked around, then draped himself over his frame. Margaret flashed me a “disgusted” glance and pointed her chin toward Raymond as if to say, “What did I tell you? See, he’s looking to see if anybody’s watching and he’s stopped because he’s seen us.” She had a “smug” air about her, as did Lorraine, as if they had both been proved right. I said nothing and tried to look as though I was just clocking what they were saying.

Lorraine and Margaret's behaviour in relation to Raymond made me feel very uncomfortable, even angry. In effect, they were merely "scapegoating" him, a very common behaviour in relation to anxiety – in this case, about caring for a patient who wanted to die. So why did I feel so angry? Also, it is interesting to note that I worked very hard not to show my emotions to Lorraine and Margaret. I shall address these points later in the text.

By the following week, the situation with Raymond and the nursing staff and also various members of the multidisciplinary team had escalated, as evidenced by the following:

At the early morning nursing handover report, Frances, one of the Filipino qualified nurses on the night shift, was going through the list of patients. She came to Raymond and stopped to suck air in whilst rolling her head and eyes slightly in exasperation.

"Raymond Well, it's a bit of a long story", she said holding his notes. "Let me read it to you *I offered a temazepam to the patient. He said he had taken the tablet earlier. I said it was penicillin that he had taken and not the temazepam. He said that he would not have it anymore. I told him that the temazepam is his usual night sedation and that it will make him more comfortable and settled throughout the night. And then . . . (her eyes were welling slightly with tears) he became verbally aggressive to me, saying further that he would not take them, 'not even for the Queen of England'. He became silent for a while and then with his right hand, he hit me in the forehead . . . He hit me! (Frances was giggling a little, "very nervously".) I did not sustain any bruise, but I told him that there is no point being rude to me and hitting me because I am just trying to help him. Then I left.*"

"Well, that's bang out of order!" declared Jill, the qualified nurse in charge of the day shift, looking very surprised. "We can't allow patients to do that." The other nurses on the day shift sat there, a few of them nodding their heads in agreement, having gasped in amazement at Frances' tale. I sat silently amongst them, totally unsurprised, or rather surprised that something of this nature had not happened sooner regarding Raymond, given the extent to which the nurses had "failed to meet his needs" or even "see him as a person". I felt that Frances was "portraying herself as the innocent victim in the fracas, 'just trying to help'". However as Watson (1999) asserts on caring, intent is not enough. It must be followed through

by behaviour that the patient deems 'caring'. It seemed that Raymond had not perceived being told that his sedation would make him feel more comfortable and settled as 'caring'. Perhaps this was because it had been the nurse's perspective "foisted" upon him.

One of the unqualified nurses on the night shift described how Frances was very upset and shaken by the whole episode. Frances was sat, still looking a little "shaken". She then explained how she had informed the site on call manager who in turn, had informed the centre manager who had come to the ward from home in the middle of the night to deal with the situation. The site manager's record of events in Raymond's notes which I read later were as follows:

Called to ward by staff nurse who reported incident of assault to me. I approached Mr. X and asked him why he had upset the staff nurse. He declined to answer. I then said that unreasonable and aggressive behaviour would not be tolerated. He said that we would have to tolerate whatever he 'bloody well liked'. He then punched the pillow hard, using threatening behaviour.

It is interesting that she had established her concern as being for the nurse at the outset (where is patient-centred care or even care that includes the patient?) and that by using the word 'assault', she had "criminalized" Raymond's behaviour. When she had then dictated her/the staff's needs to him, he had responded similarly as he had done to Frances doing the same (when she had told Raymond that she had only been trying to help him). Raymond's statement that the staff would have to tolerate whatever he 'bloody well liked' followed by his punching the pillow may have represented his "anger" at "constantly having had to tolerate what the staff wanted" - that "he had to conform to be a 'good' patient" rather than himself ("a seething mass of chaos"). Ironically, as he had told me previously, he no longer felt like a person because he had lost his physical autonomy. He had also "lost autonomy to behave or react to his life circumstances as he chose, as he really felt". It was "unacceptable to display his emotional or spiritual angst in the hospice where many people came to die". He had to be "contained".

Frances then outlined the centre manager's action plan to the nurses on the day shift of duty. I read it later in the notes:

Staff nurse shaken and upset. Patient sleeping when arrived to see him in the night. Action plan:

- 1. complete a risk assessment to minimise further risk and evaluate at least once per shift;*
- 2. security guard to sit in 4-bedded area to ensure safety of staff and fellow patient. (At this point, the only other patient in the room was Alf who had become good friends with Raymond.) (didn't remove patient from area because he appears to be settled with his eyes closed and I did not want to antagonise the situation by discussing his actions at this time);*

This appeared to be a rather “heavy handed approach” literally. Also, rather than portraying Raymond as violent with perhaps just cause, it portrayed him as “unreasonably and generally violent”, potentially to all. This, of course, “absolved the nursing staff of any blame”; they were “angels” who were ‘only trying to help’. It is interesting that the centre manager viewed waking Raymond as potentially antagonizing the situation. Again, this seemed to portray him as being “unreasonable” (if he had been ‘reasonable’, then a caring dialogue might have helped) and worse, “offered him no voice whatsoever”. She proceeded to develop a detailed action plan based on the nurses’ views (her own included) alone. “Raymond’s existing voiceless status was thus further compounded”.

- 3. nurses to administer care by attending to Raymond’s care in pairs;*

Again, Raymond was portrayed as ‘dangerous’ and the nurses had to protect themselves from him. This was not likely to increase the prospect of Raymond being seen as an individual worthy of care, let alone engaged in a close, caring one-to-one relationship from which he could have perhaps benefited.

- 4. if he refuses care, this must be documented in notes;*

This is a “legally defensive stance”. Is defensive care ‘caring’?

- 5. if he displays an intention to cause physical harm and does not respond to reasonable request. If the threat is felt to be unavoidable, the police and on call manager must be contacted immediately;*

Again, this is a very “heavy handed approach” to involve the police and again, “semi-criminalizing” his behaviour, “lessening the chance that he would be perceived as a human being worthy of care”.

- 6. caring services manager to be contacted mane;*

7. *report to be submitted to Head Office.*

The morning went on. Raymond, undoubtedly exhausted from his ordeal, slept through most of it. At about eleven o'clock, Raymond's Consultant and the ward doctors went to see him. I listened as discreetly as I could at the doorway to his room (the curtains had been drawn around his bed). The Consultant discussed Raymond's physical progress and then said, "There is another matter that I need to discuss with you. I've heard that you have hit a nurse. That cannot be tolerated. Any further violence or aggression on your part will not be tolerated. Do you understand?" Raymond replied meekly, "Yes, I'm sorry." The Consultant then added, "Should any more such behaviour occur, we may have to arrange an alternative facility for your care." He later recorded the conversation in his notes as:

The incident in which Mr. X assaulted a staff nurse was discussed with him. It was explained that this is not acceptable and any further violence or aggression could result in his transfer to an alternative care facility.

As before, there had been no 'discussion' and the encounter was "profession-rather than patient-centred and led".

It was now 1:30 p.m. and the weekly grand round commenced. Raymond was the second to last patient to be discussed. He was severely "scapegoated" by all present. His behaviour was portrayed as "bizarre" with members of various disciplines having joined in:

"The other day, Julie (a qualified nurse) and I gave him a complete blanket bath", said Bill, one of the qualified nurses. "He just lay there on his bed, pretending he was asleep, but you could see his eyelids flickering, indicating that he wasn't. A half hour later, he was up walking around with his zimmer frame! He's such an actor . . . He can do it himself if he wants to . . . but he let us do it!"

"I was walking him last week with a colleague", said the physiotherapist, "and he flung his upper body forward, bending at the waist towards the floor. He then moved the frame forward. We told him to lift his head up – it was just about touching the ground. When he lifted his head up, it came up between the two front bars on the frame. The frame was half on his back, if you can imagine! 'Like

this?', he looked up at us and asked!" She was laughing "in ridicule" at his behaviour as were most other people in the room.

"This isn't the first time he's hit a nurse", declared Bill. "Didn't you read what I wrote last week in his notes?" he asked Deirdre, the ward Sister. "He hit one of the Filipino nurses. He was lying stretched out on his bed with his arms flung outward when she approached his bedside to speak to him. He jumped in response and his hand caught her arm, scratching her." Someone (I cannot remember who) commented that the incident may have been an accident.

"He's got a thing about male nurses touching him. He's a bigot", added someone else, "leaping on the 'Get Raymond' bandwagon" (again, I cannot remember who).

"And he's a sexist", interjected the Senior House Officer.

"Did you say it was a Filipino nurse that he hit last week?" asked the Consultant.

"Yes", replied Bill.

"Do you think that that is what this is about? Do you think that he has a thing about Filipino nurses?" asked the Consultant. People around the room were holding their heads in a slightly tilted position to the side as though giving this some careful consideration. After about a minute of silence, one of the healthcare professionals (it may have been the dietician or physiotherapy assistant) asserted, "He's a bigot, a sexist and a racist! He hasn't got an awful lot going for him, then!" Again, quite a few people laughed. I literally could not believe my ears and yet sadly, I could.

On writing this data up initially, I had commented:

"This "dehumanization process" was "a means of justifying their behaviour toward Raymond". By "dehumanizing him", they "no longer saw him as a human being and could therefore justify not treating him as such". The alternative was not feasible – to see him as a human being worthy of care and themselves as "unable to care for his needs", or worse and presumably unfathomable, "uncaring" professionals. About a third of the way into this dialogue, Deirdre had asked the group if anyone had anything to offer that might help in dealing with Raymond. She had been looking directly at me when she had said it. I had not responded, as I had not been able to think what to say that would not offend them. I was consciously aware that I had felt coloured by my experience in a small experiential group on a counselling course that I had undertaken the previous year. That group had felt "extremely anxious" and had "projected their anxiety" onto me, or

“scapegoated” me. As a result, I had felt isolated from the other group members. This is a great concern for me since I am worried that if I offend the staff at the hospice and this continues I might then become isolated from them, rendering it difficult if not impossible to continue to conduct my research there. Also, I am not doing action research. I do not want to influence my study’s findings. It will be interesting to see what the staff do from this point onward concerning Raymond and other patients. I think as well that there is no turning back as far as Raymond and his situation here is concerned. I think that the shit has literally hit the fan, leaving one humungous and stinking mess that must be got rid of. I feel sick to my stomach. This is probably the hardest decision that I shall have to make as a researcher working in the field. At the end of the discussion, the Consultant told the group that he would telephone the Consultant at a local long-stay hospital to arrange for Raymond to be transferred there. (Apparently the centre manager had requested him to do so; earlier, while sitting at the nurses’ station, I had heard her hailing him as “the nurses’ hero” to Jill, for “acting so magnificently on behalf of the nurses”.) “It may take several weeks, but Raymond will hopefully be leaving us”, the Consultant had announced “semi-triumphantly”. He had also been arranging for Alf who had been waiting for several months for a bed in a residential home to become available to be transferred there as well. In treating Alf the same as Raymond (“We treat all our patients the same” was a phrase that a number of qualified nurses had stated proudly to me since I had commenced my research at the hospice; wherefore individualized care?), the treatment that Raymond was receiving was “normalized” and “any guilt that the staff may have been feeling about their behaviour was assuaged if not totally obliterated” (the ‘shit’ would be disposed of, buried from their view and collective conscience). The ‘mirror, mirror on the wall’ would still see them as ‘the fairest of them all’, or ‘the fairer’ as regards Raymond. Life at the hospice would continue unchanged at least for the time being.’

Returning to my initial analysis of my experience with Raymond, a number of weeks previously, shortly after I had begun talking and building up a relationship with Raymond on my own, he had asked me to touch the skin on his forehead. “It’s incredibly soft. Go on, touch it.” I had reached my hand out and stroked his forehead. He had been right. It had felt like silk and I had told him so. I had imagined that as a small boy, his mother may have stroked his forehead to comfort him, telling him how soft it felt. I had sensed that apart from trying to cope with his

illness, he was still grieving for his mother and perhaps had asked me to stroke his forehead as a means of deriving comfort. Sadly, “he probably would not be receiving such comfort from many, if anyone at the hospice”. This is especially ironic as he was “more isolated and alone than ever”.

When I had listened to Frances’ report of the incident of Raymond hitting her, I had felt very upset and angry - more so than I had when Lorraine and Margaret had been “scapegoating” Raymond as I have described above. I had felt as though I was witnessing something that was a little “staged” (reflected perhaps by the fact that I had initially referred to Frances’ account as a ‘tale’, meaning perhaps at least a bit of a ‘tall tale’). Immediately after Frances had given her account of how Raymond had come to hit her, she had giggled a little, “very nervously”, as I initially described. Nervous giggling is a common sign of anxiety. As the incident had since been dealt with by the site manager in such a way that Frances would be very well protected from any further harm (and she had suffered no physical harm in the first instance), it would seem that Frances’ “anxiety” may not have been in relation to the fact that Raymond had hit her or to the possibility of him hitting her again (I do accept, though, that it may be quite distressing to be physically hit by someone and that Frances may have felt emotionally upset by this. This may have also accounted for her tears immediately before she told the group that Raymond had hit her).

Frances’ written notes (forming part of the legal records of Raymond’s care) of what led to Raymond hitting her “do not strike me as wholly credible, but rather a very carefully crafted account in which she appears blameless in what happened”. (I originally commented that I felt that Frances was “portraying herself as the innocent victim in the fracas, ‘just trying to help’”, and Raymond on the other hand, as “unreasonably violent”.) According to Frances’ account, it is difficult to imagine what provoked Raymond to strike her and especially as instead of hitting her, he could have just said something like, “Well, I’m sorry, but I don’t want to take the temazepam that you’re offering me now.” Of course, Raymond had been “scapegoated”, at least by Lorraine and Margaret previously (as I had witnessed) and so he may have had some built up “anger” at the nursing staff in that regard which he chose to “unleash” on Frances. (This is not to mention any “anger” that he may have had in relation to “his care needs with respect to death and dying not having been addressed by the nursing staff”.)

On the other hand, Frances had prefaced her account with, “Raymond . . . Well, it’s a bit of a long story”, yet her actual account was very brief. This suggested that the whole story (“the whole truth, and nothing but the truth”) was not disclosed. In this vein, it is interesting that Frances did not choose to tell the group what had happened in her own words during the handover report, but rather chose to read what she had written about the event. It is easier to remember details of the truth rather than a lie, because the truth is what has been experienced. In this vein, lies are generally kept short in detail and length (Vrij et al 2008) so that the teller does not inadvertently tangle him/herself up (hence the expression ‘Oh, what a tangled web we weave when we practise to deceive’). Also, it is perhaps noteworthy that at the end of her account, Frances stated that she was “just trying to help (Raymond)”. Why did she not merely say, “trying to help”, rather than qualify her (supposed) intent with the word, ‘just’? Her inclusion of the word, ‘just’ is somewhat suggestive that there may have been something else going on. On balance of the above arguments, it appears that the likelihood is that Frances was not telling the (whole) truth (her “giggling anxiety” serving as one indicator of this), suggesting that in some way, she felt that she had contributed to Raymond’s “anger” and “unleashing” thereof. It is interesting how the other nurses readily accepted Frances’ account of events and in an almost “exaggerated” fashion, for example, “gasping in amazement at Frances’ tale” (thus “reinforcing the shock and horror of the event”, and thus in turn, “supporting Frances’ account of what happened”). It would seem that they too may have been feeling “anxious” in relation to what had happened, not because of the untruth that Frances had told per se, but because of their “underlying collusion with her in the greater untold truth of how anxiety provoking they all found it to care for Raymond, and how their behaviour towards him as a result may have contributed to him having hit Frances”. It is also interesting how one nurse who had been on the night shift with Frances emphasized how very upset and shaken Frances had been by the whole episode, as though “to help ensure that the other nurses would accept the account given (of Frances as a ‘victim’)”.

In my initial writing up of the event, my anger, even outrage at how the situation regarding Raymond was handled by the site on call manager is quite readily apparent (for example, my employment of words and phrases such as “heavy handed” and “semi-criminalizing”). On some level, in my initial writing up of my

data and as suggested above, I felt that Raymond had been “severely scapegoated” by the nurses (which it seems had indeed been the case) and I felt that the site on call manager’s approach had been “too heavy handed”. On reflection however, given the nursing account of events that the latter received (and notwithstanding the site on call manager’s “nurse- rather than patient-centred approach to care”, as I have already discussed), perhaps my response was somewhat overly strong.

Having said this, I felt sick to my stomach (just as upset and angry as I had been over reading the site on call manager’s notes, if not more so) when various members of the multidisciplinary team were “scapegoating” Raymond during the grand round afterwards. I felt that their behaviour was “over-exaggerated” (similar to the nurses’ behaviour upon hearing Frances’ account of events concerning Raymond), and “almost incredulous”. Indeed, as I indicated above, Bill’s (one of the staff nurses) account of Raymond having hit a nurse previously would appear to have been “over-exaggerated or even fabricated”, as one member of the multidisciplinary team pointed out to the group upon hearing it. In this instance, it seems that their “over-exaggerated, scapegoating behaviour” was indicative of considerable “anxiety” regarding their having to care for Raymond on the ward. They were “projecting all of this anxiety onto Raymond and doing so in a fairly large group, seemingly seeking support from each other in experiencing their ‘anxiety’ via the process of projection”. At my gut level (literally), I felt their “anxiety” whilst sitting amongst them. When Deirdre, while looking directly at me, asked the group if anyone had anything to offer that might help in dealing with Raymond, I was offered a wonderful opportunity to explore the group’s feelings with them and to facilitate an examination of their practice with respect to Raymond with a view to enhancing their care giving. However I was unable to seize the opportunity. As I originally indicated (as above), I was experiencing some competing demands to care for myself.

First and foremost, I could not think what to say that would not offend them. My experience on the ward told me that they “prided themselves on the excellent care that they felt that they provided in general”. I was worried that if I was to overtly dent this pride, they would “project their anger” onto me. Of course, while I was too frightened to consider this in the moment, had I felt able, I could have adopted a reflective approach in addressing the issue. I would not have been *doing* anything

to them, merely facilitating *them* to explore the whole situation and their behaviour and supporting them in the process (although I was in no state to support them as I too was feeling extremely anxious.). If they did “scapegoat” me, as I stated previously, I was worried that I would no longer be seen as ‘one of the group’. As an outcast, conducting my research would have been virtually impossible. They may even have refused to participate any further in my research and no longer allowed me to observe their practice.

Second, I felt quite hopeless at the time about their ability to reflect. At the time, I viewed the strength of their “anxiety” as an indication of how very far they needed to go to be able to really examine themselves and their behaviour. I remember thinking that the Consultant’s question to the group about the issue being “a thing (on Raymond’s part) about Filipino nurses” was so far off the mark. Also, it was “very much in the vein of looking outward rather than inward for the source of the problem” and reflection entails an examination of both perspectives. I do not remember thinking it at the time, but the strength of their number might have also seemed daunting to me in that, as above, “they had strength in their number in upholding and supporting their views”. Individually though, they may have been more willing to examine themselves and their practice via the process of reflection.

Third and as stated above, I was not conducting action research. My research had been formally sanctioned by the local Ethics Committee and the local Trust’s Research and Development Office as a non participant observational study. I felt that I had to adhere to what had been agreed or my research might be stopped.

On reflection now, I think that at the heart of the matter was fear on my part and that this same fear had contributed to my reactions about all of the staff’s “negative behaviour” towards Raymond as I have described in my work above.

When I was seven years old, my mother died very suddenly. Just before the start of the next school year, just over six months later, my father moved the family (him, me and my twin sister) to a small town nearby. The first thing that I can remember about the move was the three of us going to the local school to enrol my twin sister and me. I remember being sat with my sister in the outer office of the Principal’s

office while my father was meeting with the Principal and sitting there for what felt like ages. As time went by, I could hear my father's voice rising in volume somewhat and his tone becoming very assertive. I could not hear what they were saying. When my father emerged, he appeared very upset and somewhat downcast (I do not think that he was able to look me in the eye). He looked like he had been through the wars. He struggled to inform me that while he had fought his hardest, the Principal had refused to back down from his view that my sister and I needed to be in two different classes (because research at the time supposedly indicated that twins thrived better as a result) and that I would therefore be placed in the class for less academically able students. (There were only two classes for each grade and they were split according to academic ability.) I had previously attended one of the best schools in the country in which I lived, which was situated in quite a middle class neighbourhood. There had been two classes for each grade there, equivalent in every way to each other. My sister and I had been in the different but equal classes since the first grade. (There had been very few considerably less academically able students in the entire school and they were taught in a separate facility within the school). My sister had obtained better marks than me in both the first and second grades of school, but not by a very big margin. Both of us had been considered quite good students.

My overriding memory of being in the class in which I was placed was that I could not believe how "stupid" the other students were. I had not realized beforehand that it was even possible to be so "stupid". The teacher would ask questions regularly throughout the day and I already knew the answer to every question that she ever asked. There was one other girl in the class who was able to answer the occasional question, but that was it. I felt desperate to get out of there! I had always enjoyed learning. My mother had instilled the value of a good education and learning in my sister and me and had always fostered our learning in just about every way possible. The year of her death, I had won the single prize in my class for being the student who had read the most books over the year. Despite being very unwell (which I learned later), my mother had gone to the school, even on the occasions when I had been too sick to attend (I had just about every childhood, contagious disease there is that year), to bring new books home for me to read to make sure that I was keeping up with my reading. Now I was learning absolutely nothing, not to mention feeling extremely bored. I felt that my mother would be spinning in her grave to see me in this situation and that I owed it to her memory to get out of there.

From the first day that I was in that class, I tried to never take my eyes off the teacher. I wanted her to know that I was able to focus on her and what she was saying at all times (many if not most of the other students in the class were somewhat “rowdy” much of the time; they appeared to have difficulty maintaining attention). Every time the teacher asked a question, I raised my arm in the air as high as I possibly could, as though I was stretching literally to try to touch the ceiling, my arm almost coming out of my shoulder socket. I wanted her to be in no doubt that I knew all of the answers, whether she chose to ask me or another student. My arm was stretched in the air for most of the day every day.

As the ‘new kid’ in the class, I was not popular; for my behaviour as described above, I was, of course, considered by the boys to be the ‘teacher’s pet’. The result was that I was chased home after school by two boys in my class on most days, who “threatened to beat me up” if they caught me. Occasionally I managed to get out of their view on the way out of school and hide in bushes on the grounds until my sister came out of her class and we walked home together. The boys rarely chased the two of us together, as with two against two, the odds of doing either of us any harm were considerably lowered. I remember living day to day in a state of virtually constant hyper-vigilance, always worried about whether or not my sister’s class would be let out earlier than mine so that we would be able to walk home together, and in continual abject terror of what the two boys might do to me if they ever caught me. Although I was a very fast runner, they came extremely close on many occasions! I also worried constantly about how far behind I was ever increasingly lagging in my learning.

Meanwhile at home, things were extremely dire. My father was completely unable to cope with my mother’s death. (When she had initially died, apparently he had stepped out into a busy city street so that a passing car would strike him dead. In the nick of time, a friend had hauled him back to the curb.) He worked Mondays to Fridays at his ‘nine to five’ job and worked as a musician most evenings. My sister and I rarely saw him, other than for an hour or so each evening before he went out to work again. At the weekends, he was always sleeping or out. Basically, at the age of eight, we lived home alone. My abiding memory of life at home was that the food cupboards were always practically bare. All that I can remember about eating that year was having some cereal for breakfast and having to steal milk from our

neighbours to put on it. (My sister and I stole milk because its nutritional value had also been instilled in us by our mother. Though we hated milk, she had made us drink at least a glassful every day.) We were quite thin (but healthily so) before our mother died. We quickly became quite skeletal. The visual image that I still have in my mind about that time in my life is of me standing in a small general store in the town, looking up behind the counter on which the cash register was placed at the food on the shelves and wondering how I could obtain any food without any money.

Returning to the issue of Raymond, I identified strongly with him as someone who was “scapegoated” or “bullied” because of my experience as a child above. Also, I certainly know what it is like to have not even one’s most basic needs met, let alone any of one’s higher order needs (Maslow 1970). When I initially wrote up my data about Raymond and as I mentioned above, I spoke about an experience that I had on a counselling course the year before in which I was severely “scapegoated” in a small experiential group. As I wrote, I was consciously aware that my counselling experience had contributed to my behaviour concerning the treatment of Raymond by the staff at the hospice, although this awareness only occurred then, as I was reflecting on my experience concerning Raymond.

4.3 Current analysis of my story about Raymond, employing my theoretical framework

4.3.1 Connection/relationship with other(s)

Raymond’s story took place at the very beginning of my period of data collection when I was determined to maintain my ‘objective’ stance with my study participants. Therefore I started off in ‘objective’, I-It relationships with everyone. Further, I maintained these despite all that transpired over time.

I do not feel that I had I-Thou relationships with Raymond and Alf. When I was speaking with them, I was listening very intently to what they were saying and acknowledging their feelings. However on the whole, in the vein of being ‘objective’, I was only interested in gaining their perspective about things. Both of them were in predicaments with the staff and I gained knowledge (for myself for my data) of those predicaments from their perspective. I chose, however, to

remain a non participant observer and not speak with any members of staff regarding sharing any of this knowledge with them. In this sense, I did not do “justice with an open mind to the actuality that open(ed) up before us” (meaning Raymond and me and Alf and me), as per Buber’s (1970: 173) definition of an I-Thou relationship. If I had shared my knowledge of their predicaments with the staff, things might have worked out differently and perhaps to their benefit. I say this mostly with respect to Raymond (for example, perhaps it may have helped the staff to know that he wanted to die because he felt like a ‘zombie’), but Alf might not have been on the receiving end of any potential, further ‘chivvying’.

In this same vein and reflecting back, I just now realize that it might be argued that I did not experience strictly I-Thou relationships with Lydia, or Betsy and Bethan in that I held myself back with all of them at some point(s) in terms of speaking my ‘truth’ or my perception of things and as above, things may have worked out in theirs and one or more others’ better interests had I done so (not to mention my own better interests).

Regarding my I-It relationships with the staff, similarly a number of opportunities (and even one invitation during the grand round) presented themselves to me to adopt I-Thou relationships with them and speak with them regarding their behaviour. I chose not to take any of them up.

The members of staff who engaged with Raymond and spoke about him “negatively” all had I-It relationships with him. As I have stated above, it seems that Raymond was “an object to them on whom they unleashed and projected their anxiety about death and dying and/or their inability to care for him”. Deirdre also had an I-It relationship with Alf in this same vein. She never inquired about or ascertained how Alf was feeling about anything while she was with him. Rather, based on her recounting to me afterwards that he no longer appeared, as he had done previously in her view, to be a “happy man”, she merely “tried to impose her vision of what he needed on him”. As I have also recounted above, a little later that day however, the nursing staff, in speaking about Alf’s situation in his room, said, “He’s seen too much death already. It’s not good for him. The last thing that he needs is Raymond going around, telling everyone that he wants to die. Nobody

needs that". This suggests that Deirdre was instead projecting her "anxiety about death" on Alf.

4.3.2 Sacred space

As I have indicated in my re-written version of Raymond's story above (which now also includes me, in terms of my thoughts and feelings), virtually throughout the story (other than when I was on my own with Raymond and Alf) my sacred space was filled with tension. Further as I have indicated, I felt very upset and angry that the staff members on the ward appeared to be projecting their "anxiety about death and dying and about their resulting inability to care for Raymond (and to a much lesser extent, Alf)" onto him.

Also and as already stated, I was fearful when Deirdre asked the multidisciplinary group during the grand round if anyone had anything to offer that might help in dealing with Raymond. I was afraid that I might offend them if I spoke my 'truth', particularly as they seemed to "pride themselves on giving good care", and that they might refuse to continue to participate in my study as a result. The strength of their number may also have frightened me. Additionally, I was worried that my research would be stopped if I began to participate in my study, as this had not been sanctioned by the Trust's Research and Development Office. And finally, I felt hopeless about their ability to reflect, should I encourage them to do so.

Also, as I have indicated in my re-written version of Raymond's story and again just above, the sacred space of the staff involved in any way with Raymond's care and/or who spoke about him "negatively" was filled with tensions – their "anxieties about death and dying and about their resulting inability to care for Raymond".

4.3.3 Forces (internal and/or external) which influence sacred space

I have already described some of the forces which influenced my sacred space as follows:

- Competing demands to care for myself regarding ensuring the successful progression and completion of the conduct of my research;
- The nurses were "projecting their anxieties about death and dying on Raymond and scapegoating him". I had been "scapegoated" as a child in the third grade and more recently in my experiential group on a counselling

course. It is possible that I over-identified with Raymond's "suffering" as a result;

- Similarly, from my childhood, as I described, I may have also over-identified with Raymond in terms of knowing what it is like to "not have your important needs met by anyone".

Two additional influencing factors further concern the fact that I felt that I did not know where to start in terms of answering Deirdre's question about being able to offer any help in relation to the staff dealing with Raymond. First, I have previously described how I do not wish to be like my grandmother and harm people unduly in any way. I was so upset by the staff's "scapegoating behaviour" during the grand round that I was afraid that I might judge them too harshly and say something that I might later regret.

Second, as I have stated, Raymond's story occurred towards the beginning of my data collection. I had had virtually no time to reflect on my experience or data, and I really did not know what to say. The point that I am trying to make is that I felt that I had to offer the staff an answer, as opposed to engage them in the process of reflection concerning their behaviour. Perhaps this is because I am more used to being engaged in I-It relationships rather than I-Thou relationships, as I have intimated above when I concluded that perhaps my relationships with Betsy, Bethan and Lydia had not really been I-Thou relationships as I had previously thought (or at least, not consistently I-Thou relationships). Perhaps I have an erroneous perception of myself in this regard, as I have also previously stated that I feel that I engage in I-Thou relationships in my personal life.

Further and in relation to this issue, as the lecturer and PhD student amongst the group, perhaps I felt that I had to protect my ego in relation to my professional identity. Perhaps I needed to demonstrate that I had some if not all of the answers.

This begs the question do I know who I *really* am? I am now feeling somewhat concerned about this and feel that I need to seriously reflect further on these issues!

Lastly, part of my tension was that I felt hopeless about the staff's ability to reflect. This may have been the case because my experience in relation to nurses reflecting on their practice is that they are generally not very good at it, or at least, generally not in the initial stages, as they have had no (real) experience of this process within their nurse education. This may also or otherwise have been the case because perhaps I had felt threatened in terms of my feeling able to facilitate their reflection meaningfully. If so, again, then, this may have been an issue of me needing to protect my ego in relation to my professional identity.

Regarding the forces that influenced the sacred space of the staff, as stated previously, the Western world generally does not deal with death and dying well. This, therefore, may well have been a large influencing factor.

Concerning the staff's feelings of being unable to care for Raymond as well as they wished (as I understood to be expressed by Deirdre's question at the grand round), as I stated, I had previously experienced that they felt "great pride with respect to their caring role". Therefore, "their egos in relation to their caring, professional identity may have been threatened somewhat, or even considerably".

As I re-read my above narrative, I am conscious of how much I am continually judging the staff as being "uncaring". At some level, therefore, and despite me remaining verbally silent about my feelings (out of fear of being seen to judge them and hence alienate them), the staff must have sensed my negative energy in this regard. Perhaps, then, some of the staff's "scapegoating" behaviour towards Raymond, and especially with me present at the grand round and continuing to maintain my silence (which may have appeared continuing and very judgemental of them, as indeed it was) was their "anger at my behaviour". They may have felt it inappropriate to direct it at me, and therefore directed it at Raymond.

4.3.4 Possibility of expanding consciousness/self transcendence

I asked myself in the previous section of my thesis, 'do I know who I *really* am'? I have been reflecting further on this and in terms of my research process. It is an extremely important question for as I have indicated earlier, one's philosophy should *underpin* one's research process. As I explained in the introductory chapter of my thesis, I am a person who believes that the nature of the universe and human

existence is nonduality. I know this (at least cognitively), but I seem to have strayed from it somehow along the way in my research process. Therefore I will now return to it with a view to understanding my struggle with my research process.

I wish to commence by re-examining why researching the care that Raymond received was so very challenging and stressful for me. I have outlined above a considerable number of factors which influenced my sacred space with respect to my relationships with the staff members involved in Raymond's care and Raymond (and Alf). I have no doubt that they all contributed to the tensions that I experienced as I have described, but I now realize that they are secondary to one huge source of tension - my discomfort in undertaking my research process in a fashion which is completely juxtaposed to my belief about the nature of the universe and human existence as above. My belief leads me to try to enact relationships with others that embody my belief, I-Thou relationships (in the vein of caring for others as I wish to be cared for and to care for myself), and as I have stated, I try my best to do this in my personal life. Throughout most of my research process, however, and my entire experience in relation to Raymond, I enacted I-It relationships at least to some extent. In the case of my experience with Raymond, overall I did so to a huge extent and this is why I experienced such a great deal of tension.

Further and in relation to this, I now realize that my anger at the staff members who were caring for Raymond was projected anger. I was feeling extremely angry that as I have described, I felt that I had to adhere to an 'objective' research process in the form of non-participant observation as opposed to a subjective and inter-subjective one in the form of participant observation.

Additionally, this tension was causing me to know intuitively that this was not at all what I should have been doing (from my very first encounter with a patient (John) in my study, as I have described), yet in the main, I did not alter my behaviour. Sadly, while I heard my own (intuitive) voice, I did not act upon it. I chose instead to act upon the voice of others. Perhaps, then, I was also very angry with myself.

In the case of my experience with Raymond, I now realize that I felt guilty for not having responded to Deirdre's request at the grand round for help in how to care

for him. This was equally why I felt so incredibly stressed during that meeting. Embodying (an) I-Thou relationship(s) would entail facilitating (a)nother(s) to learn and grow, but I did not take up the opportunity offered.

In this same vein, perhaps my feelings of hopelessness in terms of their ability to reflect was a further projection on my part - *I* was feeling hopeless about the situation that I felt stuck in and my inability to get out of it (not to mention hopeless about my *own* ability to reflect on my practice as a researcher because I could not find the space to do so!).

Yet a further projection may have been in relation to my feeling that I did not want to engage with the staff because I did not want to offend them. *I* was offending *myself* by not having the courage to be true to myself and my belief and 'do the right thing'.

Focusing on my belief of nonduality, I next reflected on another aspect of my research process – the analysis of my data. The last time that I undertook analysis of my experience with Raymond, I introduced some more detailed analysis, including some low key discourse analysis in relation to people's behaviour, for example, regarding the incident concerning Raymond hitting Frances. In doing so, I endeavoured to illustrate what happened, employing 'traditional' science associated with how the evidence-based paradigm has largely been adopted within nursing. In other words, I attempted to deduce or pinpoint more precisely what really happened in the vein of generating empirical knowledge. This might be considered a reductionist endeavour by nature, and my first thought is that unless one is attempting to deduce purely *factual* material, the room for error in such a process is considerable if not huge. Indeed, in a nondualistic reality where everything is part of everything else, nothing may be reduced. Therefore, I need to honour the *whole* of my data in my process of data analysis. This is in line with a key objective in my research as stated previously, to present a holistic account of spiritual care giving in nursing.

Another way of considering this might be in terms of relationship. I need to be in an I-Thou relationship with my data, "doing justice with an open mind to the actuality that opens up before us" (Buber 1970:173). As I hope that I have already

demonstrated in my narrative concerning my experience with Betsy and Bethan, Lydia and Raymond (as far as I have told the latter), the whole (including me in relation to my data) is greater than the sum of the parts. In contrast, my analysis of the incident concerning Raymond hitting Frances above in no way tells the story of spiritual care giving in nursing as I have come to know it thus far.

The same general argument may be applied to my role as a researcher with respect to the positioning of myself with my data. It is vital for me to be included in my narrative in relation to my data in an I-Thou relationship with the latter. Thus it is crucial that I am the central character in my narrative and that I adopt a participant role in the vein of action research. (When I wrote my initial narrative, while I had not yet taken the decision that I would be the central character, no other key, consistent character(s) was/were identified).

In terms of an appropriate epistemology for my research, one that is in line with nonduality, Wahl (2005) suggests Goethean science. In his outlining of Goethean science as a way of knowing, Wahl argues that true theory may only be known via an alternative epistemology to that of traditional science, or Cartesian epistemology. Goethe called this 'delicate empiricism' (a spiritual science (Steiner 1911)) whereby the empiricism is completely identical or at one with that which is being studied. The observer and the observed must become one in the vein of Wilber's (2000) concept of nonduality.

Goethe proposes four requisites, or stages on the path of knowledge within his science that must always accompany thinking and such that our judgements about things reflect reality (Steiner 1911). These are wonder, reverence, wisdom-filled harmony with the phenomena of the world and surrender to the course of the world. By wonder, Goethe suggests that as souls in the universe, we may only meet the truth from this mood in the midst of all the facts around us. After wonder is reverence, meaning that we should hold reverence for every thought that comes to us thereafter. Wisdom filled harmony with the phenomena of the world, the next stage, is perhaps best expressed by the following:

We ought really never to make judgements or hypotheses concerning external phenomena; for the phenomena are the theories, they themselves express their ideas, if only we have grown mature to receive impressions

from them in the right way. It is not a question of sitting down in a corner and puzzling out in one's mind something that one then considers correct, it is a question rather of making oneself ripe and letting the true judgement spring to meet one out of the facts themselves. Our relation to thinking must not be that we make thinking sit in judgement upon objects but rather that we make it an instrument whereby the objects can express themselves (Steiner 1911: 8).

After experiencing this third stage, we still should not just be thinking, but rather engage in the fourth stage of devotion or self-surrender. This is referred to as "the very highest condition of soul" (Steiner 1911: 8). My understanding of this is that we no longer perceive ourselves as separate from all that is in the universe (once again, in the vein of Wilber's (2000) nonduality) and we let all of our attachments go as I described in relation to Buddhism earlier in the text.

Goethean science, known as a science of wholeness (Bortoft 1996), would seem to embrace my two previous suggestions concerning data analysis and the positioning of myself with my data regarding how I might move forward. It would also seem to address my concerns of being so judgemental of staff members and attached to my ego, professional roles and the impact of past events in my life in my research process with respect to my experience with Raymond. So how more precisely may I engage in this type of research?

Wahl (2005) explicates four stages of Goethean observation for adoption. Fundamental to these is that the researcher is a participant observer within the research and that the epistemology, directed towards process and relationship, permits empathy, intuitive understanding between the parts and the whole, and imagination. Such an epistemology is in line with sacred feminine principles which underpin the caring-healing paradigm, both of which I have outlined earlier. The four stages are exact sense perception, exact sensorial fantasy, seeing is beholding, and being one with the object. A fifth stage is also suggested, this being preparation for engaging in this considerably different methodology. This entails acknowledging our own, individual perception of the world based on our past experiences (as I have done to some, if not a considerable extent in my narrative thus far), such that we may expand our consciousness further and engage in self transformation (again, I have begun to do this, albeit just a little). The four stages, in relation to Goethe's stages on the path of knowledge as I have explicated above, are as follows (Wahl 2005):

- Exact sense perception – this stage is about ‘letting the facts speak for themselves’ (Brook 1998), directing our being on observing the facts in detail and utilising all of our senses whilst staving off all judgement and evaluation. The goal is to try to see things as new, as they really are;
- Exact sensorial fantasy or ‘imagination’ (Bortoft 1996) – this stage concerns the employment of imagination to see things not as fixed in time or space, but rather as moving through time from the present to the future and transforming. The goal is to imagine how things might have evolved differently yet within the realms of realistic possibilities (Brook 1998);
- Seeing is beholding – this stage concerns suspending what is perceived and focusing merely on receiving the essential nature of what is being observed with an open mind. “Beholding the object in such a way, we offer the phenomenon our human capacity for conscious awareness so that it can express itself” (Wahl 2005: 64). Often the phenomenon then reveals itself as a Gestalt-like insight;
- Being one with the object – this stage directly follows stage three and facilitates our appreciation of not just the form, but its content and meaning as well. All form is considered meaningful as it expresses itself in terms of its origin, where it is heading and how it is positioned with respect to other forms and processes. These relationships determine the possibilities for transformation of phenomena.

Thus Goethean science allows us to understand phenomena from within, is a study of transformation and unlocks our conscious awareness to experience the universe as one undivided whole. It is a ‘holistic mode of consciousness’ (Bortoft 1996). Rather than a science which examines how the whole functions, it is a science “of qualities and conscious awareness of the relationships and interactions between the parts out of which the whole emerges and which are dependent on the whole” (Wahl 2005: 68).

My study examines spirituality and spiritual care giving. Thus Goethean science would seem especially appropriate to apply in that it “stimulates rather than negates our awareness of the spiritual dimension of reality and the sacredness of nature” (Wahl 2005: 75). Further, “Goethean methodology will change our understanding of the nature of the material world, the nature of consciousness, and of our own human nature as conscious and *responsible* participants in and integral parts of

Nature” (Wahl 2005: 75). I wish to become more caring in my research process (in I-Thou rather than I-It relationships, for example) and represent my data more holistically. It would seem, then, that Goethean science is just the thing for me to engage.

Already, I have contemplated on the method of Goethean science as I have outlined above in relation to my narrative about Raymond, and the following has come to me in an ‘aha’ moment:

As I sat in the grand round and physically felt the tension of everyone in the room to the extent that I felt almost physically sick, I could have been attentive to this and contemplated with an open mind and letting go of all my attachments how I might be able to help the staff as well as Raymond. My own experiences of feeling that I knew what Raymond was experiencing as a result of what happened in my childhood and on my counselling course as I have described could have attuned me into this as might have my experiences of feeling that I knew what the staff were feeling. I knew the latter also in relation to my childhood experience of being desperate to learn and grow, also as I have described. I might not have had to even wait for Deirdre to ask someone in the room if they might be able to help with the situation. However in the event that my contemplative processes kicked in more slowly, Deirdre’s question could have prompted me to speak.

The image of me in my third grade classroom with my arm permanently stretched toward the ceiling could have come to me. This time, though, I could also have had an image of my teacher reaching out to grab my hand and pull me out of my cesspit. (In effect, that wonderful woman did precisely that and swam against the tide, or certainly against the school Principal in the process. My cry had been an appeal to her moral consciousness to ‘do the right thing’ and she demonstrated the courage to respond to my cry and do just that.)

Having let go of all my attachments, then, I could have invited the group to reflect upon the whole Raymond situation either then or at a more appropriate time and done my best to help them and me to try to understand the situation with a view as to how to improve it for everyone.

Employing Goethean science as above, I could have transformed myself and possibly the staff at the hospice, not to mention the care that Raymond and other patients might have received there. Similarly, if the staff members might have employed the principles of Goethean science in caring for Raymond, they may have approached him without their “anxieties” and come to know him subjectively and inter-subjectively rather than merely objectively. Thus “they may have been able to care for him more appropriately”.

4.4 Summary

In Chapter Four I have examined my struggle with the research process and determined that at its root lay the incongruence between my research process and my belief about the nature of the universe and human existence which is nonduality. My struggle which revealed itself through my adoption of I-It relationships with both my study participants and my data was underpinned by my attempt to be ‘objective’ and generate empirical knowledge. This is in keeping with my traditional science academic background and the manner in which the evidence-based paradigm has been largely adopted by the nursing profession.

From the very beginning of my study, my intuitive knowledge told me that my research approach was inappropriate. However I ignored it, choosing instead and partly out of fear of reprisal to act upon the voice of others in authority which represented the culturally dominant epistemology - traditional, empirical science, or Cartesian epistemology. This created tension within me as evidenced by the instability of my field boundary (my struggle between adopting a (more) dualistic versus a (more) nondualistic research approach).

Goethean science was explored as an alternative research methodology. As it is underpinned by nonduality, sacred feminine principles and the potential for transformation and is thus in line with the caring-healing paradigm, it was deemed an appropriate research methodology for examining spirituality and spiritual care giving. An example of how Goethean science may be applied to nursing practice was demonstrated.

My struggle with my research process was underpinned by my having adopted an inappropriate way of knowing in relation to spirituality and spiritual care giving. A new and more appropriate research methodology based upon a new way of knowing was put forward for researching these areas. In Chapters Five and Six I wish to shift the focus of my attention to appropriate ways of knowing in relation to spirituality and spiritual care giving for nurses in clinical practice. I have examined this in part previously in Chapter Three. In Chapters Five and Six I will take this examination forward.

Chapter Five

Spirituality: Expanding Consciousness

through the Expansion of Knowing – Part I

5.1 Introduction

In Chapter Three my thesis revealed that spirituality and spiritual care giving are barely evident, although not necessarily nonexistent in clinical nursing practice. Indeed, nurses were found to be “uncaring”. I discussed how in terms of ways of knowing, the adoption of evidence-based practice by the profession may have influenced my findings. Focusing on my story about Ben, a patient on the medical ward, Chapter Five continues my examination of ways of knowing in relation to spirituality and spiritual care giving. Nonduality is explored as a way of knowing within nursing and sources of knowledge are also considered with a view as to how nurses may improve their practice with respect to spiritual care giving.

In my examination of the care that Ben received, the issue of gaining consent from patients to participate in research studies in which researchers are engaged in I-Thou relationships with them arose. Nursing ethics are therefore also explored briefly in this regard.

5.2 Ben

I met Ben, a young man in his early twenties, on the medical ward approximately two weeks after I commenced my data collection. Ben had been on the ward for just over a week, having been transferred from the hospital's intensive care unit where he had been undiagnosed for some time. The doctors had only just come up with a provisional diagnosis of Horner's syndrome (a kidney disease).

Ben had been unable to move his limbs normally and his left leg was partially contracted as a result. Earlier in the day, two physiotherapists had used a hoist to lift him out of his bed and into a chair for what seemed the first time. He resembled an elongated, human form of Bambi on ice – dangling in mid air above the chair

with his long, skinny limbs (he looked well over six feet tall) splayed in every direction and a bewildered expression on his face. His bewilderment was especially exaggerated by severe ptosis (drooping) of one eye caused by his disease. A large head, long and freckled face, dark red curly hair and porcelain white complexion had further contributed to his dazed and unwell appearance. When I had arrived on the ward for the nurses' handover report, a nursing student had made a point of telling me that Ben and his mother had been praying frequently throughout the days for his recovery. I guessed that with no firm diagnosis they had feared that he might never recover or that he might even die. Just over a year ago Ben had been a fit and able summer camp counsellor in the state of New York. He had been the only adult living in a large tent with twenty-four hour responsibility for a large group of energetic, school aged children seven days a week. Now he was the only young man in a nine-bedded male hospital room unable to even turn himself in his bed. He was the most disabled of them all and in such a vulnerable state - such a cruel twist of fate.

I had chatted briefly with Ben and his mother earlier that day. I had also re-positioned Ben's legs once at his request and with her assistance.

"By the way, my name is Margaret", Ben's mother had shared afterward.

"I'm Janice", I had replied, stretching my hand out to shake hers.

"The nurses here have been so good to Ben. We're so grateful", she had told me. I had stood and listened, feeling quite uncomfortable. I had heard virtually all of the nurses on duty for that end of the ward "grumbling" on and off since the beginning of the shift about how 'demanding' Ben was.

Later that shift Ben asked me to re-position him in his bed. He had been lying on the same side of his body for some time and said that his hip was hurting him. His mother was not with him. Perhaps she had nipped to the canteen or to the toilet.

"Certainly. I'll just go and get some help. I'll be back shortly."

All four of the nursing staff on duty (two qualified nurses (Joe and Lucy), one nearly qualified nurse (Yvonne) and one student nurse (Sarah)) for that end of the ward accompanied me to Ben's bedside to perform the turn.

"Again?" one of them asked, "glaring" at Ben as we arrived at the bedside.

I could not quite believe my ears. The nursing staff knew that Ben needed two-hourly re-positioning. It was written in his care plan. I was looking directly at Ben who did not flinch upon hearing this. Instead he looked remarkably calm.

Without another word spoken, we quickly positioned ourselves on either side of the bed. Then, on the count of three by Lucy, one of the qualified nurses, we executed the manoeuvre. Lucy was standing directly facing Ben and about a foot at most from him. She leaned over his body, placing her hand on his upper arm.

“Now, are you going to be a *good* boy?” she asked in a “matronly, half joking tone of voice”. She was giggling slightly afterwards “as though she was pretending that she had not really meant to tell him off”. However there had been a “threatening” element to her voice and manner and there was no doubt in my mind that she *had* meant to do so. Perhaps for a second she had been aware that I was present and had attempted to ‘take it back’ because she had not wished to be seen in a ‘bad’ light.

Standing behind Lucy, I was rendered speechless. I literally could not believe what I had seen and heard. In Lucy’s eyes, “Ben had been a ‘bad’ patient, having asked for his most basic physical needs to be met by the nurses”. Ben looked directly at her. His large eyes were just staring innocently at her. He said nothing and remained absolutely still. Metaphorically, he appeared to be ‘turning the other cheek’. Everyone then left the room swiftly, again in silence, and I followed. Immediately upon exiting the room comments started to fly fast and furiously as the nurses continued walking, shooting all knowing glances at each other.

“He can do things if he wants to”, Yvonne claimed firmly.

“He’s institutionalized. They get like that”, piped in Sarah.

“He wouldn’t wash his private parts this morning and he can do that”, asserted Lucy. “His mother washed him down there. Can you imagine your mother doing that? He said that it was easier for her to do it as he’d have to wash his hands again afterward if he did it”, she sighed as if utterly “disgusted”.

The group had reached the nurses’ station about twelve feet down the corridor. Joe gripped the sides of his temples as though in agony and leaned forward across the desk so that he was resting his upper body weight on his elbows.

“I can’t take it anymore. He’s doing my head in”, he moaned desperately.

My stomach was in knots and I felt physically sick as though I had witnessed a vile act. I was acutely aware that I was the only person not joining in this gang’s “scapegoating” frenzy, shored up by the “act of collusion”. I said nothing for fear of revealing my difference and consciously made a huge effort not to look shocked or upset. I was judgemental of their behaviour but did not want to be seen as such so that the nurses would be fearful of acting ‘normally’ in my presence. I felt that if they felt that they had to be on their guard with me this could potentially bias my research findings. Also, I wanted them to accept me so that I could comfortably work alongside them to continue to collect my research. I was not willing to compromise my values, though, by joining them in their behaviour. Within a few minutes the group dispersed to go about caring for other patients. At the end of the shift various nurses commented that it had been a “good shift”:

“We’ve had time to talk to the patients. That’s always so nice, and so rewarding. That’s what good nursing care is all about. That’s what we were trained to do.”

I felt like I was in a parallel universe. “The manner in which the nurses had spoken to Ben was certainly not what I had been taught to do!”

Several days later, having reflected upon Ben’s behaviour, I felt in awe of his reaction to what I had witnessed. I recalled that he had regularly asked the nursing staff to do things for him that he had been unable to do himself both before and after the above episode. He seemingly was and continued to be the ‘unpopular patient’ (Stockwell 1984), remaining himself and asserting his needs and right to care despite “the nurses’ desire and attempt to change his behaviour”. Joe’s statement about being unable to ‘take it anymore’ suggested that Ben’s behaviour had been ongoing. Joe had been seemingly distraught that Ben had not conformed and been rendered silent under the pressure. I felt extremely humbled to have watched what I considered to be the sheer fortitude of such passive resistance on Ben’s part. Walking back to my office from a meeting with a colleague with whom I shared an office, I told him broadly about having witnessed nursing care that had upset me so terribly.

“It’s so hard to be a researcher and not say anything in such circumstances” (I had been firmly ensconced in my ‘objective’ researcher mode but had wanted to say something).

About half an hour later my colleague and I were sitting at our desks working on our computers. He turned toward me.

“Do you know a poem with some lines at the end about ‘being the master of your fate and the captain of your soul’?” he asked.

“It rings a vague bell”, I replied.

My colleague had already started searching for it using ‘Google’. Within several minutes, he printed off the following:

Invictus

OUT of the night that covers me,
Black as the Pit from pole to pole,
I thank whatever gods may be
For my unconquerable soul.

In the fell clutch of circumstance
I have not winced nor cried aloud.
Under the bludgeonings of chance
My head is bloody, but unbowed.

Beyond this place of wrath and tears
Looms but the Horror of the shade,
And yet the menace of the years
Finds, and shall find, me unafraid.

It matters not how strait the gate,
How charged with punishments the scroll,
I am the master of my fate:
I am the captain of my soul.

The poem was written by William Ernest Henley in 1875. After having had one leg amputated, he was about to undergo similar surgery on his remaining leg (Cummings 2009). “If the word ‘years’ was exchanged with ‘weeks’ in the third verse, it could have been an ode to Ben in his plight – ironically not in the face of a brutal surgical assault on his body but at the hands of nursing staff, those charged to ‘care’ for him”.

A week later I was working a late shift. I had come to the ward, hoping to see Ben and speak with him about the impact of his illness on his life and how he felt that spirituality and/or the nurses had influenced his health (and life) journey. In the handover report, I heard that his condition had improved considerably although the doctors were still fairly “clueless” about what had been wrong with him. Ben had been washing himself with minimal assistance and walking short distances with the assistance of two nurses. There was no mention of him being ‘demanding’ as he had been labelled the previous week. It almost sounded like the nurses were talking about a different patient altogether! I was happy that things seemed to be looking up for Ben. Shortly after the report I made my way down to the nine-bedder and spotted Ben, sitting straight up in his bedside chair with no hoist attachments anywhere in sight. I felt like I was seeing Pinocchio as a ‘real’ boy!

“Hi. It’s so nice to see you again, Ben. You’re looking absolutely fantastic – so much better than the last time I saw you!” My enthusiasm to actually see him so greatly improved was genuinely bubbling over.

“Thanks”, he replied, smiling warmly at me. I was really pleased at his response as I felt that we had connected at some level previously. It seemed that he might have felt this as well. “Yeah, I’m feeling a lot better.”

“I haven’t seen you smile before. It’s so lovely to see. You really do look so much better.” He didn’t say anything else. He was still grinning at me from ear to ear. It was such a vast difference in his behaviour from the previous week!

I leaned against his bed and we continued to talk for about five minutes about his progress. He told me how he had been walking a little and doing his exercises as recommended by the physiotherapists. When he was in bed he regularly worked at extending his left leg, pushing it down with his heel into the mattress to straighten it. His contracture had improved markedly as a result. He still had some way to go, though, to return to normal, but felt that he was well on the mend now.

“I’ve had people all over the world praying for me”, he announced.

“Have you, really?” I exclaimed. “How did that happen, then?”

“A prayer circle was arranged through my local church.”

“Wow, that’s amazing! Apparently, there’s growing research evidence indicating that prayer really can make a difference to people’s recovery.” I asked him if he had seen a documentary on the television that past week about such a research project. He had not and I proceeded to tell him about it briefly. He seemed interested. Ben had not yet been given information about my research study or signed a consent form. I wished to speak with him about spirituality and told him briefly about the study and asked him to consider whether he would like to participate.

“Okay. I’ll talk it over with my mother when she arrives.” He seemed positive about the study and I went and got the information sheet and consent forms for him to read. I told him that if he was happy to participate to let me know.

About an hour later I was standing at the nurses’ station reading Ben’s notes. I thought that it might be helpful to read them in advance of speaking with him. I was keen to see what the nursing staff had written about his behaviour in light of the previous week’s events. The notes recorded only his physical symptoms and abilities with two exceptions. Four days before I first met Ben he was said to be “tearful and crying with the physio”. Four days ago there was a paragraph written by a nurse on the night shift stating that Ben had been “angry that no one changed his smelly, sweaty sheets” when he had asked. She had explained that the nurses were unable to meet his request because they had been busy with another extremely ill patient. The other thing that I noticed in the notes was that the doctors suspected that Ben might have chlamydia, although it was also written that Ben had had “no sexual partners ever”. I commented aloud to one of the staff nurses at the station about this.

“The doctors seem to think that Ben may have chlamydia, yet they’ve asked him and he’s had no sexual partners.”

“Yes”, she replied. “It’s awkward. He wouldn’t give his consent for a swab to be taken from his penis. The doctors asked us to take some of his urine instead for an MSU (mid stream urine) and we sent that off (to the laboratory). He has no idea that we took his urine and sent it off.” She was “grimacing” a little uncomfortably as she told me this. She shrugged her shoulders “as if to partially disown this covert nursing action” (after all, it had been the doctors who had ordered this to be done).

“It doesn’t exactly promote a trusting relationship”, I found myself blurting out and I did not stop there. “What are they going to do if the test comes back positive?”

The nurse “grimaced” slightly and shrugged her shoulders again. My heart sunk. I was thinking that the care that Ben had received the previous week at the hands of the nursing staff had been “bad enough”. He really did not deserve this. No one did. In my experience, “lying” is often detected despite efforts to conceal it. Also, can doctors test for a disease when a patient has refused to be tested? Mind, the ‘test’ is different but for the same disease. I considered it to be a matter of shades of shades of grey or even black. I finished reading Ben’s notes and carried on with various nursing duties.

Ben’s mother arrived about an hour after I had spoken with him. It was then about 7:30 p.m. and Ben had not called me to tell me whether or not he would participate in my study. I had been in and out of the nine-bedder at least a dozen times in the course of seeing to other patients and he had had ample opportunity to call me over. I had not approached him again to ask him if he had made a decision as I felt that this could have been construed as coercion. Also, I had said when I gave him the forms that if he and/or his mother had any questions, to just ask me. I was feeling bitterly disappointed and even a little angry, although I was trying desperately hard to let these emotions go. It was Ben’s right, as it was for all patients, to participate or not and I honestly believed that. Yet at a deep level I was feeling that this was unfair. It may have been that Ben (and/or his mother) simply did not want to be involved in a research study or a study about spirituality and spiritual care. Or it may have been that as a result of the ‘care’ that they had received, they were unable to trust the staff (nurses and perhaps doctors as well) sufficiently to consent to participate. Somehow my gut told me that it was the latter.

It was now 9 p.m. and Rebecca, the qualified nurse who had been in charge of the nine-bedder, was giving report to the night shift. She had come to Ben, the last patient.

“Ben is able to transfer between his bed and his chair on his own”, she stated. Ben’s mother had come to the nurses’ station where the report was taking place to ask for a urine bottle for Ben. She was just heading back to the nine-bedder. She stopped dead in her tracks upon hearing this, turned and faced the nurses and declared emphatically and with a more than a slight tone of “anger” in her voice, “I’ve just helped him transfer back to bed. He’s *not* able to transfer by himself without any help.” She then turned and resumed walking to the nine-bedder.

I was stunned. An hour earlier I had watched Rebecca give care to Ben and talk with him and his mother. She had had a very warm and patient manner that I had seen throughout the shift in her dealings with all of the patients. I had seen that same manner when she was with them. I had then remembered what they had been talking about. Ben had requested an ointment to be applied for some itching of his skin. Rebecca had told him and his mother that as it was so late at night she would not be able to get any ointment until the morning because pharmacy was closed. She had then told them that she would see to this the next morning as she would be on duty then. Ben's mother had pulled a face as if to say that she felt that she was being "fobbed off" and that the ointment would not be ordered. Rebecca had seen this.

"I appreciate that the ointment is important. I'm on duty again in the morning and I will get the doctor to order it as soon as I see him", she had answered calmly and politely.

I had felt uncomfortable during both of the above interactions between Rebecca (and the nurses on the night shift) and Ben's mother, but in my objective researcher stance had said nothing. Rebecca had just returned to work after a fortnight's annual leave. She had never met Ben and his mother before. From what I had seen during the shift I did not think that Ben's mother's reaction at the nurses' station was in response to Rebecca and/or her behaviour. Rather it seemed to be a transferred response possibly from other nurses and/or doctors. Was this any wonder? I sensed more than ever that my research, like Rebecca's statement, might well be on the receiving end of Ben's mother's "anger" at the care her son had or had not received on the ward. I also sensed that perhaps the reason that the nurses were no longer labelling Ben 'demanding' was because he was able to physically do more for himself. Now that he was more physically independent the nurses did not see him as a 'problem'.

(Seven months later I had been interviewing Joe about spirituality and spiritual care giving. Joe had told me that he never got upset as a result of things that happened at work. I had challenged him:

"Joe, do you remember Ben, a patient who was in the nine-bedder before Christmas?"

“Yes.”

“Do you remember . . . it was a while ago . . . one evening when you were on duty, Ben asked to be turned. A bunch of us went in and turned him and after we came out of the room you put your head in your hands and stated, ‘I can’t take it any more’?”

“Yeah.”

“What was it about that situation that caused you to feel that way?”

“He was taking advantage. I mean, some patients like Ben take advantage. He wanted attention. You can tell when patients can’t do something and when they’re taking advantage.”

“How can you tell?”

“You just can. I’ve seen it lots of times throughout my career He stayed a few weeks too long. He became hospitalized. I mean, he could do things for himself but he wouldn’t . . . Patients who stay too long cost the NHS a lot of money.”)

Returning to the situation above regarding obtaining consent from patient participants for my study, I had initially written:

‘There is a certain irony here. Patients who are “badly cared for” may not trust the (nursing) staff and may transfer that mistrust to me, choosing not to participate in my study. Yet I want *all* patients to participate in my study. I also feel that by having stopped to ask for Ben’s consent, I disrupted a ‘natural’ conversation and perhaps lost the energy of that moment with Ben that had arisen out of a naturally and genuinely ‘caring moment’ (Watson 1999). The ethics of research and the ethics of caring seem intertwined here, possibly even juxtaposed. Perhaps researchers in such situations might go with the flow of such ‘caring moments’. If patients are not happy to talk with them, (surely) they will not, in the way that people generally do not hear what they do not want to hear. They can fob the researchers off, change the subject or do whatever.’

The following week, Ben was still on the ward, waiting to return to his home county for rehabilitation. I had been working with one of the nurses and attending another patient in the nine-bedder. Afterwards I went over to Ben who was lying on top of his bed. He was alone.

“Hi, Ben. Nice to see you again. You’re looking well – better than you did last week. You look considerably better every time I see you. How are you feeling?”

“I’m feeling a bit better, thank you. Nice to see you again.”

“So, I hear that you’re going to rehab soon. Are you looking forward to that?”

“Yes.” He filled me in on the plans that had been made and told me that he would be leaving the hospital the following week.

“I’m glad to hear it. You’ll be closer to home for Christmas. If I don’t see you again before you go, I’d like to wish you the best for the future.”

“Thank you . . . I’ve got your study forms here somewhere”, he said, reaching for them on the top of his bedside locker. “Would you still like me to participate in your study?”

“If you’d like to”, I replied, thinking that this was just too good to be true. I was so eager to hear his perspective on the experience that he had been through. “You don’t have to but I’d be very pleased if you did.”

“Okay.” He got the forms and we signed them. I then sat down by his bed on a stool.

“Well, I’d like to know if your illness has changed you in any way.” Ben thought long and hard.

“Well, it’s been an experience. It was certainly very worrying, especially at the beginning . . . For the first few days they didn’t know if I’d make it. They still don’t know exactly what caused it. It started with a throat infection and they think that the infection spread from that, but they don’t know why it got as bad as it did . . .”

“Is that a bit worrying . . . not having a firm diagnosis? I mean, chances are that it won’t happen again, but I guess there’s also the possibility that it might . . .”

“Yeah . . . I suppose it could happen again . . . Perhaps when I get infections in the future, I’ll go to see the doctors straight away so they can monitor me closely. Hopefully that will at least prevent such a drastic deterioration as this time.”

“Yeah, that’s a good idea What was it like at the beginning, knowing that you might not pull through?” Ben thought even longer and harder.

“It made me feel very vulnerable. I realized that I had to surrender”

“What do you mean by ‘surrender’?”

“Well, um . . . surrender to God’s will just go along with it rather than fight it, that I had to trust in God’s plan that things are as they are meant to be. I wasn’t like that at first, though. It took me a little while to realize it, but as I realized it I was able to surrender. Yeah, I have changed. Because I was facing death and because I experienced such extreme vulnerability, I am more aware that this or anything can happen at any time.”

“Do you think you’ll be able to surrender again, perhaps more readily in future if anything like this or as bad as this but perhaps of a different nature happens to you in the future?” At least a full minute and a half went by as he thought extremely hard.

“I don’t know. I don’t know if it will be any easier the next time or any other times after that. I won’t know if and until something like this happens again. I hope that I’ll be able to surrender.”

There was a silence of about two minutes while we each pondered what had been said. I decided to ask him about the ‘care’ that I had observed him receiving. I was really keen to know how it had affected him.

“I remember from a couple of weeks ago when you were really still quite sick I think it was the day when the physios (physiotherapists) first hoisted you into the chair” Ben was smiling gently, trying to remember. “A group of nurses came to turn you in the evening. About four nurses turned you and it wasn’t a very big turn. Anyway, after that one of them stood over you and told you to be a good boy. . . . How did you feel when she said that to you?” Ben was again thinking hard, only this time he looked slightly quizzical.

“I don’t remember a thing about it . . . perhaps because I was just going with the flow then.”

I had labelled his behaviour ‘passive resistance’. He was obviously far more ‘passive’ than I had realized. There was another long silence of about two minutes. I could see that he was deep in thought and I did not want to interrupt his thinking. Eventually he spoke.

“I’ve changed as a result of surrendering to God’s will (Ben was a devout Christian). I know that the Lord will sustain me through anything.” He reached for cards on his

bedside table that he had received whilst in hospital and asked me if I wanted to read them.

“Sure”, I replied. They were as follows:

The Lord will sustain him on his sickbed and restore him from his bed of illness (Psalm 41, verse 3).

And we know that in all things God works for the good of those who love him, who have been called according to his purpose (Romans 8, verse 28).

(The Holy Bible, New International Version, 1984)

“These cards mean a lot to me. They helped me get through everything. They gave me hope I have God’s will in me. God’s will is that we should embody his love for us. Can I show you this? It explains what I mean. (He reached for his bible.) Do you want to read it or do you want me to read it?”

“You can read it to me.” He read me 1st Corinthians, verse 13. I understood it to be about God’s love and that man should embody that love (The Holy Bible, New International Version, 1984). I experienced it as a deeply moving passage as it reminded me of my own true essence.

“Do you feel any pressure to live your life differently because you were allowed to live rather than die . . . to rise to whatever purpose is meant for you by God?” There was about a minute’s silence while he thought.

“No great pressure. I don’t know what God’s purpose is for me. I may not know that for a long time. I’m just going to live and do my best to live in the grace of God I’ve tried up ‘till now but I’m going to make an even bigger effort in future.” I wondered how this fitted in with his idea of ‘spirituality’.

“What does ‘spirituality’ mean to you?” I asked. As before, he pondered his answer carefully.

“Spirituality means that there is another dimension to life other than the material, physical world . . . and it is more important. The material, physical world is meaningless; it can all dissolve, disintegrate. All the education, material possessions and such can all be instantaneously wiped out as it’s just physical matter. But the other dimension, the spiritual dimension, lasts forever and so it has meaning. I think that most people live only in the material, physical world. They use their intellect or mind to care for other people. They think about what they can or should do to care for others and then they do that but that is not always

caring. Real caring comes from the heart, as an act of the embodiment of God's love. That is when we are genuinely enacting God's love for us."

"Are you saying that you know when caring is genuine?"

"Yes. I think that people know when caring is genuine . . . when it comes from the heart. For the rest of my life I'm going to try to embody God's love and try to care from the heart in my relationships with people. I now see life as precious . . . like a precious gem."

I could feel a few tears welling up in my eyes - such profound and wise words from one so young! I found it extremely moving. Ben was talking very slowly, giving all of my questions such a great deal of thought. He was still quite weak and having to speak so slowly because of his difficulty breathing because he had undergone a tracheotomy. The whole experience was extraordinarily humbling. I thought how lucky I was to be there, asking such questions and privy to such a conversation. I decided to share my feelings with him.

"I'm very moved by what you have learned for one so young. I wish that I had learned that at your age." He just looked at me but did not say anything. "Can I ask you about spiritual care? What spiritual care do you feel that you would have liked or would like now from the nursing staff?" His usual thoughtful silence ensued.

"Like these verses, I think that people should give hope. I think that they should keep a patient informed about what is happening and that what is happening is the process of their illness. And however tough it is, that they will recover. That's what's kept me going." He paused and then continued, "The best spiritual care that I received was from an Asian doctor in HDU (high dependency unit). He was most probably Hindu or Muslim. It was late at night and he had to re-site my ventflon (a needle placed into a patient's vein, usually in the arm, to attach to an intravenous infusion). He did it with great care, extremely gently. I asked him why he was taking such great care and he said that it was because everyone deserved to have the grace of God with them. I was really moved by this because it really meant something to me in terms of my religious beliefs, and I was particularly impressed because presumably the doctor wasn't a Christian. I'd like to be cared for by nurses offering hope and such grace."

"Would you prefer to be cared for by someone of your own religion or do you think that that is important?"

“For me, I don’t think that the best spiritual care could come from someone who doesn’t share my religious beliefs . . . Anyone who doesn’t share my religion might find it difficult to understand and appreciate things from my perspective A few of the nurses here helped me They were spiritual.”

“What do you mean by that?”

“They came and told me that they shared the same religion as me. That really helped. Some of the nurses and doctors also kept me informed about my progress and were hopeful about my recovery. That also helped me enormously to keep my faith. I needed to know that I would be normal again.”

“What do you mean by ‘normal’?”

“That my body will function normally, that I will be able to do things by myself. That’s what we all want. And that I will be okay intellectually.” Ben and I had been more in the ‘spiritual’ world of souls in our conversation, and now we had landed abruptly back in our daily reality (of nonduality) as bodies *with* souls.

I had talked to Ben for about an hour. I could not think of any other questions that I wanted to ask him. He was looking quite tired. I asked him if he wanted to ask me anything. He said that he did not. I told him that I did not want to tire him out too much and that I would leave him to rest. I told him that he had helped me with my study enormously and that I could not thank him enough. He looked slightly bemused. I again wished him a good and complete recovery, in case I did not see him again. He thanked me and I left his bedside. I did not see Ben again. He was discharged as planned before I returned a week later.

5.3 Analysis of my story about Ben, employing my theoretical framework

5.3.1 *Connection/relationship with other(s)*

Ben’s story, like Raymond’s story, took place at the very beginning of my period of data collection. Determined to maintain my ‘objective’ research stance, I observed the care that Ben received whilst he was being turned in bed and questioned neither the nurses nor Ben about it at the time. I held myself back in my ‘objective’ researcher role and did not speak the truth (as I experienced it) about what I had observed. Thus I was not true to myself, my values or my belief in nonduality, and felt very uncomfortable as a result. As we are all embodiments of ‘God’s love’ (as

expressed by Ben) or One indivisible whole (Wilber 2000), I was thus disconnected from myself and everyone else in the process.

Later, though, and unlike in Raymond's story, I took a more participant approach to being a researcher. I felt like I had had enough of 'playing games' by trying to adhere to the rules of traditional, empirical science and as laid down for me to follow by the local Trust Research and Development Committee. I was behaving against my own intuitive judgement and the pressure of being untrue to myself and my belief and values was becoming too much to bear (I will discuss this latter point further below). Therefore I challenged one of the staff nurses regarding the "deceit" by the healthcare team in relation to their testing Ben for chlamydia. Much later still, I challenged Joe about his behaviour regarding Ben. I felt totally in tune with myself and the universe in so doing on both of these occasions.

When Ben and I were talking privately in our last conversation together, I felt extremely connected to him, as though I was having a transpersonal caring moment with him (Watson 1999). Ben, on the other hand, seemed fairly nonplussed. I felt that I was caring for him in exploring his experience of his illness with him in relation to spirituality and spiritual care giving, but it seems that he experienced it more as just an interview with a researcher. We did not have the same history together as Lydia and I had experienced and so this may have contributed to Ben's perception of the experience.

On reflection, I think that I was experiencing a transpersonal caring moment with myself and the universe more than with Ben. Ben's experience that he shared with me reminded me of who I really perceive myself to be and my relationship with others and the universe. I think that I was moved so much because his expressed truth was the same as mine and I was reminded of the sheer power and scope of possibilities of all that may unfold from embracing and surrendering to nonduality as a way of knowing (for example, Ben's expanded consciousness stemming from his illness and suffering). Also, having become so disconnected from myself, others and the universe as a result of having undertaken my research in an 'objective' manner for just a few weeks, I desperately needed to be reminded of who I really perceive myself to be in terms of nonduality. When I was engaged with Ben in our last conversation, I felt like I was totally connected to myself and

the universe. I was reminded that there is another way of being with (an)other(s) other than that which I witnessed between Ben and the nurses at his bedside and that which I enacted with Ben in relation thereto - I-It relationships. To the nurses at his bedside, Ben was “a body to be turned” and “unnecessary work to be done”, and to the healthcare workers involved in obtaining his urine to test for chlamydia, he was “a body from which to collect a specimen”. If Ben had experienced I-Thou relationships with *all* staff members (for example, such as with the doctor in the HDU (their time together appeared to have possibly been a transpersonal caring moment, and in this regard, it would have been interesting to hear the doctor’s account of their time together)), Ben’s journey through his illness may have been so much more pleasant and if possible, even more (self) transforming. Equally, it may have been transforming for staff members.

Clearly, Ben did have some better relationships with some of the nurses, or at least with some nurses at different moments, on the ward, as he indicated to me. I will not comment upon these, though, as I do not know enough about the nature or quality of them.

With respect to Ben’s mother, I engaged with her directly for only a fairly brief period of time at Ben’s bedside when we initially met. In our introduction, I endeavoured to commence an I-Thou relationship with her. It appeared that she had or at least perceived that she had an I-It relationship with the nurses, as she did not appear to trust what they told her and even felt that they were being “untruthful” regarding Ben’s condition (as evidenced by the scene at the nurses’ station during the handover report). As I said nothing during that exchange or afterwards to her in relation thereto, and as I said nothing to her at Ben’s bedside to explain that Rebecca had been telling her the truth about not being able to order ointment for Ben until the following day (all in the name of maintaining my objectivity), sadly my relationship with her took a massive step backwards to an I-It relationship. On neither occasion did I endeavour to speak my truth to her or to engage in a discussion with her about her truth in relation to Ben’s ability to transfer between his bed and his chair. As I stated previously, as the staff had “lied” about obtaining Ben’s urine to test for chlamydia, Ben’s mother and/or Ben may well have sensed that “negative energy”. As everything in the universe is connected, that, in turn, may have initiated and/or exacerbated I-It relationships

between the two parties (or, at least, as far as Ben's mother appeared to have perceived the relationships).

In terms of Rebecca's relationships with Ben's mother and Ben by proxy, while they appeared to commence as I-Thou relationships, these perhaps transformed to I-It relationships, as she witnessed Ben's mother's "anger" on two occasions but never (at least to the best of my knowledge) made any attempt to explore that "anger" with her. In this sense, then, it might be argued that Rebecca did not do justice to the actuality or opportunity to do so that opened up before the two of them.

5.3.2 Sacred space

My sacred space was filled with tension during and after the time that I participated in turning Ben with the other nurses. I felt very angry and upset about the way that Ben had been treated. I was also filled with tension when Ben's mother contradicted Rebecca during the handover report, and when Rebecca was telling Ben's mother about not being able to order ointment for Ben until the next day. I felt uncomfortable in the midst of what I perceived as I-It relationships occurring, and not doing anything about this. Also, I was angry that because Ben's mother was "unhappy about the care that she and her son were receiving from members of staff", Ben (possibly influenced by his mother) might not consent to participate in my research.

When I was speaking with Ben and his mother on my own, except for the latter part of my final conversation with Ben, I felt that my sacred space was filled with some overflowing tension from the above.

During my last conversation with Ben, as stated above, I felt that my sacred space was full of some tension at the beginning; I was concerned that some of the care that he had received may have affected him adversely. In other words, I was projecting my anxieties about the care that Ben had received onto him. As I realized that it seemed that he had connected to his sacred space and therefore not absorbed any "negative energy" from the nurses turning him, I felt connected to my sacred space and became full of love for him and the possibilities of the universe. As Ben expressed, I felt a great sense of hope as part of God's grace.

The nurses who turned Ben with me did not seem to be connected to their sacred space, but rather to their “frustration” and “anger” that, in their view, he was not doing as much for himself as he could. They felt as they did because they viewed Ben’s behaviour as elongating his hospital stay unnecessarily, thus prolonging the occupation of a much needed hospital bed.

While Rebecca was speaking with Ben’s mother at his bedside, I sensed that her sacred space was full of love for them both. She had a serenity about her which remained even when Ben’s mother expressed doubt concerning the veracity of what Rebecca was telling her. Rebecca’s manner remained the same when Ben’s mother challenged what she was saying during the nurses’ handover report about Ben’s ability to transfer. As I stated above, though, Rebecca might have acted on the love that she seemingly felt for Ben’s mother (and Ben) by inviting Ben’s mother to explore her “anger”. This was a potential opportunity for spiritual growth for both of them, as it might have encouraged each of them to (further) embrace their compassionate, true selves (Rebecca by enacting the love that she seemingly felt for Ben’s mother, and Ben’s mother by potentially reaching a place of forgiveness in relation to the nurses’ “uncaring” behaviour, or moving in that direction as a result). When we are able to embrace our compassionate, true selves, or connect with our sacred space, we feel better, more at one with ourselves and the universe. We are reminded of who we really are, and this helps us to remember that, which in turn, may lead to further compassionate behaviour in relation to others and/or ourselves (Wilber 2000).

When I was turning Ben in bed with the other nurses, his sacred space was full of love. As stated above, he had not absorbed the tensions of the nurses or reacted to them in any way. As he later told me, having not remembered the incident, “perhaps I was just going with the flow then”. In his words, it appears that Ben had been in the process of surrendering to God’s will rather than fighting it or judging others. As recorded in his notes, though, Ben’s sacred space would appear to have been filled with some tension when he had been “tearful and crying with the physio” and “angry that no one changed his smelly, sweaty sheets”.

Ben's mother's sacred space appeared to be full of love when she initially met me. However, it appeared to have been filled with tensions when she was speaking with Rebecca at Ben's bedside and when she contradicted Rebecca during the nurses' handover report.

The sacred space of the nurse with whom I spoke immediately after reading Ben's notes and realizing that the healthcare team had "deceived" him regarding his urine sample, also appeared to be full of tensions. She appeared uncomfortable about having participated in the "deceit".

5.3.3 Forces (internal and/or external) which influence sacred space

My sacred space was influenced negatively largely by the same or similar factors as in Raymond's story:

- I experienced competing demands to care for myself regarding ensuring the successful progression and completion of the conduct of my research. In this case, these demands were my perceived need to be objective in my research approach and remain a non-participant observer (as previously) and my intuition telling me that this was inappropriate, my need to be seen to 'fit in' in terms of keeping the nurses on my side so that I might successfully complete my research, and my perceived need to obtain consent from Ben to participate in my research;
- I over-identified with my perception of Ben's "suffering". The nurses were "projecting their anxieties" about a general shortage of bed space within the healthcare system on Ben, thus "scapegoating" him. I had been "scapegoated" as a child in the third grade and more recently in my experiential group on a counselling course. As a result and not having reflected upon and processed these emotions, I projected my anxieties onto Ben;
- Stemming from my childhood and as I have described previously, I may have also over-identified with Ben in terms of knowing what it is like to "not have your important needs met by anyone".

My sacred space was also influenced by my perception that Ben was not being treated in a just manner by the nurses and other members of the healthcare team. In my view and in relation to this situation, a just manner entails I-Thou

relationships and truth telling. I consider the latter to be in line with the former as I consider it disrespectful of another to not tell him/her the truth. I did not feel that I-Thou relationships and truth telling were in operation, and I found this very difficult to accept. This is what fuelled my demand to care for Ben by challenging the nurse concerning the “deceitful” means by which his urine had been obtained for testing.

I recognize that as in Raymond’s story, I was judging the nurses. Thus as being treated in a just manner is extremely important to me, I have to ask myself about the justice of my *own* behaviour in terms of judging others. I also have to ask myself (as do the nurses in terms of Ben) about the justice of projecting my anxieties onto others (in this case, Ben, his mother, and the other nurses with whom I turned Ben and Rebecca). However, I was not continually filled with these tensions. My sacred space was influenced positively by listening to Ben having connected and connecting to his sacred space in our last conversation. This jolted me into remembering the reality of my being (nonduality) and I was then able to connect with my sacred space.

The nurses who turned Ben were not connected to their sacred space. From my conversation with Joe much later on, it seems that they may have been “anxious” about a general shortage of bed space within the healthcare system and projecting their “anxieties” about this onto Ben. Thus they may have been restricted in their consciousness from seeing Ben as a person warranting their care by the cultural and political healthcare conditions of today. They may have (also) had other tasks to perform or other patients’ needs to attend to, thus placing competing demands on their time to spend with Ben.

The nurse with whom I spoke about obtaining Ben’s urine for testing “deceitfully” was not connected to her sacred space. She felt tension with respect to having participated in this endeavour despite having told me that the nurses had been ordered to do so by the doctors. It would seem, then, that similar to me with respect to my adopting an ‘objective’ research stance, her intuition told her that this was ‘wrong’, but she followed the rules and the voice of authority (in her case the doctors’ orders) nevertheless. Everyone who participated in this “act of deceit” was restricted in their consciousness from engaging with Ben in an I-Thou relationship, seemingly by the cultural norm of health professionals knowing better than the

patient regarding care provision. They were further restricted by the scientific and cultural norm of valuing their 'objective' understanding of what was required to be done rather than Ben's subjective view on the matter and acting upon the former rather than the latter. Additionally, the nurses who followed the doctors' orders were seemingly restricted by the cultural norm of following the rules and the voice of authority as determined by hierarchical position within an organization and profession (in this case, the healthcare profession) rather than their own intuitive voice. If the doctors were male, gender may have also played a role in this situation.

Apart from the two occasions when, as recorded in his notes, Ben was "tearful and crying" and "angry", Ben was connected with his sacred space, consciously aware of the reality of his being (in essence, the same as my awareness - nonduality).

Ben's mother was not connected to her sacred space. She was "angry" that Ben was not receiving the care that she wished for him. Additionally, apart from when she initially met me, and in relation to the staff having obtained Ben's urine for testing in a "deceitful" manner, she may have been "projecting their anxieties" about their "deceit" back on them. (I am making an assumption here (and above) that other members of the team and not just the nurse with whom I spoke in this regard felt uncomfortable about their behaviour concerning obtaining Ben's urine.)

Rebecca, it appears, was the only person who was connected to her sacred space throughout. She remained calm and serene in her manner, genuinely appearing to let what was thrown at her in terms of others' "anxieties" wash right over her, whilst handling the situations in a caring manner. (Others' "anxieties", as above, were Ben's mother's and mine, the latter in relation to witnessing Ben's mother's "anxieties".) As before, though, she might have explored Ben's mother's "anger" with her.

5.3.4 Possibility of expanding consciousness/self transcendence

My experience with Ben concerns the expanding of consciousness through the expansion of knowing. As Ben testified, when we are consciously aware of Wilber's (2000) concept of nonduality as reality, when we consciously know this through connecting with 'God' or the universe of love, our consciousness is

expanded such that we recognize that we are all part of what Ben terms 'God's love'. Thus we have an enhanced potential to embody that reality or 'God's love'. Conversely, when we do not consciously know this, our potential may be reduced as evidenced, for example, by my anger at the nurses. Sadly, though, for most of us our consciousness is restricted for most of the time largely due to the conditions of our lives (Wilber 2000). These conditions may be of a personal, social, cultural, political or scientific nature, some examples of which I have described above in relation to the nurses and doctors caring for Ben.

The personal conditions of my life in terms of unresolved past issues, the social and 'scientific' norms of having to 'fit in' to obtain something desired from others (in this case, to successfully complete my data collection), and the 'scientific' norm of the ethics of obtaining consent in research all restricted my consciousness at various points in time during my experience with Ben. It may be assumed that personal and other restrictions may further have adversely affected others' consciousness. For example, Ben's mother's tensions in relation to the care of her son may have been driven by her valuing a sense of justice and fairness like me, as well as the social and cultural norm of doing one's best to protect one's child from harm.

In order to embody God's love, we need to deal with issues and conditions that restrict our consciousness. As I have stated previously, critical reflection and perhaps psychodynamic counselling may assist. These entail subjective, personal knowing. Also as stated previously, critical social theory may help to raise our consciousness about the conditions of our lives and the lives of others. When we know what these conditions are and how they affect us (and others), we are then in a position to try to change things, either the conditions themselves or our (and others') response to those conditions. Subjective, personal knowing (and inter-subjective knowing) is/are also required in this endeavour.

Meanwhile, to coin a well known phrase, 'things are what they are'. Most of us do not embody the reality of our being most of the time. Instead, we just have fleeting glimpses of that reality as I did at the spirituality conference as I described in Chapter One and much later with both Lydia and Ben. Moreover the world is *not* a just and fair place precisely because most of us do *not* embody the reality of our

being most of the time. As such, it would seem that we should just accept this rather than fight against it. As Ben expressed, there are just the two alternatives - either 'go along with the flow' or 'fight it'. By 'fighting it', we hold on to our negative feelings and fill our sacred space with tensions which, in turn, leads us to have the capacity to fill others' sacred space with tensions (because everyone is interconnected and we are filled with negative energy). Alternatively, by 'going along with the flow' or surrendering, as Ben's conversation with me demonstrated, we are able to connect with our sacred space and embrace opportunities for our consciousness to expand, hence furthering our spiritual growth. This, in turn, has the capacity to help others to connect with their sacred space, enabling them to embrace such opportunities.

To clarify, I am not suggesting that one should just let, for example, injustice reign, but rather that one should first accept it and then, embodying our reality, try to remove that injustice, or contribute to greater justice/fairness. Of course, as above, because most of us do not embody the reality of our being most of the time, the world may never be fair and just.

When my colleague referred me to the poem, 'Invictus' concerning being the captain of one's soul, as above, I interpreted it in terms of Ben and his behaviour. I now realize that it applies to us all. We are all the captains of our souls. In our daily lives we all face situations which try us and/or conflict with our values which are in line with the embodiment of our real selves. With mindfulness, we can all choose to do our best to 'go with the flow' in each such situation that we find ourselves, meaning surrender or connect with our sacred space from which to move forward and deal with the situation (if, of course, it then still exists as something with which we feel the need to deal).

Again, I am not suggesting that this is terribly if at all easy, or indeed possible for many/most of us or in many/most cases to accomplish, even over the course of our lifetimes. Rather, we are in a constant process of trying to accomplish this. As Wilber (2000) points out, we are all not consciously aware of our reality to the same extent. We possess differing levels of that consciousness. (This is another reason why it is important not to judge others. Each person's general behaviour is only in line with the level of consciousness that s(he) has reached.) Wilber (2000) argues

that it is possible to increase one's level of consciousness in one's lifetime. He stresses, however, that mindfulness that may facilitate us being in our sacred space on a regular basis may perhaps only be achieved through a *lifetime* of meditative practice. To further assist us to increase our level of consciousness, Wilber (2000) proposes that we immerse ourselves in a community of others at least as mindfully aware as ourselves such that these other people and their behaviour may serve as additional reinforcement. Tackling our personal restrictions to our consciousness by engaging in critical reflection and psychodynamic counselling, as I have indicated above, may also assist us in this endeavour.

One further point about being consciously aware of nonduality as reality is that, as Ben expressed, being 'touched by the grace of God' is experienced as a hopeful thing. This is because when we hold this consciousness, we are in touch with all of the love of the universe and beyond. There is nothing else. We are embraced by sheer love or positivity of which hope forms a part. Further, we know that *because* we are part of everything in the universe which is love, that loving universe will present us with whatever we need in the form of opportunities. Also, when we are connected to our sacred space, our consciousness is expanded and thus we are able to *identify* these opportunities. In addition, the more *frequently* that we connect to this space, the *more* opportunities we see generally (Wilber 2000). As Ben expressed in terms of his recognition of hopefulness (and abundance) in the universe, "I've changed as a result of surrendering to God's will. I know that the Lord will sustain me through anything."

In my own life, I have experienced the universe sustaining me through tough times, even when it was difficult for me to access my sacred space. For example, in my childhood and as I have mentioned in relation to Raymond's story, when I was placed in a class that was totally inappropriate for me, I found myself with a teacher who had a highly developed moral consciousness. This enabled her to go against the system to place me in the other, appropriate class for my learning needs and my health and well being. Similarly, in my then new class, I befriended one of my classmates who lived next door to me. She invited both my sister and me to her home after school. Her mother, seeing us as obviously starving, prepared us a huge meal and invited us to eat. She told us that that she had accidentally cooked too much food and that we would be doing her a huge favour by eating some of it.

We knew that this was not true but we respected her preserving our dignity in the manner that she presented the opportunity to eat to us. Hence my sister and I graciously sat in her kitchen and ate what we could. However her mother did not stop there. Considering our best interests in the longer term, she contacted the town council who subsequently arranged with my father for my grandmother to come to live with us such that my sister and I might be appropriately cared for.

At many other times, especially over the past fifteen years, when I had access to my sacred space and a conscious awareness of my reality, I have noticed opportunities presenting themselves to me. For example, quite recently, having just awoken in the middle of the night, I got up and turned the television on. I was in the general process of analyzing my data and one of my supervisors had advised me a few weeks earlier to consider Goethe's work in terms of being a researcher of spiritual care giving. There was a programme on the television about a researcher of animals, in this case, wild turkeys (BBC One 2011a). The researcher had just received a cardboard box of not yet hatched wild turkeys delivered to his home. He placed the box on his kitchen table and as he sat watching the first turkey hatch he realized that it was looking at him with a view to imprinting on him as its mother. In a gestalt moment, the researcher realized that as the young turkey had no (other) mother, he would embrace its mother's role wholeheartedly. As well, he realized instantly that if he lived with the turkeys as their mother and studied them from that perspective, he would know so much more about them (living with and learning about them from the inside out, so to speak). He sat and watched as all of the other turkeys individually hatched and also imprinted on him. He then lived with them every moment of every day (except for when they slept in their shed at night) until they had all grown up and flown away to establish their own independent lives.

As the researcher had his gestalt moment, so did I. I was transfixed on watching the programme from the outset, knowing that it had major relevance to me in terms of how I should analyze my data. As the programme unfolded, I realized what that relevance was. The researcher did learn so much more about the turkeys than he might have otherwise, for example, that they had individual personalities, what those personalities were and that adolescent turkeys struggle with their mother in terms of establishing their independence just as human adolescents do. The researcher even had relationships with all of the birds and these differed according to their different personalities. When I eventually read Goethe's work, I found that

the researcher of the wild turkeys had, in essence, adopted Goethe's method of inquiry.

More ironically, several months ago my same supervisor commented at one of my supervisory sessions on how my data went to places that other people's did not in terms of exploring spirituality and spiritual care giving. He said that it went into the 'earthly' or brutal harsh reality. After this session when I arrived at the train station to return home, I went into one of the book stores. Immediately I saw a book entitled, 'The man who broke into Auschwitz' (Avey & Broomby 2011). This is an immediate must read, I thought – this man went into one of the most brutal, harshest realities ever! I read the book as soon as I could. The man who broke into Auschwitz was a British prisoner of the second world war in a labour camp near Auschwitz III. Working alongside Auschwitz III prisoners, he felt a moral obligation to bear witness to their suffering and so he posed as one of them on two separate occasions. On each occasion, at the end of the working day, he returned from the labour camp to their barracks with them and stayed there until the march back to the labour camp the following day. At the heart of the narrative, though, is a story about a Jewish Auschwitz III prisoner whom the British prisoner met at the labour camp. They had the briefest encounter one day which very ironically resulted in a short series of events which eventually saved the Jewish prisoner's life. It was a story about 'going with the flow' and seizing opportunities and how that enriched both of their lives (it actually saved the Jewish prisoner's life).

However my story does not stop here. My taste for reading more about Auschwitz as a result of reading this book led me to read Primo Levi's (2007) book, 'Survival in Auschwitz: If this is a man' about his experiences as a prisoner in Auschwitz. His entire experience was tremendously harrowing and the plot is precisely that when we are able to see opportunities, as Levi was forced to do in order to survive, appropriate opportunities reveal themselves to us as and when we require them. Levi seized each opportunity and survived, albeit by the narrowest of margins. Some might say that he was extremely lucky. I would agree, but also that he was extremely spiritual and in tune with everything around him. Levi's book is a testament that there is always hope if you open yourself up to spotting it – a useful way of living for us all and for patients, nurses and other healthcare workers in helping patients to live with their illnesses and suffering. As Ben's story illustrates,

with the knowledge of nonduality as our reality, we may further expand our consciousness and grow spiritually as a result.

In my experience with Ben and as I have described above, I really needed to re-learn from him in order to re-connect with myself as part of a loving universe. As I have also described, through his illness and “suffering”, Ben became a most wonderful source of knowledge about both spirituality and spiritual care giving. Sadly, though, there were other nurses and healthcare staff who may have benefited from hearing what he (and other patients who have experienced expansions of their consciousness through their illnesses and suffering) had to teach them. As I have described from what I observed, though, it is somewhat unlikely that they will seek out these rich sources of knowledge. This is because, also as I have described, their consciousness appears to be restricted. Their practice is based upon ‘objective’ rather than subjective knowledge, they listen to the voice of authority or hierarchical position instead of their own intuitive voices, and they feel that they know better than their patients what care should be provided.

Finally, there is the issue of my tensions regarding my consent forms for my study. As it transpired, this was not a problem with respect to obtaining Ben’s consent to participate in my study. The issue, though, is that it might well have been. This is because there is the potential that when a researcher such as I interrupts a naturally occurring conversation in an I-Thou relationship (or as near to one as may be beginning to be achieved) to explain his/her study and ask for such consent, this may readily be seen by the prospective study participant as indicative of an I-It relationship. In other words, it may be perceived that the researcher only wishes to engage in a relationship with the prospective study participant as a means of achieving his/her own ends (for example, to successfully conduct his/her research or ‘use’ or even abuse him/her). Ben’s story reveals how Ben’s mother appeared to feel so mistrustful of the nurses and so angry as a result of seemingly perceiving herself to be in an I-It relationship with them.

Current research ethics require that informed consent be obtained in the interests of protecting the rights and health and well being of study participants (Christians 2005). Yet this was established in a more traditional, ‘scientific’ research

community in which the researcher tended to be an 'objective', non participant observer of his/her research sample, and may have treated his/her research sample (more) as objects. Hence there was no issue concerning disturbing a burgeoning I-Thou relationship and no cause for any conflict of values with behaviour, potentially resulting in tensions on the part of both the prospective study participant and the researcher. With respect to research such as mine, however, in which such tensions arose, I feel that these ethics might be revised such that there may be as little as possible or no potential detriment to the sanctity of the researcher-study participant, I-Thou relationship. In a caring, I-Thou relationship, perhaps it could be left to the researcher's own subjective judgement of the situation as to whether formal, written consent is appropriate.

5.4 Summary

Chapter Five has examined how expanding ways of knowing in nursing and expanding sources of knowledge may contribute to enhanced spiritual care giving by nurses within their clinical practice. Nonduality was explored as a way of knowing and found to have the potential to expand nurses' consciousness, thus furthering their own spiritual growth. This, in turn, may enable nurses to facilitate patients (and others) to do likewise (in this case, it was the other way around, and Ben (re-)accomplished this for me). Nurses' expanded consciousness in relation to nonduality affords them a sense of hopefulness as well as knowing that the universe will provide whatever is needed in the form of opportunities. Further, it enables them to spot these opportunities better when they arrive.

However in order to embody nonduality or God's love, nurses need to deal with issues that restrict their personal, social, cultural, political and/or scientific consciousness. Critical reflection, mindfulness, psychodynamic counselling and critical social theory are all potential means to facilitate this. Immersing oneself in a community of likeminded practitioners of mindfulness may further assist. A major potential difficulty in nurses employing these strategies successfully, however, is current restrictions on their consciousness. For example, their practice is based upon 'objective' rather than subjective knowledge, they listen to the voice of authority or hierarchical position instead of their own intuitive voices, and they feel that they know better than their patients what care should be provided. This last restriction on their consciousness is particularly sad in that patients who have

expanded their consciousness through their illnesses and suffering offer a wonderfully rich source of knowledge for nurses of which the latter may not avail themselves.

The issue of gaining consent from patients for participation in research studies in which researchers are engaged in I-Thou relationships with them was also explored. As the process of obtaining consent may transform the relationship from an I-Thou to an I-It relationship, it was concluded that the ethics of obtaining consent for participation in research studies might be revised to minimize the potential of this occurring. It was further concluded that perhaps the researcher's own subjective judgment in individual cases could determine if formal, written consent needs to be obtained.

Chapter Six continues my examination of how expanding ways of knowing in nursing and expanding sources of knowledge may improve spiritual care giving. This will be accomplished by applying what I have learned in Chapter Five to another experience of delivering patient care.

Chapter Six

Spirituality: Expanding Consciousness through the Expansion of Knowing – Part II

6.1 Introduction

Chapter Six carries my examination of ways of knowing in relation to spirituality and spiritual care giving that I commenced in Chapter Five forward with the same view - to enhance spiritual care giving in clinical nursing practice. Focusing on my experience with Brenda, a patient on the medical ward, and her husband, Malcolm, whom I met very shortly after caring for Ben, I attempt to embody the spiritual lessons or knowledge of which I was so starkly reminded in my experience of caring for Ben. In this process, nonduality is further explored as a way of knowing within nursing, further sources of knowledge are (more explicitly) revealed and the nurse's role in spiritual care giving is expanded and made clearer.

6.2 Brenda and Malcolm

On the morning that I first met Brenda and Malcolm, I arrived on the ward to find Natalie, the nurse in charge, greeting me with warm enthusiasm, and with, "Thank goodness you're here today". It sounded somewhat ominous. Natalie explained at the end of the handover report that she was the only qualified nurse on the early shift for that end of the ward (usually there were two nurses), along with two healthcare assistants and one student nurse (a "cock up" in the off duty that had been altered by the ward manager). As they were short of staff, then, Natalie asked me if I was happy to help out as one of the numbers. I explained that this was fine with me, but that I wished to work with other nurses in my role as a researcher for as much of the shift as possible, so that the remit of my research role would be fulfilled. She agreed. She then filled me in briefly on the patients. She said that one lady in particular, Brenda, might need support that morning, as her Consultant was due to meet with her and her husband at about nine o'clock to tell them that he had discovered that she had cancer.

Immediately after report, Natalie proceeded to give the patients their medications (this took considerable time, and she was the only person who could do this). I was allocated to work with Dirk, one of the healthcare assistants, in the female nine-bedded room. We set about making some beds and inviting patients to sit in their chairs and have a wash before breakfast (Dirk and I were in the usual mode of flying to get the work done).

I was not long in the room before I realized that I knew Brenda from the previous week. My heart sunk. Brenda was a tiny, dainty, thin, seventy-four year old lady with a really 'sweet' face. It was oval, with fairly large expressive eyes, a perfect, pink complexion, and a tiny, slightly receding chin. She had come in with severe weight loss (two stone in the past ten months), an abdominal mass by her umbilicus, nausea, difficulty eating, abdominal pain and diarrhoea. The previous week, I had heard her Consultant tell her on his round that he would try to organize a special abdominal x-ray for her that day. He had done so, and she had gone down for it at about noon. She had arrived back on the ward about thirty minutes later and had immediately asked the nurses if they knew the result. Someone had explained to her that it would take some time, but that we would know fairly soon.

Brenda's anxiety concerning the uncertainty of her diagnosis would soon be over, to be replaced by potentially a far greater anxiety and even more uncertainty. I felt especially sad because I really liked Brenda. She was a quiet lady who generally kept to herself, yet was very socially polite and showed concern for the other patients. When Bronwen, another patient in the room with senile dementia, had been getting agitated the previous week about being unable to remember anything, Brenda had expressed to me facially that she empathized with Bronwen's tragic plight. Little did she know then that she might be in need of such empathy. Hopefully, she would receive it today.

At about 9:15 a.m., Natalie rushed up to me and asked if I would accompany the Consultant and his junior ward doctor to speak with Brenda and her husband, Malcolm. They were all proceeding into the patients' section of the day room at the time. Natalie was still busy giving out the medications and wanted to continue. I was slightly taken aback as I had not anticipated this, but quickly agreed and followed them into the day room. My first thought was that while Brenda and

Malcolm might need support, I did not know her very well and I had never met Malcolm before. Was I the best person to offer them support, a (relative) stranger? My immediate thought thereafter was that I felt that Brenda and I had 'connected' the previous week through our shared empathy for Bronwen. Hopefully, she would feel that I was a caring person who had something to offer her.

We sat down and the Consultant gathered himself together. Brenda and Malcolm were sat side by side on a large sofa. Malcolm was a tiny, short, balding man who also had a 'sweet', kindly face. Brenda and Malcolm both looked very serious and very frightened. The Consultant was sitting on a smaller sofa at right angles to their sofa, about two feet away from them. The female junior doctor and I were perched on a long stool directly facing Brenda and Malcolm, about six feet away from them.

"We've done a number of tests now, and feel that we are building up a picture of what is causing your symptoms. Can I clarify that you would like me to be forthright with you about what we have found?" Brenda and Malcolm gulped hard, and continued to both look directly at the Consultant.

"Yes. We would like to know everything, as then we will know what we are dealing with", said Malcolm. Brenda nodded in agreement.

"The tests show that as you felt, there is a mass by the belly button. The doctor here (looking at the junior doctor) did a test, introducing a needle into that mass and taking some tissue directly from it. We analyzed that tissue and I'm afraid that the news is not good." Brenda and Malcolm looked terrified then. They had not moved at all, and were both completely transfixed on the Consultant. "We found cancer cells in that mass."

Brenda's and Malcolm's faces fell. They looked completely devastated and appeared to be in shock. The Consultant continued, "Can I ask you again, are you certain that you wish to know the full extent of our findings?" As before, Brenda and Malcolm nodded yes, continuing to look absolutely terrified.

"We don't think that the mass in the belly button is what we call the primary site of the cancer. We think that the cancer has started elsewhere and has gone to the belly button afterwards. The cells from the test tell us that. We think that the

cancer has probably started either in the lower bowel or in the stomach. We did that test, a sigmoidoscopy, on your lower bowel but we weren't able to see anything because the bowel was narrowed. Now that narrowing doesn't mean that the cancer started there. That narrowing may be caused by some of the cancer that has travelled there since. As I say, we don't know for certain where the cancer started."

"Are you sure that it's cancer?" asked Brenda in desperation.

"Yes . . . I am sorry. I take it that this is not the news that you were expecting?"

"No", replied Malcolm. "We had hoped that it might be something that would require just a small operation . . . to remove the lump. We thought that there was just one lump The GP said that he didn't think that it was anything very serious because Brenda had such a healthy complexion."

"Well, as I said, while we're still not absolutely sure where the cancer started, it seems to be in the abdominal cavity and in the pelvic cavity. I don't think that an operation is going to help the problem, and especially as Brenda is so weak. We don't want to make things any worse for you."

"No," replied Malcolm sadly.

Brenda appeared to look almost guilty that she was not stronger in herself to be up for such treatment. Neither of them seemed remotely aware that the doctor was perhaps suggesting that an operation might not be able to accomplish much to stem the tide of the situation in which they found themselves. I felt extremely sad for them to receive such terrible news. To me, it sounded as though Brenda was 'riddled' with cancer and that she would not have much longer to live. I was not sensing, though, that Brenda and Malcolm were quite picking up on this.

"There's a meeting tomorrow with the multidisciplinary team that deals with oncology cases", the Consultant continued. "Members of various professions are there who deal with palliative care issues, for example, doctors, dieticians, pharmacists and specialist nurses. They are experts in managing the treatment of symptoms that you have such as pain and nausea. I will speak with these expert doctors about whether they feel that chemotherapy or radiotherapy may help. It would be useful to know the primary site of the cancer, though, to know which drugs would be most effective in dealing with it. I don't know whether putting you

through further investigations to determine the primary site is a good idea, though. I will ask for their advice at the meeting tomorrow and feed that information back to you.” The Consultant and Malcolm arranged a meeting the next day for this feedback.

“I’ve given you a lot of information today for you to take on board. I think that perhaps this is enough for today. We can always talk again. Do you have anything that you want to ask me now?”

“No,” Malcolm replied. Brenda nodded her head in agreement.

“Okay. If you think of anything that you’d like to ask, it might be a good idea to write it down, and you can ask me when I see you.”

The Consultant rose to his feet and left the room. His junior doctor followed swiftly. Brenda and Malcolm turned to face each other for the first time since the Consultant had begun talking and both burst into floods of tears, wrapping their arms around each other. It was an extremely private moment in which both their pain and love for each other were powerfully tangible - a sacred moment.

“Perhaps you’d like some time on your own,” I said, rising to my feet. I thought that there might be things that they might wish to express to each other privately in the face of their news. “I’ll just be outside if you need anything. You can remain here as long as you like.” I exited.

I stood leaning against the wall in one of the small corridors joining the main ward corridor to the day room. The ward’s main reception desk was directly in front of me. I was completely engrossed in my own world, enveloped by both the sober sadness and tremendous beauty (Brenda’s and Malcolm’s love and caring for each other) of what I had witnessed - two such contrasting emotions juxtaposed against each other. Various members of staff passed by, rushing, as usual, to “get the work done”.

After about twenty minutes, I prepared a tea tray and took it into Brenda and Malcolm. It was such a small gesture, but I wished to convey the socially accepted meaning behind it – that they were cared for. They were both still tearful. I drew up the long stool that the junior doctor and I had sat on to the large sofa and set the tray down on it. I sat down on the sofa where the Consultant had sat. Malcolm

invited me to partake of the tea with them. I was unsure whether he was suggesting this because he felt that it was the thing to do, or whether he genuinely wanted me to stay. Caught slightly off guard with the swiftness and unusualness of his question, I decided to err on the side of caution and declined his offer. I had no intention of leaving them, though, before the time seemed right to do so. I wanted to know how they were and I focused the attention back onto them.

“How are you?”

“Well, it certainly wasn’t what we were expecting . . .” Brenda and Malcolm looked at each other and Malcolm burst into tears, laying his head upon Brenda’s tiny shoulder and putting his arm around her.

“You can’t do that”, said Brenda. “You must be strong. I need you to be strong for me. Come on, now.” Malcolm could not stop crying. “Come on, now. Stop crying.” Malcolm simply could not. Brenda was looking quite distressed. I felt that if Malcolm felt the need to cry, then that was what he should do, and interjected,

“Perhaps it’s a good thing for him to let it all out. Perhaps he can be strong again afterwards.” Malcolm continued to cry and Brenda started to cry again. Perhaps *she* had been trying to appear strong for *Malcolm*, and had been afraid that his crying would make it harder for her to hold her own emotions in.

“All this blubbing”, she spluttered. . . . “All this blubbing” After a few minutes, they both stopped crying.

“You’re right,” Malcolm said to Brenda. “We’ve got to be strong. We’ve got to fight this.”

“Yes,” replied Brenda. “We must carry on. What choice do we have? I don’t want to be in a state, though, where I’d rather be dead”

Already, I thought that Brenda was starting to think ahead concerning how the illness might progress and/or what the treatment might mean. My own father had been diagnosed with a particularly lethal form of terminal cancer over ten years previously. He had undergone an initial round of chemotherapy and radiotherapy which enabled him to live for three years after his diagnosis (his Consultant had initially told him that he might live one and a half years at most). When his cancer had returned, my father decided not to fight it. He had come to terms with his own mortality and had just wished to ‘go with the flow’ and die with dignity. He died with such dignity shortly thereafter and with all of his closest family around him. I do not

think that I ever felt so proud of him and to be his daughter. It is such a cultural norm, certainly in the Western world, to 'fight' cancer, and as such, his decision had taken some considerable courage. He had even lost a dear friend as a result; she had felt that he had inappropriately 'given up' (instead of 'fighting it') and could not forgive him for it. I kept thinking that if Brenda was 'riddled' with cancer and her death was imminent, perhaps a better option might be for her and Malcolm to just 'go with the flow' and not receive any treatment that might prolong her life, and especially if it also made her more uncomfortable. Mind, I had understood that the Consultant had merely suggested *palliative* treatment. However as Malcolm had talked about "fight(ing) this", it struck me that Brenda and Malcolm might not know the difference between this and treatment to actually try to eradicate the cancer, the latter with a view to Brenda potentially surviving the disease.

"We've got to hope for a miracle", responded Malcolm, clutching at straws.

"Miracles happen. They happen every day. You never know when it may happen for you." The thought of his losing Brenda was perhaps too much to bear. I was sat just listening as they both struggled to grasp the enormity of it all. I thought that they would need more time to try to come to terms with the whole situation.

"We've only just had our diamond wedding anniversary in December," said Malcolm, "although we didn't really celebrate as Brenda wasn't feeling well at all." They faced each other and each put one arm around the other, again both welling up with tears.

Several minutes passed in silence. They then 'gathered' themselves and focused their attention on the next 'hurdles' that they would face together - telling their daughter and granddaughter and Brenda's siblings the news and speaking with the Consultant again the next day about further treatment. "We've just got to wait until tomorrow and see what the doctor says. Then we'll know what we've got to deal with next (Malcolm seemed to be seeking some certainty in an evolving world of yet more uncertainty)."

I left them to spend more time alone together in the moment and to drink their tea. I met Natalie just outside the patients' day room and updated her on what had happened and how the couple were coping. We then both continued our usual business on the ward.

About an hour later, Brenda and Malcolm were both still in the day room. Natalie told me that she was going to go in to assess the situation for herself. I invited myself along (I was keen to see how she would approach this) and she readily agreed. We entered the day room. Brenda and Malcolm were still sat exactly where I had left them and had stopped crying, although their eyes (Malcolm's in particular) remained red-rimmed. Natalie sat where I had sat when I had been with them on my own and I sat on the smaller sofa beside her.

"How are you?", she asked them.

"It's an awful lot to take in, but we're beginning to come to terms with it. We've got to tell people now and then see what the Consultant says tomorrow after his meeting with the specialists", answered Malcolm.

"We keep blubbing and blubbing", added Brenda. "Oh, we've got to stop all this blubbing and get on with it, haven't we?"

Natalie asked about who their family were and they told her. She then continued, "Can I ask you what you understand about what the Consultant said to you?" Brenda and Malcolm offered her a recap of what they had understood while Natalie listened empathetically. It was fairly much as I had explained to Natalie. "Is there anything that we can do for you in the meantime?" offered Natalie. "Are you religious? Can I ask a member of a church to come to see you here?"

"I'm a Catholic", answered Brenda. "I went to mass on Sunday here in the hospital. No, I'm okay, thank you."

"Is there anything else that we can do?"

"No, thanks", they both replied.

"Well, okay then. Let me know if there is anything", said Natalie, standing to leave.

"We will. Thank you", the couple replied. Natalie exited the room and I followed.

About an hour later, I was at the nurses' station, reading Brenda's notes. I had read with interest that Brenda's recent chest x-ray suggested cancerous lesions at the base of both lungs. I pointed this out to Natalie who was sat beside me, adding that the Consultant had explicitly told Brenda and Malcolm that he was telling them everything, yet he had not mentioned this.

“Oh”, Natalie pondered. Brenda’s junior doctor, who had been in the room with the Consultant, the couple and me earlier that morning, was standing at the station. Natalie commented on this to the doctor, and the doctor replied,

“Yes. We told them everything.”

“Did you tell them that it has also spread to the lungs?” Natalie asked.

“Yes, I think so.”

I interjected, “No, I’m sure that they weren’t told that.”

“Well maybe not, then but they know that the cancer has spread Anyway, I think that they have enough to take in for now.” While I had agreed with the doctor to some extent (after all, they were really reeling from the news), I had wondered what ‘enough’ was, and for what purpose, and for whom.

“Yes, I guess so”, replied Natalie. I had felt very uncomfortable. I thought that Brenda and Malcolm did not realize just how much the cancer had spread and what the implications were. Yet presumably they felt that they knew the whole truth, as the Consultant had explicitly stated that he was telling them everything. I said nothing, intent on maintaining my ‘objective’ researcher role as much as possible and observing what transpired (I had still not (seriously) reflected on this aspect of my behaviour and its implications by that point in time). Nothing more was said about the matter, at least not then.

Approximately another half hour later, Natalie was sat again at the nurses’ station, writing her notes. All the ‘work’ had been done, and I asked her if I might talk with her about Brenda and Malcolm. She agreed.

“Natalie, can I ask you what you were aiming to achieve when you went in to speak with Brenda and Malcolm?”

“I wanted to check what their understanding was of what the Consultant had told them. I asked them to explain what he had said in their own words so that I could hear their interpretation of what had been said. Then, I guess partly because you were there, I asked them about any needs that they might have in relation to their religion. I don’t know if I would have done that if you weren’t there”

“What does spirituality mean to you?”

“Oh, that’s a hard question. I don’t know I guess it’s . . . who you are I don’t know how to explain what I mean . . . I guess I’m not making much sense

...” I nodded at her and listened patiently. “Like you could listen to music, and that brings out to you who you are . . . It’s what puts you in touch with yourself . . .”

“Do you think that Brenda and Malcolm have any spiritual needs at this point in time?”

“Oh, that’s hard Yes, I think they do They may have religious needs and that’s why I asked them about their religion but spirituality is more than just religion I guess it’s what makes you feel good in yourself like when you listen to music, it can make you feel really good about yourself Of course, it can also make you feel really sad, for example But I guess that’s still spirituality Oh, I don’t know . . . This is really difficult I think that spirituality can mean love . . . Love can help you meet your emotional and psychological needs . . . but spirituality is somehow even bigger than that Coming back to what Brenda and Malcolm need, they need love from us . . and they need understanding . . . of what they’re going through . . . I know that we can never fully understand that because it’s not us that’s going through it . . . but we can try our best to understand it . . . by asking them what it is like from their point of view And they also need some space . . and some time . . to get over the worst at this point . . . and we can give them that . . . like allowing them to take all the time that they need to be together after the doctor spoke with them That will help them to think about things . . . and to make some sense out of what they have been told”

“Is there anything else that you’d like to add?”

“No . . . maybe in the future . . . Ask me again some time I’ll think about this some more but for now, I think that Brenda and Malcolm need love, understanding, space and time.”

(With hindsight, I might have checked with Natalie what she meant by ‘understanding’. Was this understanding about the *disease*, or understanding about living with the *illness*?)

Just after lunch, I went to see Brenda again. Malcolm had gone home to begin telephoning people to tell them about what had happened. He would be back in a few hours. Brenda was lying on top of her bed, deep in thought. I sat on the chair beside her bed.

“How are you doing?” I asked.

“Oh, I’m still blubbing on and off. It’s so embarrassing.”

“If you find yourself needing more privacy, just give us a shout or ring your bell and we’ll come and close the curtains for you.”

“Okay I guess I’ll be moved to another hospital, *****, for treatment now.”

“Probably.”

“I’m going to have to stay in hospital now for treatment . . . I may never get home again.” My heart sank. Was this her best option for living out the rest of her life?

“Perhaps you won’t require all of your treatment as a hospital in-patient”, I suggested. “Perhaps you can be at home, and have some treatment as an out-patient.” (I was using the word, ‘treatment’ as palliative care.)

“Oh, Malcolm will never manage that . . . He’ll never manage on his own.”

“Well, there are lots of support services that can be offered these days . . . to help people manage at home . . . Nurses can come in and do things and offer support, to help people manage. Perhaps such things may help Malcolm to manage. Do you want to go home?”

“Yes, but only if I can still have the treatment that I need . . . I need to have whatever treatment I can . . .”

Again, my heart sank. I had the distinct impression that Brenda felt that there was ‘treatment’ that might help to rid her of the disease (perhaps this was true to some extent, but as I said above, I suspected quite possibly if not probably not from what the Consultant had said to her). I felt that she had been “misled” somewhat by the Consultant, if not “lied” to, in that the whole extent of her disease had not been (clearly) spelled out to her, nor had his plans for ‘treatment’ (although I appreciated that he could not have known precisely what the ‘treatment’ might entail before speaking with the experts, the palliative care team). I did not feel that it was my place to spell out to Brenda the extent of her cancer (I was not an expert in her condition, nor did I feel that it was the nurse’s role to do so (I had been educated that this was part of the doctor’s (medical) role)). Also, she was still reeling from what she had been told and I felt that it might be too early to lay even more bad news on her. Nevertheless, I took it upon myself to try to compensate a little for the doctor’s “less than whole truth”. I did this partly because I did not know if I would ever see Brenda again and I felt that I would not be able to live with myself if I did not do it.

“Brenda, if you want to go home, perhaps you should say this to the doctors. Then they will know what you’d like. If the doctors know that you want to be at home, perhaps then they can arrange things, and arrange with social services and such for support in the home for you and Malcolm. I don’t mean to say that you won’t be better off receiving at least some treatment in hospital (again, I was meaning palliative care) . . . That may be necessary . . . Perhaps rather than narrow your options down, though, you can think more widely about them You could think about this.” Brenda nodded in agreement but did not say anything. Already, I wondered if she felt trapped between a rock and a hard place. Also, I did not feel that she thought that this decision was hers (alone) to make. It was as though she had been put on a gauntlet and was now forced to run the full course, regardless of its effect on her.

As it transpired, Brenda was still on the ward the following week. At the morning handover report, I heard that the doctors had spent the previous ten days or so putting her through a number of scans and x-rays, trying to identify the primary site of her fairly widespread cancer. It was the pancreas, but they did not think that chemotherapy would help her at that stage of her disease. They had made her ‘not for resuscitation’ (although there was no evidence in her notes that this had been discussed with her) and were planning to send her home in the next day or so to attend the local oncology hospital as an outpatient for further specialist assessment for possible radiotherapy. In the meantime, the palliative care team had visited her in hospital and re-assessed her anti sickness and pain medication. As usual, this was proving a bit of a difficult balance to achieve with respect to her level of alertness. Brenda had become somewhat weaker and had fallen beside her bed a few days previously (perhaps drowsiness had contributed to her fall). No physical damage had been sustained. The nurses had asked the occupational therapist to see her before discharge to assess her ability to negotiate stairs which she had at home. They had also requested that the palliative care team continue to monitor her in the community after discharge.

I spent the bulk of the morning working with Dirk, a healthcare assistant, in the side rooms. At the patients’ mid morning coffee time and with Brenda’s permission, I pulled up a stool beside her chair in the middle of the nine-bedded ward to catch up with her.

“It’s nice to see you again, Brenda. How are you?” Brenda looked slightly more frail than when I had last seen her.

“Oh, not too bad, considering. I’ve had more tests and x-rays. They’ve been trying to find out where the cancer started and now they know. It’s in the pancreas. I hope I’m going home in a day or so. I can’t wait to be at home. It’s so boring here. They’ve arranged for me to go to ***** Hospital as an out-patient when I leave. I don’t want any treatment if it doesn’t make a difference, though.”

“What do you mean, ‘if it doesn’t make a difference’?”

“If it doesn’t make a difference. If it’s not going to help make me better If I’m not going to get better.” I sensed that Brenda now knew that things were not good at all, that the cancer was fairly undoubtedly too widespread for any form of more aggressive treatment to make but a small dent in the trajectory of her disease. “I want to go home. It’s so boring here. There’s nothing to do but sit and think.” Her eyes began to well up with tears. “Oh, I don’t want to be blubbing” She was so full of tears that she could not continue speaking. I felt that it might be good for her to just continue to cry as she seemed to need to do so.

“Would you like me to pull the curtains around?”

“No, I’ll be alright”, she replied, just managing to stop the tears running down her face. “I’ve been crying on and off ever since I was initially told that I had cancer. I’m better than I was. It’s so hard to believe. At times, I’ve asked, why me? Nobody in my family has had cancer. I’ve been so careful all my life. I haven’t smoked. I only drink a few sherries occasionally and I eat a good diet. I can’t understand why this has happened. Still, I guess that’s just the way that it is and there are people far worse off in the world than me. Still At home, I’ll be able to do what I want and the food will be better. The food here isn’t always what I’d like to eat . . . what I feel like, like egg and toast. There’ll also be things to do at home . . . People can come and visit me and we can talk in peace and quiet. And Malcolm won’t have to keep coming here twice a day. He said that he wants us to talk once I get home (she rolled her eyes at me in “fear”). I don’t know if I’ll be able to (She became tearful again.) I’m worried about how he and my daughter and granddaughter will cope after I’m gone. Silly, isn’t it?”

“I don’t think it’s silly. You’ve cared for them for so much of your life . . .” A confused, elderly, blind woman, lying in her bed across the way and facing us, began calling out, ‘Hello, hello’ repeatedly.

“I don’t want to get like that”, Brenda said, again becoming slightly tearful. I sat beside her in silence and stroked her forearm gently. I wanted her to know that I appreciated what she was feeling and that I cared for her. “You know”, Brenda continued, “the other thing that I keep thinking is how did the doctor not know that I had something seriously wrong with me? She said that she’d never seen a belly button like mine and sent me for x-ray. About nine months went by between then and now. It took weeks and weeks, about seven, before the first x-ray was done. And my belly button was so unusual that they took pictures of it to put in a textbook. Nobody had ever seen anything like it before in person. You would think that they would have guessed from that that something was really wrong. Still . . . she did order the x-ray right away. It’s not her fault. But the other doctors afterward . . . You’d have thought that they would have known . . . *because* it was so different That should have made them think that it could be something serious But there’s nothing that can be done now There’s no point thinking about it because there’s nothing that anybody can do now. You can’t turn the clocks back. Still I can’t really understand how they didn’t think it could be serious If they had diagnosed the cancer earlier, I could have started treatment earlier and things might have been different now”

I was sat listening to her intently and empathizing with her. My own mother, as I have stated previously, died tragically after having been misdiagnosed for over a year, not that an earlier diagnosis would have definitely made a difference. Brenda was expressing the full tragedy of her situation to me. I felt that she was desperately trying to make sense or find meaning in what had happened to her and that she was perhaps a little angry at the doctors for not having diagnosed her correctly sooner. In spite of their missed earlier diagnosis, though, she was trying to move forward with her life and just ‘go with the flow’. However I sensed that she was struggling to let go of her “anger” completely and just ‘go with the flow’. I encouraged her to do the latter:

“Sometimes, it happens that people have symptoms of a disease that are different from what doctors usually see. The doctors don’t understand those symptoms as part of the disease that they are, because they don’t relate the two . . .” I had witnessed this on a number of occasions during my career and thought that this may have been the case with respect to Brenda. While I was telling her this, I was consciously thinking that I did not know what had happened and I also did not want to protect the doctors if they had been “at fault”. Nevertheless, I was mindful that

this wondering was causing Brenda considerable tension or distress and as she had said, there was nothing that anybody could do about it at that point in time that would prolong or save her life.

“Yes. I guess so I believe in life after death. At least, I hope there’s life after death” (She became slightly tearful once again.)

“Does it help that you believe in life after death?”

“Yes, that’s my religion. (Brenda was a Roman Catholic.) It helps a lot”.

“Have the nurses helped you since you’ve been here?”

“Well . . . not really. They’ve asked me how I’ve been, but they’ve been *too* sympathetic . . . *Too* much sympathy is not a good thing . . . It doesn’t help.”

“Did you say anything to them about it?”

“It made me cry my eyes out. I couldn’t!” We both chuckled slightly at the irony.

“What *could* the nurses do to help?”

“Just listen, but not feel sorry for me. That doesn’t make me feel better at all.” We sat in silence for a minute or two. I was then interrupted by one of the qualified nurses asking for my help.

I explained to Brenda that I needed to leave and got up and followed the nurse out of the nine-bedder and down the corridor. That was the last time that I ever saw Brenda.

6.3 Analysis of my story about Brenda and Malcolm, employing my theoretical framework.

6.3.1 Connection/relationship with other(s)

As stated above, I was still clinging on a little to my ‘objective’ researcher stance in caring for Brenda and Malcolm. Specifically, I did so when I was not completely happy with the junior doctor’s response to my initial challenging of her in relation to what Brenda and Malcolm had been told about the extent of Brenda’s cancer. I also did so when the Consultant was speaking about palliative treatment, yet Brenda and Malcolm did not seem to comprehend (fully) that this was very different from treatment to try to eradicate the disease and save life. When these events were occurring, I said nothing (more) about either issue. In this sense, then, I enacted an I-It relationship with Brenda and Malcolm; I was not completely truthful

with them. I still have some doubts, though, about whether or not more of the 'truth' of the reality of Brenda's cancer at that early point in time would have been in their best interests, as they were still reeling in shock. When I last spoke with Brenda, as I stated, I felt that she appeared to appreciate (more) the full reality of her situation. As a result, I did not then feel a need to spell it out any further for her.

Over the time that I otherwise spent with Brenda and Malcolm, I feel that I had an I-Thou relationship with them. Specifically, I tried continuously to encourage them to open up to what was happening in relation to them, to surrender and 'go with the flow'. I did this in relation to encouraging them to express their feelings (rather than to try to contain them), encouraging Brenda to consider letting the doctors know what she wanted in terms of how she might live the rest of her life (rather than follow a medical course of treatment if it was not going to prolong her life), and encouraging Brenda to let go of the issue regarding her late diagnosis.

Natalie endeavoured to have an I-Thou relationship with Brenda and Malcolm by being what I experienced as genuinely empathetic with them regarding their situation. As she expressed to me, she understood that Brenda and Malcolm needed "love, understanding, space and time." However, other than this and offering Brenda the opportunity to speak with a member of the clergy (which Natalie admitted that she only did because I was present and presumably because she thought that that was what I wanted to hear), she did not appear to appreciate (fully) what, if anything, might arise from the situation that they were in (I will speak more about this below). In this sense, I do not feel that she had an I-Thou relationship with them.

As the doctors were "not completely truthful" with Brenda and Malcolm, I do not feel that they had an I-Thou relationship with them. However, like me and according to what the junior doctor told me, they appeared to feel that providing more information at that early point in time may not have been in Brenda's and Malcolm's best interests. Having told the couple that the cancer had spread somewhat and even though he had not yet consulted with the palliative care team, the Consultant might have usefully done more to check that Brenda and Malcolm understood that palliative care rather than a more aggressive form of treatment was being proposed

(although perhaps he considered the term 'palliative' so common, that it did not occur to him that patients and their families may not know its meaning). Also, the Consultant's role appeared to be chiefly information giving. (He did ask Brenda and Malcolm, though, if they had any questions at the end. Presumably, then, he was also interested in an exchange of information. Similarly, one of Natalie's key objectives in speaking with Brenda and Malcolm had been to ascertain their understanding of the information that they had received from the Consultant.) Further, after enacting this role, the Consultant and the junior doctor left relatively abruptly. In these senses, they did not appear to be (particularly) interested in Brenda and Malcolm as people living with an illness, but merely as persons to whom information needed to be given. (The same might be said to some extent about Natalie in this regard, although she did ask Brenda and Malcolm how they were.) Having said this, the Consultant checked twice during his meeting with Brenda and Malcolm the extent to which they were happy to receive (more) information.

As Brenda spoke of the nurses on the ward being "too sympathetic" towards her after her diagnosis and in relation to her situation, it would seem that they had an I-It relationship with Brenda. The offering of sympathy as opposed to empathy and which made Brenda want to cry is indicative of "negative energy". The nurses were not seeing any potential positivity or hope emerging from Brenda's situation which did not do her justice. Thus I feel that they had an I-It rather than an I-Thou relationship with Brenda.

6.3.2 Sacred space

My sacred space was filled with some tension before I went into the meeting with Brenda and Malcolm, the Consultant and the junior doctor. My sacred space was also filled with some tension while I listened to the Consultant breaking the bad news to Brenda and Malcolm, and afterwards while I was standing outside the patients' section of the day room while Brenda and Malcolm were still therein.

My sacred space was further filled with some tension when I read Brenda's notes and realized that she and Malcolm had not been told the full, precise extent of the spread of her cancer. It was the same again after the junior doctor admitted to me

that Brenda and Malcolm had not been fully informed as above, yet she was not going to do anything about this.

Apart from the above instances, I feel that I was able to fully embrace my sacred space and that I did so in the care that I provided both Brenda and Malcolm, as I have outlined above.

So what does this mean about the nature of sacred space? Is sacred space a place where there is no tension? Does one's sacred space just somehow suddenly, from time to time, empty itself of tension(s) on its own, and what exactly do I mean when I say that I was "able to fully embrace my sacred space"? I have touched somewhat on these points previously within the text, albeit quite implicitly. I will explicate them here.

For me, embracing my sacred space means that I am able to connect with the true core of myself that connects me with the rest of the universe – pure love, in line with Wilber's (2000) concept of nonduality. This same deep place within myself is also the place where all of my other feelings lie, for example, fear and anger (although Walsch (1998) argues that there are only two real emotions – love and fear, and that all other negative emotions, such as anger, are born out of fear). When negative emotions lie in my sacred space, it is (more) difficult for me to connect with the true love that is at the core of my being. It is as though the love is so buried or obscured by the other negative emotions, that I just cannot find or connect with it or connect with myself. My behaviour then, in a sense, is influenced by these other negative emotions, and I feel like I am being led astray, away from my true, loving self (my 'dark(er)' side has taken over). When I am consciously aware of such behaviour, this often evokes a sense of shame in me. Having said this, I am not always (fully) conscious of my behaviour in the moment, as sometimes I am too caught up in experiencing or being attached to and/or acting out my negative emotion(s). Buddhism, as I have explained earlier, would say that I am too attached to myself or my ego (as opposed to the universe) (Kulananda 2000).

Some examples may help to explain what I mean. Just last week, one of my students whom I am supervising on a post-registration module emailed me at

approximately 4 p.m. on Thursday to ask me if I would come out the following day to his clinical area where he practises to conduct an assessment of his teaching and assessing skills. He told me that he was sorry, but he had not managed to get around to booking an appointment with me any earlier due to work pressures. This assessment comprises part of the formal assessment for the module and must be written up by me. The student must then attach this paperwork at the end of his/her summative assessment and submit everything electronically as one document. The student's summative assessment was due in by 4 p.m. on that Friday. Without the assessments completed, the student would be referred on the module and this, in turn, would affect the classification of his degree. My other students on that module had all completed their teaching and assessing in clinical practice weeks beforehand. I had appointments scheduled in my diary for the Friday. If I were to conduct the student's assessment, I would need to re-schedule these. Also, conducting such an assessment and the writing up thereof usually takes me approximately three to four hours. It would take me a further forty-five minutes to travel to and from the student's area of clinical practice.

When I first read the email, I was angry and fully aware of feeling that way. I remember thinking, "What does he think he's doing, leaving it to the very last minute and then expecting me to jump through hoops for him? I'm surely every bit as busy and pressured as he is, what with working full-time and doing a PhD. This is going to cause me even more work and put more pressure on me! Why should I put myself out for him?"

It took me approximately fifteen to twenty minutes to calm myself down. During that time, I thought about what I would need to do to conduct his assessments on the Friday and whether or not I could actually manage to do everything in time such that he would be able to include the paperwork as part of his submission. I also reflected on my anger. I tried hard to move away from focusing on myself to focusing on the student.

I realized that I had judged him as "irresponsible" and "inconsiderate" for leaving things until the last minute, and that perhaps things really were so difficult for him that he had done so. I had been afraid that he would be seen to be taking unfair advantage of me. I was also conscious that some of my past work colleagues readily labeled students as irresponsible and/or inconsiderate, when, in my own

experience, it has almost always turned out that they were not. I realized that I may have been influenced by their behaviour but that I could break away from it. My anger diffused and I felt much better in myself. I felt in touch with my sacred space or loving self. I then emailed the student and arranged to conduct his assessment with him on the Friday. When I got to his workplace the following day, he explained more fully what had been happening with regard to his role in the clinical area and the tremendous pressures that had been placed upon him by his managers. I felt humbled to hear his story and very happy that I had been able to help him out with his assessment in the face of such adversity.

Another example concerns my PhD supervision. When I first commenced my supervision, I felt that one of my supervisors was somewhat impatient with me (I felt a considerable amount of “negative energy” coming towards me from him). It seemed to me that he was unhappy with my progress as a student and I felt very threatened by this (I remember thinking of him as a bull in a china shop and I felt very afraid; I desperately wanted to be a successful student and my fear was that this would not be the case). My response to his behaviour was to be very defensive in mine at our meetings. Neither of us, in my view, had embraced our sacred space and the general atmosphere at our meetings was not particularly pleasant as a result (the “negative energy” in the room felt palpable to me).

Over a period of some time, though, things changed completely. He became the named member of my supervisory team for booking my appointments and dealing with some administrative issues and I found him to be completely reliable in these roles. At one meeting, I suggested something that was different to what he and the rest of my supervisory team had in mind for the way that my work should progress. He reflected hard in the moment and agreed with my suggestion, thus seemingly indicating to me that he respected me and my judgement. At another meeting, I arrived in the room before him. I was speaking to my other supervisor about my experience on my train journey earlier that day and he expressed that he thought that I or we had commenced the meeting without him. He appeared to feel somewhat slighted by this. I reassured him that this was not the case and that I would never do such a thing.

As the tide began to turn, I became consciously aware that positive energy was coming my way and I made a conscious effort to respond with like energy. Instead of being verbally defensive in my behaviour, I began to allow him to have the floor at our meetings and really listened to him, trusting that whatever he was saying was valuable and in my best interests, whether I knew it at the time or not. I also reflected long and hard on why I had felt so fearful of his seemingly impatient behaviour in the first place. I realized that my fear stemmed from other instances in my life and that I had inappropriately and subconsciously brought them to our relationship. At the same time, I felt more and more positive energy coming from him. It seemed that he too was making a conscious effort to engage with me from his sacred space. It felt like the two of us were both fully focused on truly appreciating and valuing the other.

We now have what I consider to be one of the best working relationships that I have ever had. I asked him relatively recently what it meant precisely to have reverence for another person (in line with Goethean science (Steiner 1911, Wahl 2005)) and how I could demonstrate the concept in my thesis with respect to my relationships in my data. I said that I felt that the concept was very difficult to capture and that I did not think that I could express its meaning in words. I now realize that what I have described above is perhaps as close to describing two people having reverence for each other in a relationship as I may demonstrate. I have also realized that the whole of the Goethean science method might usefully be applied to all relationships, as the method encompasses the essence of I-Thou relationships in which both parties are embracing their sacred space.

In the examples that I have described, I have consciously attempted to embrace my sacred space. I have worked hard to do so by engaging with and reflecting on the tension(s) that occupied my space such that I was able to resolve that/those tension(s) and embrace my true, loving self in that space as a result. Thus I was able to surrender and 'go with the flow' of what was happening. My ability to do so has not happened over night, but is something that I have developed from years of mindful practice in this regard. Sometimes I am able to achieve it in the moment. Many other times, as above, I am not able to do so. With continued practice, though, I feel that I am getting better at it as well as generally quicker, depending on the circumstances (some negative emotions attached to some circumstances take (much) longer to process than others).

As I have explained earlier, Wilber (2000) states that we all have some awareness (conscious or not) of nonduality as the highest level of human consciousness and the vast majority of us (who do not exist permanently in a state of nonduality) struggle on a daily basis to be truly compassionate to our true, loving selves. Thus I am reminded frequently by my own behaviour and the behaviour of others around me that compassion is not always enacted. This causes me pain, whether I am on the actual receiving end of a lack of compassion or not, as it is always (potentially) hurtful to some extent to the person who *is* on the receiving end because it is negative energy. I do not feel happy when I experience such pain directly or by proxy and this motivates me to try to embrace my own sacred space as much as possible. Thus I am reminded virtually constantly to be mindful to try to embrace my sacred space. Of course, as I am increasingly mindful and working on processing my negative emotions as a result, the negative emotions that continue to arise in me are generally that much more familiar to me (in the context of my life experiences) and so may generally be processed more easily and quickly as a result.

Returning to my story about Brenda and Malcolm, the Consultant's, the junior doctor's and Natalie's sacred space did not appear (or at least not for certain) to be filled with any tension at any time. Having said this, I did not spend a great deal of time with any of them nor engage with them in such a manner that I could (more) accurately assess this.

Malcolm's sacred space was filled with tensions for the entire time that I knew him.

Brenda's sacred space likewise was filled with tensions, although she appeared to have decided to 'go with the flow' in my last conversation with her and in light of a fuller knowledge of the extent of her disease. As she expressed to me, "I don't want any treatment if it doesn't make a difference, though . . . if it's not going to help make me better."

The sacred space of the nurses on the ward whom Brenda described as being “too sympathetic” towards her would appear to have been filled with tensions, as they were offering “negative”, rather than positive energy to Brenda.

6.3.3 Forces (*internal and/or external*) which influence sacred space

As in all of my stories, my sacred space was influenced somewhat, albeit less so, by competing demands to care for myself regarding ensuring what I considered to be the successful progression and completion of the conduct of my research (in this instance, once again, specifically in relation to being ‘objective’ as a researcher). In this vein, through fear in relation to my research, I did not do any more than I did to tell Brenda and Malcolm or try to ensure that they were told the full extent of Brenda’s disease. This conflicted with my values of justice, fairness and truth telling, as I have explained above.

Before I went into the meeting with Brenda and Malcolm, the Consultant and the junior doctor, I felt anxious because I knew that Brenda and Malcolm were going to receive very bad news, and with me present, whom Brenda hardly knew and Malcolm had never met. I was fearful that I might therefore be seen as a kind of ‘voyeur’ by them, and I did not want this to happen, as it would be indicative of an I-It relationship at a time when they might most usefully appreciate being in an I-Thou relationship with a nurse. As above, this conflicted with my values, in this instance with respect to being in I-Thou relationships, and as I have also explained above.

Whilst listening to the Consultant breaking the bad news to Brenda and Malcolm and then standing in the corridor outside the room afterwards, I was absorbing the shock and bad news along with them. I was feeling very stunned and sad (sad because I felt love for Brenda and Malcolm and I felt sorry that this was happening to them. It seems, then, that perhaps I felt somewhat fearful for their future, viewing death as a “negative” process). In the short term, I feel that this is a natural, human response, but it meant that I was not connecting with myself at all. After I got over the shock and my feelings of deep sadness (the latter by remembering that death is a natural process, just part of our existence as humans, and there is hope in death), I was able to connect and remain connected with my sacred space and ‘go with the flow’.

After attending the meeting as above, when I realized that Brenda and Malcolm had not been told the full, precise extent of the spread of her cancer, I felt tension. This conflicted with the values of justice, fairness and truth telling (all interrelated in this instance) that I hold very dear. I felt that justice and fairness had not been enacted as the Consultant failed to engage in an I-Thou relationship with Brenda and Malcolm by not telling them the whole truth which I felt that they deserved to hear. I felt that it was further unjust and unfair that Brenda and Malcolm had been “robbed” of then being able to do justice to the situation that they found themselves in, and especially in terms of (planning) their future. As I have stated, it is my understanding that there is a well established professional ‘rule’ of doctors and not nurses informing patients of their diagnosis. My understanding of this rule is that this is the doctor’s role because s(he) has the medical expertise in the matter. This seems appropriate to me. However in the case of Brenda and Malcolm, in my view and as I have stated previously, while the Consultant told them that the cancer had spread somewhat and talked about palliative care for the future, he did not check that they understood that palliative care rather than a more aggressive form of treatment was on the cards and what this meant.

It seems to me that if doctors have the responsibility for telling patients their diagnoses, they should also have the responsibility for ensuring that patients have the full, known picture of the extent of their medical condition and that they fully understand the full, known implications thereof (inasmuch as these may be known). As the Consultant did not assume this second related responsibility, I felt a great deal of tension as above. My tension was exacerbated by the fact that I then did nothing to ensure that Brenda and Malcolm *were* told the full truth.

However the situation was somewhat complicated. As the Consultant had implied to Brenda and Malcolm that he had told them the whole truth, if they had been told more information later that day by any member of the healthcare team, it might have appeared that the Consultant had “lied” to them. This would have been somewhat awkward, but more importantly may have been detrimental to Brenda and Malcolm having trust in the Consultant. (However I appreciate that there is some irony here in that the Consultant perhaps should not have been trusted by them precisely because he did “lie” to them.) I agreed with the junior doctor to some extent in that Brenda and Malcolm had received quite a lot of information.

My view was that they needed to know the full picture of Brenda's illness soon, but not necessarily that day. In short, it seemed to me that the Consultant's "lie" could not be undone that day without potential (further) damage to Brenda and Malcolm, and thus the action that needed to be taken was simply for the medical staff to put them in the full picture soon thereafter. While I have stated that I did nothing to ensure that Brenda and Malcolm *were* told the full truth, on reflection, my expressed concern regarding the matter in my conversation with the junior doctor may have spurred this on to happen if it had not already been in the planning.

Returning to the issue of my sacred space, I feel that I was otherwise able to fully embrace it largely because I made a conscious effort to do so. As I stated at the beginning of this chapter, I was mindful of what I had recently been reminded of in the way of spiritual lessons in Ben's story, and I was determined to enact them for the benefit of Brenda and Malcolm (and for myself, such that I could be true to myself or act in accordance with my beliefs). Included in my conscious effort was my determination not to judge anyone in relation to Brenda and Malcolm's story. I feel that I accomplished this and so this contributed to my ability to 'go with the flow' and not project any negative anxieties in relation thereto onto others. Also included in my conscious effort was my determination not to over-identify with Brenda and Malcolm in terms of knowing what it is like "not to have one's important needs met by anyone". I feel that I accomplished this as well, although partly if not largely because I felt that their most important need was finally met within a reasonable time frame; within the next week, Brenda seemed to have been told the whole truth about the extent of her cancer. Further, there was a possibility of me projecting anxieties in relation to my parents' deaths onto Brenda and Malcolm (and others). To the best of my knowledge, this did not occur; I feel that I have successfully processed my emotions in relation to their deaths some time ago.

As I was unable to accurately determine the sacred space of the Consultant and the junior doctor, I feel that I may only comment that their leaving the room quite abruptly after speaking with Brenda and Malcolm might have been indicative of them fleeing tension associated with breaking bad news and/or dealing with death and dying, or it might have been that they needed to see another patient, or otherwise needed to be elsewhere immediately thereafter. (This is similar to what I felt was the case with Lydia's multidisciplinary team after they had spoken with her. Also and as I have intimated earlier, the amount of information that the Consultant

imparted to Brenda and Malcolm about her condition and his limited checking for understanding thereof may have been indicative of him feeling these same tensions. As I have stated previously, the latter may (also) have been indicative of an assumption that Brenda and Malcolm knew the meaning of 'palliative' care.)

I was also unable to accurately determine the sacred space of Natalie. However, there was nothing in her behaviour that suggested that she had any tensions. It is therefore inappropriate for me to comment here upon any forces which may have influenced her behaviour.

It appears that Malcolm had feared the worst in terms of Brenda's diagnosis. (He had gulped hard when the Consultant had asked him and Brenda if they wanted him to be forthright in disclosing Brenda's initial test results.) Additionally, he remained "fearful of the possibility of Brenda's death", despite advocating that they 'fight it' (the cancer). Malcolm never expressed precisely what he was "fearful" of in terms of Brenda's death and sadly, I never asked him.

Brenda, likewise, was "fearful of her diagnosis and death". She told me that her religion was of some comfort to her, although as she was "fearful of her death", this did not appear to be the case. Also, she told me that she *hoped* that there was life after death, suggesting that perhaps she did not totally embrace her religion. Brenda was also "fearful of how Malcolm and her daughter and granddaughter would cope after her death, as well as any adverse condition that she might find herself in before her death as a result of her diagnosis and/or potential treatment for it". Brenda never shared anything more about what she "feared" about her possible, if not fairly imminent, probable death (if, indeed there *was* anything more), and as with Malcolm, sadly, I never asked her. Brenda's tensions were further caused by her wondering why the doctors had not managed to diagnose her cancer earlier and the fact that her diagnosis was made so late. However Brenda eventually appeared to decide to 'go with the flow' in light of an apparently fuller knowledge of the extent of her disease. It would seem, then, that she also may have managed to 'go with the flow' in relation to the issues surrounding her late diagnosis.

I did not ask Brenda who the nurses were who were “too sympathetic” towards her and I never spoke with them about their behaviour. Therefore, I feel that I may only comment that their behaviour (similar to that of the Consultant, the junior doctor and Natalie) might have been indicative of them fleeing tension associated with dealing with death and dying, of which most people in the Western world are fearful.

Finally, as in Ben’s story, people’s ability to ‘go with the flow’ with respect to Brenda and Malcolm’s situation may have been influenced by their restricted consciousness in relation to the personal, social, cultural, political and scientific conditions that may have impacted upon their lives. For example, Brenda and Malcolm’s ability to ‘go with the flow’ also appears to have been influenced, at least initially, by their apparent need for Malcolm to remain “strong” for Brenda (a social, cultural and historical condition of men feeling a need to be strong for or protect the women in their lives). They both also felt a need to control their emotions (this is likewise a social, cultural and historical condition, in this instance of the British needing to maintain a ‘stiff upper lip’, and the need to keep spirituality within the private, rather than the public domain of our lives). The fear of death and dying, yet another social, cultural and historical condition, influenced and may have influenced a number, if not most or all of the people in this story. For example, Brenda and Malcolm appeared to view it as a negative, unnatural process, rather than a positive, potentially transformative, natural one.

6.3.4 Possibility of expanding consciousness/self transcendence

My objectives in caring for Brenda and Malcolm were to embody, at least to some extent, some of the spiritual lessons of which I had been so starkly reminded in Ben’s story and to broaden the possibilities for them in living (and dying) in relation to Brenda’s diagnosis of cancer. More specifically, in relation to the latter, I wished for Brenda and Malcolm to enter into the space of living the remainder of Brenda’s life and her dying such that these possibilities might reveal their qualities to them. Thus in the vein of researchers employing Goethe’s methodology, I wanted them to be able to ‘surrender’ and thus come to know what they are observing or experiencing in a fuller and richer capacity (Steiner 1911, Wahl 2005). As the Baptist pastor, Marvin Winans, who spoke at Whitney Houston’s funeral expressed (Sky News 2012), I wanted to “allow God to take (them) through the wilderness area, knowing that (they’re) going to be better for it”.

In working towards facilitating them to potentially experience expanding consciousness, I felt that I needed to work to facilitate them overcoming the restrictions on their consciousness which might hamper any such expansion. In this vein, then, I endeavoured to:

- encourage them both to cry (as a means of embracing their reality. They wanted to do this, but tried consistently to hold themselves back);
- encourage Brenda to consider (an)other possibility(ies) other than receiving (more) aggressive treatment for her cancer (other social and cultural norms which may have restricted her in this regard are the perceived need to 'fight' cancer with aggressive treatment, and in relation to this, to believe that we may control everything in our lives, including death);
- encourage Brenda to let the doctors know what she wanted in terms of how and where she wished to live the rest of her life (I considered it too early to be encouraging her to also consider how she wished to actually die);
- encourage Brenda to let go of or surrender her issues in relation to her late diagnosis of cancer and resulting late treatment.

As I am writing this, I realize that in order to facilitate an expansion of their consciousness, I might have also encouraged Malcolm in these latter three areas as appropriate. In order to determine such appropriateness, I might have encouraged or arranged for dialogue either between Brenda and Malcolm in this regard and/or amongst the three of us, with their consent. I might have also facilitated them to 'go with the flow' in relation to *all* of the areas (again, as appropriate) that I have identified thus far in analyzing their story as above (for example, Brenda's tensions in relation to leaving Malcolm, their daughter and their granddaughter alone after her death). Of course, encouraging others to 'go with the flow' will not necessarily mean that they are able to actually do so. 'Going with the flow' entails being able to live in the 'now', and that entails being able to connect to one's sacred space and be without fear or expectation (Tolle 1999).

Another gestalt moment has just occurred for me. As I have expressed and in the vein of our reality being nonduality (Wilber 2000) and everyone and everything impacting on everyone and everything, I also felt that *I* needed to work on overcoming my own restrictions on my consciousness which might have hampered

Brenda and Malcolm's potential expansion of consciousness. I did this in relation to a number of tensions which I discussed in the previous section of this chapter, however I might have very usefully tried to address *all* of these, as appropriate. Similarly, I might have very usefully tried to work with the *other* healthcare professionals involved in caring for Brenda and Malcolm, in relation to *all of their* such restrictions on *their* consciousness. For example, I might have spoken with the "too sympathetic" nurses on the ward about their behaviour, what lay behind it, how it impacted upon Brenda (and Malcolm, and potentially everyone else on the ward), and how they might have altered their behaviour to enhance Brenda's (and Malcolm's, and potentially everyone else's) experience. Further, in so doing, I would have been employing Goethe's methodology (Steiner 1911, Wahl 2005) to an even fuller extent. Thus I have identified and appreciated the need and benefit for an even further participant researcher stance in my research.

Reflecting on my narrative about caring for Brenda and Malcolm (and others within their story as above), I realize that underpinning and implicit within it is the notion that spirituality is knowing the higher potential of the human being through suffering regardless of the ailment that they have or their life circumstances. Having re-connected with myself as part of a loving universe and re-expanded my consciousness as a result in my experience with Ben, when I set out to embody some of the spiritual lessons or knowledge that I had gained in my care of Ben in my subsequent care of Brenda and Malcolm, I brought with me a great sense of hopefulness (although initially, as I have described, it appears that I felt fearful for their future, rather than hopeful). However I was not consciously aware of anything more specific in terms of that hopefulness.

As I discussed in Chapter Five, when we are consciously aware of nonduality as reality, our sacred space is full of the love of the universe of which hope forms a part. We also know that as we are part of that loving universe, it will present us with whatever opportunities we require as well as the ability to spot those opportunities. Of course, if we are to *use* these opportunities to further expand our consciousness, we need to have the *potential* within us to do so. The hope that I mentioned above is within us in our sacred space, and that hope is for ourselves. In other words, as we *are* love, we have the potential to *embody* that love which is already within us (and all around us). Further, as love is unbounded or limitless,

the higher *potential* for ourselves is limitless. Thus spirituality concerns knowing people's unlimited higher potential through suffering that always exists.

As evidenced by my narrative and the care that I gave to Brenda and Malcolm, I *knew* from shortly after the outset with Brenda and Malcolm (when the Consultant told them that Brenda had cancer) that what was happening to them, their "suffering", was an opportunity for them and I *knew* that they had the potential to take that opportunity and expand their consciousness as a result. I knew these things because while I was no longer consciously aware of them, having so recently re-connected with myself consciously as part of the universe of love, that awareness was on the surface of my unconscious. My role as their nurse, based on this knowledge, was to assist them to spot opportunities and take them up and to support them in the process. I employed personal knowledge that I had gained about them and from my own life experiences (as a nurse and person) and critical social theory (including the employment of reflection on my own life and circumstances) to assist me in this endeavour.

In contrast, I am now also consciously aware that the Consultant, in not telling Brenda and Malcolm the full truth as I have discussed, did *not* appear to recognize their higher potential. Otherwise he would have told them the whole truth, trusting that the universe would provide whatever they needed in the aftermath. I realize as well that this is why I was upset when he did not tell Brenda and Malcolm the whole truth – he did not know or envision the potential that I did for them. Expanding our consciousness through expanding our knowledge of nonduality is thus very important in our care giving. As the other nurses who cared for Brenda and offered her "sympathy" demonstrate (and as study participants in this and other stories of mine, such as Raymond's, demonstrated in other ways), we have a tendency to view suffering in a negative light. It is seen as something that we do not wish for ourselves and others, something to feel sorry about and something from which to try to distance ourselves. It is something that we fear. Spirituality, however, concerns knowing suffering as something to be embraced and viewed as an opportunity for expanded consciousness. Brenda was "very upset" to be on the receiving end of "sympathy" in her circumstance of "suffering". She did not find it at all helpful, as she expressed. Perhaps Brenda was aware at some level that the universe held something else for her - something better that did not require her to

“feel sorry about”, or “fear”. I hope that she was able to experience that as Lydia and Ben did.

As I have engaged in my analysis with purposive mindfulness, I am aware that as indicated above, my mindfulness has bred mindfulness and more and more ideas have occurred to me. In the Goethean science tradition, I have ‘surrendered’ to my data and the learning process, and as a result, an increasing number of opportunities for learning have revealed themselves to me (Steiner 1911, Wahl 2005). If spirituality is to ever become more of a reality rather than more of a myth in nursing practice, mindfulness in every sense that I have explained must be fostered in nurses.

6.4 Summary

Chapter Six has extended my examination of how expanding our ways of knowing in nursing and expanding our sources of knowledge may contribute to enhanced spiritual care giving by nurses within their clinical practice. Through the conscious application of the spiritual lessons or knowledge that I re-connected with through caring for one patient on the medical ward to another and her husband shortly thereafter, my consciousness was further expanded in terms of the concept of nonduality. I learned that spirituality concerns knowing the unlimited higher potential of the human being through suffering regardless of the ailment that they have or their life circumstances. Thus as long as we listen to our inner voice, spirituality concerns knowing suffering as something to be embraced and viewed as an opportunity for expanded consciousness, in the knowledge that the universe will provide us with what we need in this process as well as the capacity to identify what we need such that we may employ it.

Stemming from this and as I have demonstrated, the nurse’s role in spiritual care giving is to gain personal knowledge about his/her patients (and their families or significant others as appropriate) and employ this in tandem with his/her personal knowledge about her/himself and critical social theory to assist patients (and their families or significant others as appropriate) to identify and take up opportunities to expand their consciousness. The nurse’s role is also to support them in the process. Further, as our reality is nonduality, the ability to access one’s sacred space and surrender and ‘go with the flow’ of events is important not just for the

nurse and his/her patient, but also for any other parties involved. To this end, the nurse may also employ critical social theory with other healthcare professionals involved in the care of his/her patients such that restrictions on *their* consciousness which impede *their* caring may be overcome. Thus personal knowledge (which includes self knowledge) (Carper 1978) and critical social theory are important sources of knowledge in spiritual care giving.

Chapter Seven applies what I have learned from my examination of expanded ways of knowing in nursing for spiritual care giving in Chapters Five and Six to nursing practice, by examining spiritual care giving from the perspective of nurses rather than patients. In the process, it also expands on some of the environmental and cultural issues that I have explored earlier in my thesis, most specifically in Chapters Two and Three, that render spiritual care giving difficult for nurses.

Chapter Seven

Difficulties with Spirituality in Clinical Nursing Practice

7.1 Introduction

I have focused in previous chapters in my narrative on the patients in my study as teachers of spiritual care giving. It might be argued that as professionals, we should surrender to their better knowledge as teachers of how we may facilitate their spirituality. The latter has been shown to be fundamentally an issue of being known through the “harrowing” life experience, and being known to have a higher potential as a human being through suffering, no matter what ailments and in what circumstances they find themselves.

My narrative has also demonstrated that nurses experience considerable, if not tremendous difficulty at times in facilitating patients’ spirituality. Thus far, I have touched on some of the issues that underpin this challenge, specifically with reference to my own spirituality and various stories about nurses and patients, the latter exposing some of the environmental and cultural issues. In this chapter, I wish to explore further, from the nurses’ perspective and in light of my examination in Chapters Five and Six of how expanding our ways of knowing in nursing may contribute to enhanced spiritual care giving, how restricted nurses are in the challenge to offer spiritual care and why. It is only through further understanding about this side of the coin as well that spiritual care giving may be enhanced.

I have chosen to focus chiefly on Kathy, one of the nurses at the hospice whom I met toward the end of my period of data collection, as she had only just started working there (she had previously worked on an acute care ward in a large hospital). As someone new to the unit, Kathy experienced a fairly stark culture change from her place of previous employment and this caused her considerable “anxiety”. I met and then shadowed her on several occasions and she was keen to share her experience with me. I have selected various experiences of me shadowing her which demonstrate the difficulties that she faced in her working environment that make spiritual care giving difficult.

7.2 Kathy

The first day that I met Kathy was on a day when I was shadowing Jill, a very experienced staff nurse who had worked on the unit for quite some time. After the handover report, Jill told me how frustrating it was having responsibilities on the ward that took her away from the patients' bedside. She said that there were very few days when she could give much hands on patient care and that she often went home feeling that she had not been as much a nurse as an administrator.

"Even the paperwork has increased almost beyond belief in recent years. We're not even allowed to have a conversation with a patient's family without documenting the conversation in case they decide to take legal action at some point."

"Gosh", I replied, "when you've got a lot of work, that could really potentially put you (nurses) off wanting to talk to relatives, having to document everything in detail afterwards. Ironically, that would achieve the exact opposite of desirable practice – that nurses welcome and take opportunities to speak with relatives."

"Yeah, I guess that's true."

Later in the morning, Jill told me in great detail a story about when she had been physically threatened by a patient's relative for not giving a dying woman another dose of a specific painkiller when the woman had already received the maximum daily dose of the drug.

"I explained to the lady's husband that I couldn't legally give her any more (of the specific painkiller), but that I was happy to give her one of her other PRN (prescribed to take as necessary) medications for pain. He wanted her to have a specific painkiller and nothing else. I could understand this, but he wouldn't accept my explanation and had me against the door. He went to punch me and hit the door directly beside my head. I was terrified, although Dr. White (the Consultant for another ward who was looking on) said that I looked really calm and in control. I felt like saying, 'Why didn't you get over here and help me?!' Anyway, the man took out a complaint against me and it was investigated. It took months and months and I needed union representation. Eventually it came to nothing, but I'd really been through it. It was just awful! Everyone was affected by it. They all (the other nurses) knew that I had union representation and things really changed here for everyone. They all realized that it could have been anyone . . . it could have

been them. The worst thing was that I had no support from management here. Nothing. That really hurt, and afterwards it was a long time before I felt comfortable on the ward again. You worry that it can happen again . . . You're never quite the same again . . . It was a long time, at least a good few months before I wanted to speak to patients' relatives again . . . The other nurse who had a problem here, she had seen a patient fall by the door of her room. She was questioned (by management) as to how that could have happened. The patient was really unwell and hadn't been walking. Nobody thought that she was strong enough to even get out of bed herself and so they didn't believe her story that the patient had walked to the doorway. The nurse told them, 'I don't know how she got out of bed and walked. I can only tell you what I saw – that she fell by the doorway of her room.' That nurse really went through it! What can you do, but tell the truth about what happened?"

"Sometimes things happen that are logically inexplicable", I responded. "They just do. That must have been really awful for her (the nurse involved)!"

"Yeah. It's scary."

I wrote at the time, 'In the 'rational' world of nursing management, there is no place for the inexplicable, and yet nursing encompasses the inexplicable at times. The whole notion of spirituality does not belong in the clearer cut world of 'rationality'. Many nursing situations also expose nurses' vulnerability (for example, the domain of spirituality), especially on a ward where so many people are dying all the time. "Horror stories" or "atrocious tales" like this remind nurses how "vulnerable" they are in their practice, including "at the hands of their own managers".'

Jill continued, "Years ago, the matron would protect her patients and her staff. She'd stand up for them, and defend them. Doctors defend each other now and support each other. But now, no one stands up for the nurses. They're just left on their own to fend for themselves. I know matrons perhaps controlled things a little too much and that wasn't always a good thing, but at least they supported their nursing staff."

I wrote at the time, 'Feeling that there may be "no management support", staff may try to protect themselves from displaying their "vulnerability" or entering into

situations that may make them feel (more) “vulnerable” (another reason to hide vulnerability away).’

Sadly, as horrifying as it seemed to me, Jill’s story above concerning nurses’ “vulnerability” at work, was not unusual, as she further explained:

“Kathy was on duty a few days ago. One of the patients was dying and her three daughters didn’t get along. It’s a long story, but the lady died just after 3 p.m. with none of her daughters present. She was found dead by another more distant relative of hers who told Kathy. Kathy then went to the relatives’ room to see if there were any family members present. Two of her three daughters were there and Kathy broke the bad news to them. There were a number of other people with the daughters, their partners, sons etcetera, and it seemed that all the adults had been drinking (alcohol). One of the daughters, Eileen, ran on to the ward demanding to see her mother and became hysterical, throwing her limbs about and screaming, running up and down the corridors on the ward. This wasn’t helped by the fact that Kathy had asked if she was ‘Judy’, the daughter who had been taking care of her mother and who was well out of favour with the other daughters (Kathy had heard about Judy in the afternoon handover report when she had come on duty that day). We had to close all the doors to the other patients’ rooms so as not to upset them. It was awful! When Kathy (who had been off for a few days and had never met any of the family) had asked Eileen if she was Judy, Eileen was so angry that she tried to punch Kathy in the face. She didn’t manage to actually hit her, though, which was something. Nevertheless, Kathy was absolutely terrified for her own safety” (her “vulnerability” really exposed).

At this point, Kathy had come into the treatment room.

“Yeah, I’ve never been so scared. I thought she was going to kill me! . . . You just can’t believe that families can behave like this, especially when their mother is dying. I mean, I understand that families can have some big problems amongst themselves sometimes . . . Families can be really dysfunctional, and this family seems to be, but you expect them to be able to put these aside when their relative is dying!”

The next time that I was at the hospice, I shadowed Kathy on a late shift. She had been working on the ward for about six weeks, but had not been there for the

previous six days. At the beginning of the shift, Kathy told me that she was supposed to have gone home (which was some distance away) during her time off, but had been ill with a bad cold, and had spent a number of days tucked up in bed. Her grandmother had been ill, and her mother had wanted her to come home. Kathy said that she would try to get there instead in a couple of weeks time, but for a shorter period of time. She was disappointed, especially because she really missed her home and family (she had only moved to the area relatively recently), but she told me that she would soldier on.

Before Kathy commenced her work, Deirdre, the ward Sister, had a quick chat with her by the desk. Kathy told Deirdre that she felt a little nervous because she had been off and only knew two of the patients (all the others were new to the ward since the previous week). "So, you had a nice break, then", Deirdre assumed, and then carried on talking about ward business. Kathy had opened her mouth, as though to speak, but had not been able to get a word in edgewise. I was shocked at Deirdre's behaviour and had felt somewhat sick for Kathy. I felt as though Kathy did not matter at all as a person to Deirdre, rather merely as someone who had turned up for work to perform necessary duties.

Kathy was in charge of the shift and had allocated herself half the work load along with one of the part-time healthcare assistants. She decided to familiarize herself with the patients by going around the ward and chatting briefly at least with all of them. She told me that she wanted to read some of the patients' notes as well (she managed to read a few afterwards). As she made her rounds, Kathy asked the patients how they were and listened as they told her. They sometimes also raised concerns, such as dressings that needed attention or concerns about their medication. Kathy arranged to attend to some of their needs later and/or gave them information or explanations about things, for example, the drugs that they were taking. She was responding well to what appeared to me to be their foremost concerns at the time. She was warm and friendly with all of the patients except one, George. George had been spoken about at length by Deirdre at the handover report. There had been a family meeting at the hospice the previous day with George's wife and son, Deirdre, and one of the doctors who had come in at the end. Deirdre had described to the nursing staff what had happened:

"Well, I had no idea what I was walking into. You know, he was in catering, and into the importance of food hygiene and such. His poor wife! He expects

everything to be just so at home and she is expected to do everything exactly as he wishes. She has to move his table two inches this way and three inches that way. She's not allowed to scrub the toilet floor with a mop because it's not cleanly. She has to get down on her hands and knees to scrub the floor with a cloth and it's his pee that she's wiping off the floor! I tell you what he'd get from me! It didn't use to be so bad before he retired. He'd be out working all day and then he'd be out evenings. He was hardly ever home except at weekends and over the summer holidays. She could stand it then because she could re-group in between his spells at home. But since he's retired, she can never re-group. He's there all the time and things will only get worse (he had a brain tumour)! Over fifty years they've been married. Can you imagine?! She says that she's stuck it because of the children. And his son! Poor boy! He's nearly forty years old now, and he says that he still gets teased by his mates down at the pub because of his father. When he sold his first car in his early twenties, his father wasn't happy about the sale and demanded that he go to the man to whom he'd sold it and get his money back. And the family never ate out at a restaurant all the time that he was growing up – not even at a MacDonald's! George might go in and sit down, and then he'd start complaining about the cleanliness of the place and the food hygiene and get up and leave! Isn't that awful! It's amazing what people have to put up with!"

No one had challenged Deirdre when she said this, including me (I had been in my more 'objective' researcher role), and some of the nurses had even joined in, expressing how appalled they were at the situation.

When Kathy came to George's bed, she asked him how he was, but stood sideways and about four feet away while doing so. With her other patients, she had walked right up to them and/or sat on their beds while talking with them. It seemed that she was carrying some "negative emotions" towards him with her, possibly stemming from Deirdre's prior conversation about him. I felt uncomfortable watching this, as I had done when Deirdre had been telling the nurses about George's home and married life earlier. Just a week ago, I had been with Kathy at George's bedside and her response towards him then had been so different – the same as towards the other patients today.

Later, over our dinner break, Kathy told me about the recent ward meetings.

“There was a D grade meeting (nurses are graded differently according to their qualifications and nursing position) and the Filipino nurses (all of them D grades or more junior staff nurses) are really unhappy. Apparently, they were told that they were coming here to work in ‘cancer care’. When I heard this at the E grade (more senior staff nurses of which Kathy was one) meeting that I went to, my very first meeting since I came here, I wondered what I had come to . . . What kind of a place is this (that “dupes” people like that)? They’re all leaving at the end of January when their contracts are up. Some of them are going to London . . . They know people there and some are even going to other countries. They only really get on with Meg (a member of the housekeeping staff – this is what I had observed as well (Meg was the housekeeper whose role on the ward I described in Chapter One as uplifting spirits)). Nobody else, really. It’s a shame. Anyway, at the E grade meeting, we were told that we’re responsible for their work. Apparently, they don’t always give pain medication to patients who are in pain. One of the managers came to the ward one day and took one of them around, asking her if various patients were in pain. They disagreed. The manager thought the patients were in pain, but the nurse didn’t think so. It’s difficult to assess pain in cancer patients . . . and it is so important that no patient is left to suffer in pain. The Filipinos are happy to give the medication when someone else says that s(he) thinks that the patient is in pain, though, but they don’t always see it themselves. Anyway, I’ve never worked anywhere before where you’re responsible for what other qualified staff do. But here, we’re told to check everything. It’s a lot more responsibility.”

I felt quite upset upon hearing this, as I viewed it as also potentially “extremely offensive” to the Filipinos. I wondered where the trust relationship was here (the Filipinos had been hired as competent, qualified nurses), and why the hospice did not put on a pain assessment study day for them instead (if, indeed, it was required).

When we returned to the ward from our break, Kathy picked up the documentation belonging to one of the patients for whom Tracey (the other qualified, Filipino nurse on duty), had been caring that shift. She noticed that one of the drugs that had been due at 6 p.m. had not been signed for as given and approached Tracey to question her about it. Tracey explained that she had forgotten to sign that one drug and then signed for it. Then, about a half hour before finishing time, Kathy

asked Tracey how her shift had been. It sounded very scripted, as though Kathy had been told to ask her this. Tracey also seemed to think so as she looked at Kathy with a hint of “disdain” and told her that it had been fine, as usual. And as usual, as the only Filipino on duty, Tracey has spent virtually the entire shift on her own.

(The British and the Filipino nurses never mixed with each other on duty. I had spoken with four of the Filipino nurses, Tracey, Frances, Gail and Julie, about this previously. They had told me that even though they felt that they spoke English fairly well, they were afraid of being misinterpreted. As Frances had expressed, “We may use the right words, but they might come out differently to how we mean them. It’s so easy to be misinterpreted. We don’t speak with the others (non Filipino nurses) unless we have to. We talk to each other. It’s really lonely, though, when you’re on (duty) by yourself, when you’re the only Filipino, and that’s usually the case”.

“And some of the (non Filipino) nurses are too formal”, had added Tracey. “You’re afraid to speak with them in case you don’t get it right.”

“Because they’ll judge you in a negative way if you don’t?” I had asked.

“Yes”, Tracey had responded. The others had nodded in agreement. “Plus it’s different where we come from. At home, in the Philippines, the nurse needs to know everything about the patient. She may be asked questions by the doctor or the patients and their families and she is expected to know the answers about their condition and treatment. It’s not acceptable that she doesn’t know everything. It would be viewed as unprofessional. She must know everything. Otherwise, it appears to the patient that the nurse who is caring for him doesn’t know what she is doing and you can’t have that At the grand round, sometimes you don’t know your patients very well. You may have just come back from holiday or your days off or something and you don’t know them very well, and so you don’t want to go and be in that position.”)

When I left the ward after the shift finishing time, Kathy was standing in the corridor opposite the desk with all of the patients’ drug charts for the entire ward on a trolley. She was going to check them all before she went home. She told me that she could not allow a mistake to be made on her shift. Presumably if she did not pick up and correct a mistake made by one of the Filipino nurses, or worse, if she

made an error herself, she would be talked about as the Filipinos were behind their backs, and labelled 'irresponsible'.

Earlier, I felt that I had observed this same quiet "desperation for perfection" when I had observed Kathy 'reassuring' one of her patients, Felicity, a post hysterectomy patient, over and over again that everything was fine, that the nurses would take her to the toilet and manage her vaginal discharge. Deirdre had insisted at the handover report that day that the nurses were to do this. It seemed to me that Kathy felt such pressure to achieve what Deirdre wanted and to be 'perfect'.

Bill, a senior staff nurse on the ward, had previously led me to believe that another ward Sister at the hospice, Angela, was not so "controlling". Apparently, though, this was not the case. The site manager, Enid, one of the qualified nurses from the same other ward, had been on the unit earlier that day and told me that she had recognized me from her training days. We had reminisced for a short while, talking about our experiences with one of the ward Sisters at another hospital who had been "controlling" in the extreme. We had spoken of the difficulties and misery that that had caused. "Oh well", I had said, "at least she's the worst Sister that I've ever encountered and will likely ever come across." Enid had rolled her eyes and pointed her head toward her (other) ward, to indicate that worse was there. "You're kidding!" I had exclaimed. "Oh no", she had replied. "I'm not!" She had then proceeded to tell me that she had tolerated an extreme degree of "controlling" behaviour for two years and although she loved caring for the patients at the hospice, felt that she had to leave. She felt that she could not take it anymore. Rhona, one of the healthcare assistants on the ward, had told me previously that she was glad that she only worked on the ward part-time. She had added, "Otherwise, I wouldn't be able to stand it (the Sister's "controlling" behaviour)."

The following week I shadowed Kathy on an early shift. She was on duty with Bill, another E grade nurse, and Betty, one of the Filipino D grade nurses. Deirdre would be coming on duty later at 9 a.m. Kathy told me that she was delighted and a little relieved to be on with so many other qualified staff because it gave her the opportunity to take a bit of a break from assuming ultimate responsibility for the ward. "I like to be in control", she told me, "and it's easier for me to feel in control this way" (she only had to be responsible for herself). She assigned Bill the co-

ordinator (administratively in charge of the ward) role until Deirdre came on duty, allocating herself four patients and Betty the remaining six.

Before the patients' breakfast arrived, Kathy updated me about one of the patients who had died over the past week.

"Godfrey died on Sunday. Do you remember how anxious his wife, Jo, was on the Friday late shift when we worked together last week?"

"Yes", I replied.

"She really wasn't accepting that he was going to die. Well, on the Saturday she complained that he hadn't been turned on that shift (he had been repositioning himself in the bed). Anyway, Godfrey became more ill on Saturday and I asked the doctor on call to have a word with Jo. I felt that Jo should know that it wouldn't be long now (before he died), so that if she wanted to do anything, say, perhaps tell him anything before he died, she could. At any rate, I felt that she should know that his death was imminent. So the doctor spoke with her and Jo also wasn't happy about his medication. She felt that it was making him too drowsy. She wanted him to be more awake more of the time. Anyway, the doctor explained to her what medication he was having in his syringe driver (a small machine powered by a battery that pumps medication contained in a syringe into the patient intravenously and at a steady rate which may be altered) and why, that we wanted him to be pain free and not too agitated, and she seemed happy with that. Well, when he died on Sunday, Jo seemed a little more accepting of his death. She seemed less anxious than she had been. But I went home on Sunday night, and this may sound silly Now, don't laugh, but I was so worried, and I don't know why . . . but I wrote down every single detail that I could remember about all of the care that I had given him."

"Gosh!", I exclaimed in an empathetic tone of voice. "Were you worried that Jo might make a (formal) complaint?"

"Yes . . . I guess so . . . I know it sounds silly and I don't really know why I thought that . . . but I thought that I'd better write everything down, just in case."

"Gosh, that's awful that you were so worried that you felt that you had to do that It must have taken you ages! (Kathy nodded her head meekly.) I never really thought about it before (since I've been here), but I can relate to what you're saying. I can remember feeling similarly on quite a few occasions when I was practising. Perhaps there's a fear that when relatives aren't coping with, say, an

impending death, that they might project their negative emotions onto the staff, and this may take the form of a formal complaint?" (As I said this, I could remember vividly how stressed I had been about such matters on a number of occasions in my past clinical experience, even though so many years had since gone by. I had been so stressed about situations, even when I had known that the care that I had given was excellent. It was so stressful just to think that horrible things could happen to you through no fault of your own. That's just the way it was, though, and part of the job. Nothing had ever come of it for me, but I could remember colleagues who had "suffered" enormously because they had not been so lucky. It had given me sleepless nights! All of this was similar to what Jill had been telling me just two weeks previously).

"Yes. That makes sense. I definitely had feelings of potential repercussions I know that everybody here (bereaved relatives) is followed up by someone after a death, but there are so many different people from so many different organizations who do that . . . You don't always know who is following up a particular relative . . . and you rarely hear back about how the relatives are coping afterwards . . . I mean, sometimes you hear about this at the grand rounds, but it feels so disjointed to me overall . . ."

"Yeah, it would really help to know how they're coping. It would probably help you to know right now how Jo is doing? (Kathy nodded in agreement.) I mean, you'd know that if she was doing okay, that perhaps you could relax, at least a little."

"Yes Well, it's interesting that you say that I spoke to Charles (the chaplain) when I saw him early in the week. He was close to Jo, and I asked him if he could go and see her. I haven't heard anything back yet, but I thought it might help Jo if Charles went to see her."

"Yeah. I hadn't thought about this before either, but perhaps it might be better if bereavement services were offered earlier I mean, *before* the patient has actually died . . . so that the relatives could be helped to deal with their emotions earlier . . . so that they might be less apt to project any negative emotions onto the staff? . . . It's difficult, though . . . I mean, before the death, the relatives want to spend their time with the patient, not a bereavement counsellor or a specialist nurse It's a bit of a conundrum It's a shame, though, that these situations do occur and that nurses feel so stressed by them. Perhaps it's something for you to think about as you work here? . . ."

"Yes. Perhaps there's a way that at least things don't feel so disjointed I will think about it."

Later, Kathy talked to me about Velma, a ninety-one year old lady, who had been admitted to the ward the previous week because she had been finding it difficult to cope at home. At handover report that morning, the night staff had shown us a hand written note on a small card to the staff from Velma. It had said that she must have her GTN (glycerol trinitrate, usually for the treatment of angina) spray one half hour before her meals, that her meals should be served soup first, then the main course and then the dessert (not all together on her tray at the same time), and that she would like a dessert spoon with her dessert rather than a smaller spoon. Everyone at the report had laughed, as though this was over the top and unreasonable behaviour on her part. (Later at the grand round, Dr. Amos, the Consultant, and Deirdre had also laughed upon hearing this, and Dr. Amos had said, "and we'd better obey her wishes because she's pretty scary!" Everyone at the grand round had then laughed at his comment.)

"Velma has an issue of control", Kathy told me. "I understand, because she's never been in this situation before and she's lived alone. I also understand because I'm like that! (She laughed heartily.) I like to feel that I have control over things. I'd be the same if I were her!"

When Kathy was about to go into Velma's room and care for her, she stopped in the doorway and said to herself, "I need to muster up the energy." I asked her about this afterwards. "I need to find energy to be with her because she's high maintenance", Kathy explained.

"What makes her "high maintenance?" I asked.

"She likes to be in control and likes things just so."

"That requires patience from you?"

"Yes. It's also hard to get into her head . . . At least, she doesn't relate well with me. She doesn't like, as a person, to sit and talk. I haven't 'bonded' with her. That's all I can say, really. Maybe it's partly the religious thing as well (Velma was a missionary). I mean, I'm not religious and she is, and she has her bible right there I don't know. I just don't bond with her."

At the end of the shift, at the grand round, Irene, a longstanding, terminally ill patient with cancer on the ward, was discussed. Her condition had continued to

fluctuate, although she still did not require the specialist palliative care treatment at the hospice. Kathy introduced her case to the group for discussion. Dr. Frank, the Senior Registrar, talked about how Irene's condition was still fluctuating and that there was the need to again consider sending her to a nursing home. The social worker told the group that a place had come up at a nursing home (but not the one to which Alfred, her husband, wanted her to go), and that Alfred would not go to see it.

"He's holding out for ** **** (his favourite nursing home)!", exclaimed Deirdre. "We'll have to book an ambulance and send her to *** ** (the home to which Alfred didn't want Irene to go), rather than to ** **** (his favourite home). "He wants to send her to a home in a better area (of the city) because he feels that the care will be better there", Deirdre criticized.

"Well, call me a snob, then", Dr. Amos, the Consultant, interjected. "I wouldn't send my relative to a nursing home in ***** (a poorer area of the city)." The group fell silent. Dr. Amos was beaming with pride at his forthright and honest expression. He continued, "Well, as Alfred insists on holding out for his favourite nursing home and a place there may still not come up for a long while, we'll have to look at the serious possibility of sending her to a community hospital, and they're not very nice. Legally, though, we can do that." Then, speaking to the social worker, he said, "Tell Alfred that (he began to half chuckle) you spoke with me and I sounded really angry because he wouldn't go to see the other nursing home (as a sort of "threat" to Alfred for being "difficult"). I'll play him at his own game."

Dr. Amos was asking the social worker to "pile the pressure" on Alfred to agree to visit the less favourable nursing home and to subsequently agree to send his wife there. As I sat there, I felt somewhat sick to my stomach. While Dr. Amos had, on the one hand, sided with Alfred in saying that he would not want his relative to go to the other, less favourable nursing home, his comment, "I'll play him at his own game", seemed so unnecessary, and for me, appeared to have such a "mean spirited" edge to it. It reminded me of how the staff had talked about the Filipino nurses behind their backs at the E grade meeting that Kathy had told me about, and how they were being subsequently treated on the ward by the other nurses.

The following week, I shadowed Kathy once again on an early shift. This time, she was the co-ordinator for the shift, at least until Deirdre arrived at 9 a.m. At the

handover report, we heard that Bruno, one of the male patients with cancer of the brain, had returned to the hospice at 1:40 a.m. that morning in a very inebriated state, having gone out to a pub and having promised the nursing staff that he would return to the hospice by 8 p.m. He had left the hospice with two friends, but had apparently been escorted back to the premises by two strangers whom he had met in the pub. When Bruno had not returned to the ward by 9 p.m. that evening, Kathy had informed the site manager before she had gone off duty. After report, Kathy approached Bruno's bedside and asked him how he was feeling.

"Oh, not so good, this morning", he answered a little sheepishly.

"No, I wouldn't have thought so", Kathy replied, rolling her eyes a little "all knowingly" at him. "Do you have a headache?"

"No. I've had a good sleep, though."

"Can I ask you why you did it? Was it to get out of here, have some distance away and be by yourself?" Kathy exhibited some curiosity about Bruno's behaviour, although she was leading him in asking the second question.

"No, I was feeling better than I have been for some time and so I went out to celebrate. The drink got the better of me", Bruno replied, again with his head down a little sheepishly.

"Well . . . I do have a bit of a bone to pick with you, though. You told me that you would be back by 8 (p.m.) and you didn't get back until after 1:30 (a.m.). I'm responsible for you while you're here and I need to know where you are. You should have let me know (that you would be back later than originally agreed)", Kathy said a little sternly, "like a mother telling off a naughty child". Perhaps her "anxiety" about not having "controlled" his return to the hospice at the agreed time had gotten the better of her, causing her to behave towards him "as a parent rather than an adult".

Bruno shrugged his shoulders, as though he could not help himself, and uttered a sheepish (and in a "childlike" manner), "Sorry."

"Can you promise me that you won't do that again while you're here?" Kathy continued, again a little sternly and in a "parental" tone of voice. Bruno nodded sheepishly (again, "like a naughty child") in agreement.

"Well, okay, then", Kathy asserted, "like a mother who had just laid down the law, and had the higher (moral) ground". "That's it, as far as I'm concerned. We'll consider the matter closed, and I won't bring it up again", she continued in

“parental” mode. “Others (meaning nursing management) may bring it up, though. I don’t know.”

Bruno just looked at her, “like the naughty (school) child” who had managed to stave off one parent, the mother (the teacher), but may still have to face the other, the father (the headmaster).

“I’ll leave you to eat your breakfast, then. It should be here any minute now”, Kathy stated and left the room.

Bruno’s explanation that the drink had got the better of him literally meant precisely that. He had become unable to be responsible for his behaviour. Kathy’s “telling him off” for then having behaved “irresponsibly” (in her mind, not having come back on time, or having rung her to tell her where he was) suggested that he was not, in her view, allowed to drink excessively such that it could get the better of him. However this may have been part of his means of coping with his illness and if so, she was, in effect, “telling him that his coping mechanism was unacceptable”, at least while he was an in-patient at the hospice. His behaviour had not harmed anyone. I wondered what the problem was.

Later that morning, we came across Michael, a terminal cancer patient in his early fifties, who had come in for symptom control and was severely constipated. He had been given a microlax enema the previous evening with a very poor result. A rectal examination had been done by Kathy beforehand and his rectum had been full of hard faeces. He was being cared for that morning by Harold, one of the Filipino nurses. Kathy and I encountered Michael in the corridor outside his room in his wheelchair, being pushed by his partner. Harold was standing at the side of the chair.

“Have you had your bowels open again?” asked Kathy.

“No”, stated Michael firmly.

“Would you like another enema this morning?” continued Kathy.

“No, and I’ve had enough of people asking me that over and over again. I’ve said that I don’t want another enema and I don’t want to be asked again”, said Michael shouting “angrily”, glancing at Harold as though he was to blame. “I just want to get out of here. I’m going outside for a while.” He was looking down the corridor past Kathy as though she was interfering with his getaway. Michael’s comment

that he had been asked the same question repeatedly suggested to me that perhaps he felt that he was being “treated like a child”.

“Okay, then”, said Kathy calmly. Kathy was respecting Michael’s “anger” and desire to escape and not talk about it at that point in time, even though she had no idea what had happened to “upset” him. She stepped aside slightly, allowing Michael and his partner, Doreen, room to pass. Afterwards, she spoke with Harold who informed her that he had offered Michael another enema that morning, but he had refused. Harold was shrugging his shoulders meekly and as a “child” who is “not responsible” for his actions (I had observed that he did this all of the time whenever a qualified member of staff questioned him about anything; it was a kind of “playing the innocent’ role”, as in ‘Who, me?’ It seemed to me that it may have also been in response to the British staff “treating him like a child” who needed “constant reminding or telling regarding what to do”). Kathy did not challenge Harold further about his behaviour with Michael.

Approximately two hours passed and it was coming up to lunchtime. Michael was still not back and he had missed his six hourly controlled drug pain medication. Kathy informed Deirdre that Michael was not back and then Deirdre and Kathy spent about five minutes looking outside the building and around the grounds for him. There was no sign of him. On her way back into the building, Kathy passed the social worker. Kathy caught her eye, stopped her, and explained the situation to her, expressing considerable “anger” at what had happened in the process. The social worker commented, “Well, these things can’t be helped. Perhaps the best thing to do is just wait and see what happens, and try to relax in the meantime?” She had seen that Kathy was “upset” and was encouraging her to ‘go with the flow’.

Afterwards, Kathy, who was then putting something away at the main ward desk, said to herself in a half “angry”, half “dejected” tone of voice, “It’s always me. Why is it always me that this happens to?” (She meant that Bruno had been AWOL from the hospice the previous night and now the same thing had happened with Michael).

About a half hour later, Michael returned to the hospice. He had been out at the local pub, enjoying a lunch with his partner. Kathy went to see him to give him his missed pain medication and then chatted with him about the situation with his

bowels. She did not tell him off. She began by asking him how he was feeling concerning his bowels and what he wanted to do in that regard. As she chatted with him, she knelt by his head at his bedside (he was stretched out on his bed). Her tone of voice was calm and caring. They were engaged in an “adult-adult conversation”. After ten minutes, during which time Kathy had described a range of options for him in terms of managing his bowel difficulties, Michael decided to have a larger enema after lunch.

Afterwards, I chatted with Kathy about what had happened that morning:

“Kathy, you were saying at the desk earlier that, ‘It’s always me. Why is it always me that this happens to?’ Can you tell me what you were feeling and thinking when you said that?”

“Yeah Things always seem to go wrong for me First Bruno last night, and now Michael this morning I mean, I know that they’re adults and that they’re responsible for their own behaviour and I can understand that they may want to leave the building at times that they may be upset and may just want to be away from here for a bit . . . but it always happens to me” Kathy was “framing the patients’ behaviour as an issue for *her*” – their behaviour appeared to be more about *her* than about them. At the same time, she told me that she understood their behaviour, yet her “parental behaviour” suggested that perhaps she did not. I challenged her about this apparent contradiction:

“You seem to appreciate that both Bruno and Michael need to go out and be away from the hospice Deirdre has also expressed this appreciation this morning as you’ve heard yet the two of you seem to be angry that they have gone out. Why is that?”

“Well, the nurse in charge has a legal responsibility for the patients and I’m concerned about them as well . . . if they’re okay . . .”

“But you’ve told me that they’re adults and responsible for their own behaviour. Does that not include leaving the hospice?”

“Mmmm . . . I see what you mean . . .”

“You seem to understand that cognitively, yet your behaviour seems to indicate otherwise. What do you think that’s about?”

“Mmmmmm Michael was due his controlled drug pain medication. He’s on it regularly and he really can’t miss a dose . . .”

“Surely he knows when his medication is due and that if he goes out then, he will miss it, at least until he comes back?”

“Mmmm Yeah If his doses aren’t at the regular times, though, it means that he may need some after he has gone to sleep for the night. It’s important that he have them on time.”

“But still, isn’t that his choice?” I challenged her again.

“Yeah I mean, I’ve said to you before that I like to be in control of things and I’m sure that that’s a part of it Part of it may be about where I worked before The nurse in charge was always held responsible for things like this and I’ve heard of bad experiences”

“Are you worried that such a bad experience will happen to you here?”

“Mmmm The staff are lovely here Everyone has been so supportive since I started I wouldn’t like to think that that would happen But here, it seems that the co-ordinator is responsible for what the other nurses do on the shift, as I’ve also told you before I don’t agree with that. I don’t think that it’s fair and it places such a burden on the co-ordinator You have to run around and check everything that the other nurses do You can’t be responsible for what other people do nurses or patients It’s hard enough being responsible for yourself . . . but I can manage that” As I felt that Kathy explained, the hierarchy of responsibility at the hospice seemed to “encourage more parent-child, nurse-patient relationships than adult-adult relationships”. The same, of course, might be said for the nurse co-ordinator-nurse relationships and the British nurse-Filipino nurse relationships.

Later in the grand round, Bruno’s absence the previous night was discussed.

“That’s his life. He likes to be up and about and do his own thing, so he doesn’t need to be here”, asserted Deirdre. Her criteria for staying at the hospice seemed to include abiding by the ‘rules’ for acceptable (coping) behaviour. Ironically, then, he couldn’t live ‘his life’ at the hospice, or at least, not without “recrimination”. No one offered any resistance.

Dr. Hastings, the Registrar, shared her thoughts with the group that Bruno might be depressed and one or two of the nurses agreed. Dr. Hastings decided to commence him on anti-depressants, but as this was not considered a reason to

continue his stay at the hospice and as his pain control was also discussed and deemed adequate, it was decided that Bruno would be discharged imminently.

The fact that Michael had absconded was also mentioned at the meeting. “It’s just not on, patients going out without telling us”, asserted Deirdre again (legalities aside, “the patients had to ask for permission, like children”). As before, no one challenged Deirdre and no one appeared to disagree with her.

Later during the grand round, Dr. Hastings discussed Wilber, a terminally ill patient with brain cancer. Wilber had been re-admitted, after having been at home again for just a week or so. His family had no longer been able to manage him there:

“I’ve had a long chat with Wilber. He feels that his aggressive behaviour is due to his feeling of a lack of control as he is unable to do as much for himself now as he could just a short while ago. It’s important that he be able to be in control as much as possible. We (she and Penny, the new Senior Registrar) talked with him about maintaining a balance – giving him control over what he is able to do for himself, and the staff here helping him with things that he is no longer able to do for himself.”

The medical staff were taking the lead here in terms of Wilber’s care needs and sharing their agreed (with Wilber) goal and plans for his care with the rest of the healthcare team. They appeared to see it as their role to extend prescribing his care beyond merely the physical, and further, to inform the rest of the team how they felt that he should be cared for. It occurred to me that perhaps they felt that if they did not, the nursing staff (who seemed to generally need to “control the patients”) would not care for him as they and Wilber felt appropriate. This seemed to be the case, as evidenced by the following subsequent discussion, again initiated by Dr. Hastings, about Jeff, another patient who was in his thirties and who had terminal brain cancer:

“Jeff is pretty much the same this week. His symptoms are under pretty good control. We’d like him to stay here and Dr. Amos (who is on holiday) has said that that’s what he’d like. It’s difficult We don’t know how much longer he’s got, and it could be a while, but we think that this is the best place for him as his wife doesn’t feel that she can cope with him at home with the two young children as well. How does everyone else feel about this?” Dr. Hastings looked nervously in

Deirdre's direction, seemingly anticipating disagreement. Rhona (one of the healthcare assistants) saw this and quickly called out that she thought that it was a great idea, as though to pre-empt Deirdre. Everyone across all the disciplines then verbally expressed agreement and at the end, Deirdre joined in.

Dr. Hastings had employed the weight of the Consultant, Dr. Amos' voice, in his absence to try to sway the argument. Whether or not this had made a difference in the agreed outcome, she had succeeded. Having advocated on the patient's and family's behalf, sadly it appeared to me that it had been Deirdre and/or (some of) the other nurses whom Dr. Hastings had perceived as going to potentially "oppose what the medical team had perceived to be in their best interests", and so much so that she appeared to have purposely planned her argument with Dr. Amos in advance. Not all of the nursing staff, though, seemed happy on this occasion to follow or take the lead from Deirdre.

7.3 Analysis of my story about Kathy, employing my theoretical framework

7.3.1 *Connection/relationship with other(s)*

I have mentioned numerous relationships in this chapter of my work and the vast majority of them that I have described in any depth were I-It relationships. A major exception with regard to Kathy was her relationship with Michael after he had absconded from the hospice. Before he left, Michael had, in effect, told Kathy (and Harold) off for "treating him like a child" and it would appear that Kathy had reflected upon this. She may have also been influenced by the social worker who advised her to let his absence be, in essence to find her sacred space, surrender to the situation and just 'go with the flow'. At any rate, instead of then "treating him like a child" when he returned, as she had done with Bruno (perhaps she had reflected on her behaviour in that regard as well), Kathy altered her behaviour and engaged in an I-Thou relationship with Michael to try to resolve the problem that he was having with his bowels.

The other possible exception with regard to Kathy was her relationship with Velma. I did not write in my initial data what happened after Kathy entered Velma's room and I cannot recollect this from my memory. Kathy had spoken to me of "mustering up energy" to enter Velma's room because she felt that she needed patience to

engage with her. I wonder if Kathy was, in effect, telling me that she was trying to find her sacred space in order to be able to 'go with the flow' of what might happen (I will speak more about this later in this chapter). If so, and regardless of the fact that Kathy did not feel that she had "bonded" with Velma, Kathy may have then managed to engage in an I-Thou relationship with her.

I have not mentioned this in my text above, but several nurses at the hospice told me that when Deirdre was on duty, "if they were seen to not be doing anything, they were reprimanded", even in front of other staff members. They expressed that Deirdre's rationale for this was that the organization must be seen to be getting value for its money. In other words, they were employed as workers to get work done, a means ('Its') to an end.

As for me, I was still adopting my more 'objective', I-It researcher role most of the time, although I did challenge Kathy in relation to her "controlling behaviour" with patients.

7.3.2 Sacred space

In the time that I spent with Kathy, I felt somewhat enveloped by fear, indeed so much so at one point that I was re-living some of my own "atrocious tales" in relation to my past clinical experiences as I have mentioned. In most if not all of my experiences of feeling so fearful in life, it is somewhat if not extremely difficult to find one's sacred space (hence, for example, my struggle in my supervisory relationship that I described earlier).

As the vast majority of relationships that I have described above in any depth were I-It relationships, it would seem that there was very little happening in the way of people accessing their sacred space.

Kathy did seem to manage to find her sacred space on at least one occasion, when she was speaking with Michael after he had absconded from the hospice. She may have also found it before she went in to speak with Velma.

Likewise, I managed to put my fears aside about not being an 'objective' researcher and challenged Kathy to reflect on her "controlling behaviour".

7.3.3 Forces (internal and/or external) which influence sacred space

As I have stated above, the chief force which seemed to influence the nurses being able to find their sacred space was fear. Fear seemed to permeate the ward, and it seems that this partly, if not largely resulted from the nurses being "at the receiving end and in the midst of other I-It relationships". It seemed that they feared further "treatment as 'Its'", including "not being supported by management if they should inadvertently find themselves in a situation where their professional conduct was being questioned". The overwhelming feeling that they expressed to me in this regard was extreme "vulnerability".

In relation to Michael, it seemed that Kathy had mustered up (her) energy (as she did with respect to going to see Velma) before walking into his room to try to resolve the problem that he was having with his bowels. It also seemed that this involved making some sort of effort to seemingly connect with her sacred space while trying to let her "fear of not being in control" (over him and the situation) go. With so much "fear" generally around her on the ward, though, this may have taken some considerable effort, for fear, as I have indicated above, is often contagious. Also as I stated above, Kathy may have done this as a result of reflecting on several things – felt tensions in terms of Michael telling her (and Harold) off for "treating him like a child" before he absconded, the "adult-child manner" in which she had treated Bruno, and the social worker having suggested that she 'go with the flow' in relation to Michael absconding. Further, wishing to behave as she knew she should (treating her patients as adults, in line with her values and beliefs) may have been the driving force in pushing her to overcome her "fear of not being in control". In relation to Velma, it seems that Kathy's "fear" was of losing her patience with her (losing control of herself) and thus behaving in what might be considered an 'unprofessional' manner.

With regard to Deirdre "treating the nurses as means to an end", it would seem that she may have been influenced by an important, if not overriding goal of the organization – to obtain value for money. She may have felt that a significant part

of her value to the organization was in “overseeing her staff such that they worked as hard as possible”, in order to ensure value for money for the organization.

Deirdre had other “issues of control” in relation to patients: whether they were worthy of compassion or being treated well by the nursing staff (for instance, George), how they should be cared for (for instance, Felicity, and by implication as I have described, Wilber), if they or their care merited them continuing their stay at the hospice (for example, Bruno, and by implication as I have described, Jeff), and whether their behaviour whilst a patient at the hospice was appropriate (for example, Bruno and Michael). It seems that she also had an “issue of control” in relation to the Filipino nurses’ performance with respect to the administration of medications, and especially with respect to the provision of adequate pain relief for patients.

It might be argued that as above, her intentions in these regards were also with respect to “trying to ensure value for money for the organization”. However, this may not be applied to all of these instances, for example, her need to “share personal and what might be considered unnecessary information” about George and his family with nursing staff at the handover report. I know that Deirdre “experienced considerable pressures” whilst I was at the hospice. Additionally, from my conversations with her, I know that she experienced some “fears of (possible) failure”, and these may have influenced her “fear of not being in control”. Her seeming need to generally be so “controlling” may have stemmed from these “fears”. Further, as Deirdre might be considered “highly judgemental of others”, especially with regard to George, it seems that she may have also had some “unresolved personal issues”.

As with Deirdre, the Consultant’s desire to “play (Alfred) at his own game” might be considered an “issue of control” – “trying to ensure value for money for the organization”, in that beds needed to be cleared to admit new patients (beds at the hospice were virtually always at a premium in relation to patient need whilst I was there). However, as it seemed to me that there was a somewhat “mean spirited” edge to his comment, like Deirdre, he may (also) have had “unresolved personal issues” which influenced his behaviour. Of course, in the vein of nonduality as

reality, both Deirdre and the Consultant may have (also) been influenced by each other's "fearful behaviour".

As for me, I was able to put my fears aside about not being an 'objective' researcher and challenge Kathy to reflect on her "controlling behaviour" for several reasons. First, I was concerned about her well being. It seemed to me that she was so driven to be 'in control' and 'perfect', that her well being might not be sustainable for very much longer if she continued to work in the hospice environment, and especially as she was also being asked to assume responsibility for care being delivered by other qualified nurses. Second, I was concerned about the patients at the hospice (I did not think that their health was being promoted by such "controlling behaviour" either). I had witnessed a great deal of "less than optimum care" as a researcher and I was coming up to the end of my data collection period. I felt a moral obligation to the patients to try to do something that would enhance the care that they received. Third, and in line with my concern for the patients, I knew that Kathy had the potential to reflect on her behaviour and change her practice for the better.

7.3.4 Possibility of expanding consciousness/self transcendence

I chose to focus on my experiences with Kathy, a nurse at the hospice, to further examine what spiritual care giving is like from the perspective of nurses. As I stated previously, Kathy's recent employment there and her general readiness to share her experiences of things that were occurring in front of us as well as behind the scenes with me, such as various nurse meetings, assisted me to clarify issues of what was influencing the nurses in terms of being able to offer such care. In her own words, Kathy was a person who liked to be "in control". It might be argued therefore, that her experiences may have been influenced by this in ways which other nurses' experiences may not have been. Nevertheless, it was precisely the fact that she wanted to be "in control" that may have more clearly exposed other "control issues" on the ward. I had noticed that these same issues occurred on the ward when I was shadowing other nurses. However the fact that Kathy experienced their effect so acutely and severely served to usefully highlight them and their (potential) effect on the nurses' ability to give care for me.

I have discussed previously some of the issues which influenced nurses' spiritual care giving on the general medical ward, most specifically in relation to Betsy's experiences in Chapter Two, and the issues are somewhat similar if not the same. While I was on the general medical ward, I only encountered the ward manager once. He was otherwise always in his office just off the ward itself if he was on duty when I was there. On the one occasion that he came out of his office, he approached the very mature and experienced nurse whom I was shadowing. He spoke to her with such "disdain" and "disrespect" that I could hardly believe my ears and was utterly horrified. She, in turn, was so "upset" that she was unable to remember what he had then asked her to do, and I felt morally obligated to step in to help her by telling her what he had said and then helping her do what he had asked. Afterwards, on that same shift of duty, the same nurse tried to tell me about something that had happened on the ward between the two of them eighteen months previously. She was still so "upset" about it that she started to cry. She appeared to try her hardest to hold her tears back from me, but she was unable. She was also still so "upset" that she was unable to continue our conversation and tell me what had happened. Thus while the environment at the hospice may appear to be (somewhat) unusual, I am not convinced that it was any worse than on the general medical ward. It may even have been *more* conducive to spiritual care giving!

Fundamentally, and as my theoretical framework for my work indicates, it seems to me that spiritual care giving concerns itself with a view to expanding consciousness through suffering, having recognized the potential for this in others. The nurse engages with the patient in an I-Thou relationship and both parties work to process any forces such as emotions and restrictions on their consciousness such that they may embrace their sacred space. The nurse facilitates the patient (and relevant others, for example, the patient's significant other(s) or other staff members) in this regard as appropriate. From my further exploration of sacred space in Chapter Six, it seems to me that spiritual care giving may even encompass the whole of Goethe's stages on the path of knowledge within his science, applied to the study of persons (Steiner 1911, Wahl 2005). Thus nurses should give spiritual care to patients with a sense of wonder, reverence, wisdom-filled harmony and surrender to the course of the world. Such an approach to spiritual care giving requires nurses to be 'open' and loving to everyone, including their patients. What my research has found, however, is that they may be "very fearful and closed" and feeling "very vulnerable". Thus the nurses' ability to find their sacred space may

require considerable effort and be very difficult (but not impossible), as it was for Kathy. This may be the case especially as, like Kathy, nurses may already be exhausted from trying to deal with all of the tensions that they are experiencing, with little if any opportunity to process these (at least whilst on duty). In this same vein, it might be very difficult for nurses to deal with issues that restrict their personal, social, cultural, political and/or scientific consciousness.

What struck me most and very profoundly when I was shadowing Kathy was that she appeared to be 'lost' to quite a considerable extent. By this, I mean that much of the time, she seemed to be almost an "automaton" - desperately trying to be 'in control' and 'perfect' (which is not a realistic goal for anyone to achieve all of the time; we are human and by virtue of that, we all make mistakes), and doing what she had been told by Deirdre (or otherwise influenced to do by Deirdre). Further, when I was encouraging her to reflect on her behaviour, she seemed to appreciate cognitively that the patients were adults and as such were free to make their own decisions, yet out of fear of losing 'control' and what the consequences of that might be for her (based on her past and present experiences of working as a nurse), she was unable to match her behaviour with her belief. In this sense, I felt that she was somewhat 'lost'. Was it any wonder that she struggled at times to be in I-Thou relationships with patients, when she was not bringing her 'I' to the relationship? How then can she be expected to engage in spiritual care giving? In contrast, what built and has continually strengthened my relationship with my male supervisor is each of us being true to ourselves (our beliefs and values and the core of who we really are as persons – compassionate beings) and the other (bringing our 'I's to our relationship to form an I-Thou working partnership). What I am suggesting here is that people cannot be in an I-Thou relationship if each person has not embraced their sacred space and surrendered to being at One with the universe of love.

The other thing that struck me in working with Kathy and as I focused on her struggle to engage in I-Thou relationships, was how much she was "surrounded by I-It relationships" (for example, Deirdre's not allowing Kathy to get a word in edgewise when she had made a "false assumption" about her time off, and the Consultant wanting to "play (Alfred) at his own game"). Deirdre and the Consultant are the heads of their disciplines on the ward, and each is "modelling I-It relationships" for the staff who work there, including for each other. I noted with

interest that the Consultant seemed to express some compassion for Alfred at the grand round before he stated that he wanted to “play (Alfred) at his own game”, by saying that *he* would not be happy to send *his* relative to the less favourable nursing home either. However this seems to me to be merely “a ‘show’ of compassion rather than the genuine article” when it is then followed by “behaviour that does not appear to be compassionate”. In essence, his initial behaviour is then cancelled out. The overriding message that I received as I experienced the situations in which I was involved was that if I were a member of staff at the hospice, I could expect to be treated as an ‘It’, and especially as this was how the Filipinos nurses were treated (in the way that they apparently felt “lured” to work there “under false pretences” in the first place, and then how they were subsequently treated, as I have described). The “fear of being treated as an ‘It’” (again) was precisely a large part of what both Jill and Kathy feared, as they relayed to me in their “atrocious tales” about themselves and others.

A further point regarding the difficulty that the nurses experienced being in I-Thou relationships with their patients concerns their being “treated as ‘Its’ or means to the end of getting the work done” by Deirdre, as I have described above. The nurses told me that they were so “afraid” of this happening that they would sometimes wander about, desperately trying to look busy, if, in their view, there was nothing to do at a particular point in time, for example, if their patients were napping because they were fatigued from their illness and/or treatment. Again, what does this accomplish in terms of fostering nurse-patient, I-Thou relationships on the ward? Sadly, the nurses told me that they would avoid being seen to be “just talking” to patients and would avoid sitting down, especially close to patients on their beds. While I appreciate that there may be important cross infection issues involved here, such avoidance behaviour is nevertheless, in the main, hardly a recipe for good spiritual care giving!

Halldorsdottir and Hamrin’s (1997) research findings demonstrate that it may be “soul-destroying” to be treated as an ‘It’. If, as I believe, we are primarily souls (and again, this is part of Wilber’s (2000) and Watson’s (1999) theses, that we are souls with bodies (as opposed to bodies with souls)), then one’s ‘I’ may be decimated by being treated as an ‘It’. As above, how then may one engage in an I-Thou relationship? Indeed, this was the situation in which I found myself at the commencement of my relationship with my male supervisor, as I described earlier.

I had suffered a “soul-destroying experience” in my past, and had not yet completely worked through it, such that I was unconsciously bringing it to our relationship. Thus I had not found my sacred space and been able to surrender and ‘go with the flow’ at my supervisory meetings with him.

In my relationship with my male supervisor, in a sense, it was each and every one of the seemingly ‘small’ things, like correcting an inaccurate assumption made or really listening and considering what was being said, that really mattered in the development of a good, caring, I-Thou relationship. Of course, in reality, these ‘little’ things are ‘huge’. In my experience in that relationship, it was consistency that really mattered, and the feelings of being ‘known’ and respected. As a student, the chief way that I felt respected was when I was viewed as having potential for further learning and was given autonomy to take my work forward (as when my male supervisor agreed with my plan for doing so, as I have described previously). Importantly, this was accomplished under regular, useful, constructive and guided direction. Thus I was provided with autonomy and supported in the process.

In contrast, Kathy was “not expected to think for herself”. Instead, she was “expected to follow the rules and the Sister’s lead”. In this sense, “the use of her intuition and personal knowledge was discouraged”. As I have demonstrated, she had the potential to think for herself and to employ these ways of knowing in her practice through reflection, but none of this was encouraged or wanted. Spiritual care giving, as I have discussed, requires that these ways of knowing be utilized and that the nurse know the potential in his/her patients (and relevant others) for expanded consciousness. It is difficult to envisage how nurses can be expected to see the potential for expanded consciousness in others and to assist them to realize that potential by employing these ways of knowing when “their own potential is not recognized” and they are “actively discouraged from employing these ways of knowing”.

At the hospice and as I have indicated, the medical staff seemed to recognize that Deirdre’s behaviour was “not (always) conducive to what they seemed to consider ‘good’ care giving”. As a result, they appeared to seek means to manage the situation such that her behaviour would not obstruct their plans for patient care.

However also as I have indicated, their behaviour (specifically, the Consultant's behaviour with respect to the data that I have included in this chapter) was "not always conducive to 'good' care giving" either.

As I have indicated previously in Chapter Four, after having cared for Raymond, the medical staff (and Deirdre, to some extent) seemed to feel that they had "not behaved in an (entirely) appropriate manner", or at least "not provided the best care possible". Subsequently at one of the grand rounds, the Consultant along with the chaplain suggested that as there were so many deaths on the ward (all natural), the nurses should be facilitated to grieve for their patients. They suggested that the staff (from across the various disciplines) share their feelings with each other about patients who had died each week at the end of the grand round. The Consultant also suggested that as he coped with his grief by going for a walk outside the building, the nurses should be encouraged to come to the large ward dayroom to do the same whilst they were on duty. During the remaining two and one half months that I was at the hospice, to the best of my knowledge, neither of their proposals was ever realized in practice. I spoke with Jill and three of the Filipino nurses (Tracey, Frances and Gail) about how they felt regarding the suggestion that they speak about their feelings at the grand round. They told me that while they felt that it was a "positive move", none of the nurses wanted to do so and that they did not feel that the grand round was the place to speak about such feelings. They told me that they preferred to cope with their grief in their own way, by themselves or with fellow colleagues whom they also considered their friends.

I feel that the proposals that were suggested were to be commended in that at least something "positive" was being offered for the nurses, or so it appeared to those making the proposals. However, such proposals to assist with spiritual care giving must take account of the holistic context in which the nurses work. In this instance, on a ward where "the culture was to always be seen to be moving and doing (in the way of more 'technical' tasks)", and where "the nurses' feelings of 'vulnerability' were already (almost) palpable", I was totally unsurprised that the proposals died instantly. As Brenda (one of the patients on the medical ward) would have said if she were speaking on behalf of the nurses regarding the latter, "We can't afford to risk, let alone be openly 'blubbing'!" Sadly, neither the Consultant nor the chaplain appeared to have any idea that "the culture in which the nurses worked could not possibly support their proposals".

Returning to the notion that the senior staff, both medical and nursing, seemed, to some extent, to influence spiritual care giving, I am reminded of research in the 1980's (Orton 1981, Fretwell 1982, Lewin & Leach 1982, Ogier 1982) that demonstrated that the ward Sister was the chief influence in relation to the ward learning environment. Perhaps likewise, they are the main influences for the ward spiritual care giving environment. Perhaps, then, a focus, if not *the* focus for enhancing such care giving, should be on how *they* conduct and speak about all of *their* professional relationships.

Finally, I wish to emphasize that in the whole of my data, individual nurses on both the general medical and hospice wards appeared to be affected differently by their environments with respect to spiritual care giving. I witnessed examples of "excellent" and "poor" spiritual care giving on both wards. Nevertheless, the culture on both wards was similar and "did not appear to support (excellent) spiritual care giving". In this vein, then, the culture for spiritual care giving needs to be addressed if spiritual care giving is to become (more of) a reality.

7.4 Summary

From the nurses' perspective and in terms of their practice, Chapter Seven has examined what I have learned in Chapters Five and Six concerning expanded ways of knowing in nursing for spiritual care giving. Additionally and in this same vein, it has expanded on my previous examination of environmental and cultural issues (largely in Chapters Two and Three) that impact upon spiritual care giving.

Spiritual care giving was found to be difficult chiefly because nurses are "treated as 'Its' in I-It relationships" with their ward Sister (or manager), "I-It relationships are also modelled" at times with regard to patients by the ward Sister (or manager) and some senior medical staff, and nurses are "encouraged to practice I-It relationships" with other nurses in some circumstances. This causes the nurses a great deal of "fear" and "stress". Nurses also "feel that they have to be 'perfect' at all times in their practice" which additionally causes them a great deal of "fear" and "stress". Thus in their relationships with patients, nurses have difficulty accessing their sacred space. Further, nurses are "not expected to think for themselves", but instead they are "expected to follow the 'rules' and the Sister's (or manager's)

lead". Hence they are "not encouraged to employ their intuitive or personal knowledge". With their "potential thus not utilized" and not employing this knowledge, it is difficult to envisage how nurses can be expected to see the potential (for expanded consciousness) in others (let alone themselves) and to assist them to realize that potential. Changes to enhance spiritual care giving were proposed by others, but these failed as they failed to take account of the existing care giving culture.

Chapter Eight discusses my findings and the implications thereof as a whole. Conclusions and recommendations are made from this critical analysis.

Chapter Eight

Discussion and Implications of Findings

8.1 Introduction

This chapter draws together the key themes of my narrative that I have examined throughout my thesis with a view to making sense of my narrative as a whole in terms of what it means for spiritual care giving in clinical nursing practice and for researching spirituality and spiritual care giving. It commences by evaluating my findings as a whole, and then more specifically with respect to the individual nurse, followed by the nursing environment. The history of nursing is then explored in order to contextualize the difficulty in spiritual care giving. Issues stemming from this are discussed in terms of possible ways forward within nurse education and clinical nursing practice to make spiritual care giving more of a reality within the latter. Finally, based on my experience of researching spirituality and spiritual care giving in nursing, research in nursing for the future is considered.

8.2 Revisiting the aim of my research

I set out to explore the experience of patients and nurses with respect to spiritual care in order to enhance spiritual care giving in nursing. The literature suggests that nurses experience difficulties with this aspect of their practice and that it needs to be improved. However the topic area is under-researched in terms of examining spiritual care giving as it is actually experienced (inter-)subjectively by both nurses and patients. Thus a narrative approach was adopted for my research in order to do so. It was hoped that an in-depth examination of the process of spiritual care giving as it is experienced by patients and nurses, and specifically in terms of how spirituality is conveyed through relationship (as per my theoretical framework based on the literature and my own experience of spirituality, especially in relation to my family), might reveal the way forward to enhance this important aspect of nursing practice.

Similar to previous literature, I found spiritual care giving in clinical nursing practice to be largely absent, although not necessarily nonexistent. Thus it is neither a myth nor a reality, but somewhere in between. It is not nonexistent, but equally, it is not

an embedded reality in nurses' experience. However unlike previous research, my narrative, in engaging with actual spiritual care giving experiences, also reaches into the depths of what a relational approach to spirituality means in reality. It depicts some very harrowing experiences such as the scene that unfolded between Betsy and Mrs. Foster at the latter's bedside, the scene at Lydia's bedside when the Consultant told her that her death was (more) imminent than she (and I) had thought, the scene at Ben's bedside when he was "reluctantly turned by a group of nurses" (one of whom "told him off" because she felt that he should be doing more for himself), the grand round at the hospice when Raymond was "scapegoated" by virtually the whole of the multidisciplinary team, and the scene with Malcolm and Brenda when they were told of Brenda's cancer by the Consultant. Equally, my narrative also reaches into the heights of what a relational approach to spirituality means in reality, depicting some truly sublime moments such as when Ben told me what spirituality meant to him in relation to his illness (and especially about the doctor who re-sited his ventflon with the grace of God), and when Lydia did likewise after the Consultant informed her of her (more) imminent death. It is by examining how spirituality is conveyed through relationship at the depths and at the heights of spiritual care giving that my narrative, unlike previous research, reveals how I came to find the myth and the reality of spiritual care giving to be living in tension and spiritual care giving to be so lacking in clinical nursing practice.

8.3 The individual nurse and spiritual care giving

My narrative demonstrates that it *is* possible for nurses to be compassionate and provide spiritual care at times. However nurses generally experience tremendous difficulty doing so because they are unable to access their sacred space, or surrender to what the situation is. Thus instead they experience the situation as harrowing. This is because we experience reality as dualism, a secular as opposed to a spiritual world, almost all of the time.

As I have explained previously, according to Goethean science, we get into spirituality, our (more) unconscious reality, by surrendering, by being able to be in the situation as it is (Steiner 1911, Wahl 2005). This is because the situation, *as it is*, comprises reality in nondualism; as I stated in terms of Buddhism in Chapter One, we are all just One - everything is interdependent and interconnected and exists *only in the moment* (Kulananda 2000, Wilber 2000). We experience things when the causes and conditions are present and when they are no longer present,

things cease to exist. It is then, when we allow things to just be as they truly are, connected as One, in love, that we are liberated to respond to all living things with loving kindness, great compassion and wisdom (Kulananda 2000 & Wilber 2000). Thus it was when I was in such moments, connected to my (spiritual) self and the universe, that I experienced the sublime moments of spiritual care giving, reaching into the heights of what a relational approach to spirituality means in reality.

In dualism, however, we do not exist in the moment, but in the past, present and future. Further, we perceive ourselves as separate, permanent, solid ego-identities. Therefore we may experience things such as unresolved emotions that restrict our consciousness and affect our behaviour long after they are present. Thus it was in these moments, when I was unable to access my sacred space, that I experienced situations as harrowing, reaching the (dark) depths of what a relational approach to spirituality means in reality.

For example, in the case of Raymond, I was kept back by my fear of not adhering to being an 'objective' researcher and thus going along with traditional academic convention (in the vein of empiricism). I have paid the price, so to speak, in the past for not always following traditional conventions in my life, and so influenced by my past experiences, I feared (in the present) possible reprisal (in my future). I was also kept back (in the present) by unprocessed emotions (from my past) in relation to the aftermath of my mother's death. Additionally, I was struggling with "the healthcare convention of nurses being in I-It rather than I-Thou relationships with their patients". I was over-identifying with having been treated as an 'It' in my past, and quite frankly (I am just becoming consciously aware of this now), worried for the future should I or any of my loved ones become a patient. Because we view ourselves as separate, permanent, solid ego-identities, we also believe that there is life and death, and so we may have a fear of death and dying when in a nondualistic reality these do not exist. For example, in the case of Raymond, many of the nurses appeared to be kept back by their fear of death and dying. Also, they may have experienced death and dying around them in their past as unpleasant, unwelcome events and feared these for their future, in relation to themselves and/or their loved ones.

Reflecting back on my narrative, I am struck by the extent to which I am embedded in a dualistic as opposed to nondualistic culture, the extent to which we all live in a dualistic world and hardly ever realize it. For example, a major difficulty that I experienced as a researcher concerned my field boundaries. I first addressed this issue in terms of being a non-participant or participant observer in Chapter Two, although my conflict regarding which method of observation to adopt continued throughout virtually the whole of my data collection period. It occurs to me now that if nonduality *is* the reality of our being, the very notion of me even considering being a non-participant observer versus a participant one is nonsense. If All is One and everything is interconnected, I am a participant observer by default, at least to some extent, whether I *choose* to be or not.

In this same vein, in Chapter Two I went on to say that the Trust Research and Development Office from whom I had sought permission to undertake my study had told me that I must be objective in my research approach, and throughout my thesis I have spoken about my felt need to be 'objective' as opposed to 'subjective', as they insisted. Again, if All is One, I realize now that this also is nonsense. One cannot be 'objective', as 'objective' means "external to the mind", "dealing with outward things or exhibiting facts uncoloured by feelings or opinions" (Concise Oxford Dictionary 1996). Nonduality means that *nothing* is "external" or "outward" and *everything* is connected to and therefore affected or "coloured" by everything else.

Further, I stated in Chapter Two that my intention was to observe practice as it is normally, meaning without my presence, and in Chapter Three I discussed one of my perceived difficulties with my narrative concerning the positioning of myself in relation thereto. I was speaking about this as though *I* could be anything *but* the central character, yet I was the *only* person constantly present in my narrative because I was the researcher – it *was* (and *is*) *my* narrative.

Finally, towards the middle of my thesis (in Chapter Four), I reflected on my relationships with nurses and patients, such as Betsy and Bethan and Lydia, and wrote that I realized that I had been treating them as 'Its' rather than 'Thous', contrary to what I had thought earlier (at least to some extent). Again, if all is One, I realize now that the notion of people being 'Its' as opposed to 'Thous' is nonsense. People are not separate from All/each other. Our minds and eyes

which perceive and view ourselves and others as separate from All and each other cast a false illusion of our being.

To sum up, the point that I am making is that throughout my narrative, to one extent or another, I was embedded in a dualistic as opposed to nondualistic culture. If I had experienced reality all of the time as nonduality, a spiritual rather than a secular world, I would not have suffered harrowing experiences. I would have been able to access my sacred space, live in the moment, and provide spiritual care with true compassion. However the opposite was the case, and I only very occasionally had glimpses of reality as nonduality, as apparently Lydia and Ben did as well. According to Wilber (2000), we all have glimpses of this nondualistic reality. The difficulty is that they are mere brief glimpses and the second or minute they occur and we realize that they are occurring, we are pulled back into our conscious reality of dualism where they no longer exist, except as memory. We are then so bombarded by issues concerning the past, present and future in our dualistic reality that we generally struggle to even remember the memory all of the time. Is it any wonder, then, that in my study I found spiritual care giving to be barely evident, although not necessarily nonexistent?

As in Vivat's (2008) ethnographic study exploring spiritual care giving that I mentioned in Chapter One, I did not see nurses (or other members of staff) (other than myself on very few occasions) engaging with patients at a deeper level or discussing death and dying with them. Instead and as I have described, they appeared to distance themselves from conversations and patients where a deeper level of such discussion might arise. It would seem that like the nurses in Vivat's study, they could not cope with patients' "distressing emotions" (as I could not on occasions), and as my data reveal, especially as it might mean them having to endure (more) harrowing experiences. (They already endured harrowing experiences within their working lives, as I have described previously.) "The patients were thus not generally known at a deeper level such that their spiritual needs might be addressed". Instead, like Raymond, "they were left to quest on their own".

8.4 The nursing environment and spiritual care giving

In Chapter One, in discussing my personal experience of spirituality in relation to my family and Aiden's death, I indicated that the environment that we experienced at the hospital facilitated us to connect with our sacred space and in the end, to take the decision to end Aiden's life. I further indicated that I felt that the environment would be important for nurses in spiritual care giving, specifying that ideally it should be one in which nurses are able to take risks and deal with uncertainty in going into the unknown with patients on their spiritual quests. I felt that it should also be conducive to nurses practising mindfulness in order to connect with their sacred space, and critical reflective practice in order to consider their individual patients' needs and how these might be met. Additionally, I felt that role models of a higher level of consciousness who are more able to (readily) connect with their sacred space and demonstrate good spiritual care giving might be useful, as would adequate staffing levels such that nurses have space and time to engage (more) with patients at a deeper level.

Sadly, my data, especially as I have outlined in Chapters Two and Seven, reveal that "the environment was not conducive to spiritual care giving in either setting". (You may recall that I spoke of Meg, the housekeeper at the hospice, as having a 'free' spirit and being able to uplift other people's spirits as a result. In essence, Meg was able to access her sacred space regularly, as evidenced by her singing in her own world into her pretend microphone, but my point was that Meg was not part of this environment in the same way that the nurses were). "Environmental factors such as power structures, ward routines, staffing levels just adequate to get the physical tasks and procedures done (and often at a severe push and with no time for reflection), noise, competing demands to care, poor role models, poor support from management and poor communication rendered it very difficult for the nurses to connect with their sacred space and provide spiritual care". Instead, the nurses were left feeling "emotionally stressed" (sometimes with "unresolved emotions" and restricted consciousness as a result), "vulnerable" and "afraid". This is hardly a useful starting point for nurses to take risks, deal with uncertainty, connect with their sacred space and engage with patients at a deep(er) level, especially when doing the latter might mean engaging in (more) harrowing experiences as I have stated.

A further point concerning the environment and its impact on nurses' spiritual care giving is in relation to spirituality being experienced subjectively and inter-

subjectively. In an environment where evidence-based practice is interpreted such that it dismisses the subjective in favour of the objective, as I indicated previously in Chapter Three, nurses may veer towards practising in a fashion that values objectivity more than (inter-)subjectivity.

As stated previously, whilst analyzing my data and re-writing my narrative, I have been able to reflect (on action) to a greater extent and this is and will be a continuing, ongoing process. What I have realized in terms of being able to connect with my sacred space is that whilst I was collecting my data and initially writing it up, I was generally caught up in the 'doing' of my research, collecting my data undertaking 'objective', non-participant observation, with many things running through my mind constantly in relation thereto, as I have described previously. As a result, I generally did not come to 'know' my study participants or connect with my sacred space (I was not 'being' with them as a spiritual being, connected to my sacred space) as much as I might have. (I managed this better and at times with some patients such as Lydia, Ben and Brenda, but in these instances, I was alone with them and focused more on being a nurse and caring for them than being a researcher. As such, I was not 'doing' my research when I was with them, and hence I was able to 'be' with them and 'know' them. Also, I was almost in my own protected bubble because unlike the nurses, I had no other responsibilities at the time.) Thus my 'being' (a spiritual being, connected to my sacred space) and my 'knowing' (both my personal knowledge in relation to what I was observing and my intuition, the latter because I sensed that what I was doing (treating my study participants as 'Its' by the manner in which I was observing them was not 'right', or in line with my personal beliefs and values) (both subjective ways of knowing)) were pushed out by my 'doing', the task of collecting my data for my research. In other words, my 'doing' of my research (that which might be (more) *objectively* observed and measured), took precedence over my 'being' with and 'knowing' my patients, both indicative of the embodiment of my spirituality or my (inter-) *subjective* self. I *allowed* it to take precedence because in the culture in which I work, I knew that it was valued more, and so I went along with this, albeit out of fear of repercussions if I did not, as I have expressed previously.

Likewise, as I have stated previously, "the nurses were generally so busy and caught up in and focused on 'doing' various tasks and procedures in the line of their duty and as required by the organization that they did not come to 'know' their

patients or connect with their sacred space and embody their spiritual 'being'". (Like me, though, many of them told me that they managed to get to know their patients and connect with them when it was 'quieter', meaning that there was less to 'do', for example, at the weekends when there were fewer doctors about.) Thus their 'being' (as spiritual beings, connected to their sacred space) and their 'knowing' were pushed out by their 'doing'. As one nurse at the hospice told me, "You won't get told off for not giving spiritual care!" By that s(he) meant that as spiritual care was not something that could be (objectively) seen to be done, it was not deemed important. Conversely, everything that *could* be seen to be done *had* to be done.

Reflection-in-action might have helped the nurses' 'being' and their 'knowing' become more prevalent in their practice (as it seems to have done to some extent in relation to Kathy's practice, for example, and as it might have done had I reflected-in-action whilst collecting my data), but the nurses generally had far too much work that required 'doing' to engage in this potentially transformational activity (Freshwater 2000). Also, reflection-in-action entails a conscious effort and mindfulness in relation to the process. The practice situation needs to be clearly articulated, and at a more advanced level such that internal supervision (Casement 1985) also occurs, the practitioner needs to have an awareness of his/her thought processes. As Rolfe, Freshwater and Jasper (2001: 132) state, "reflection-in-action therefore involves doing, thinking about doing, and thinking about thinking about doing". Further, Schon (1983) adds that on-the-spot experimenting should also occur, involving exploratory experimentation, move-testing experimentation and hypothesis-testing experimentation. Through these processes, the problem may be engaged with, understood, and theorized or hypothesized about such that the practitioner's general knowledge and theory about the problem become known as specific knowledge to the problem, or what Rolfe, Freshwater and Jasper (2001) term 'theory of the unique case'. The development of the latter is essential for spiritual care giving as spirituality and spiritual care giving are unique to the individual. Rolfe et al (2001) state that their explanation of reflection-in-action, as I have outlined above, is a simplified version of an even more complex reality. Thus while it may be enormously useful in the practice of spiritual care giving, it is even more difficult to envisage that nurses may practise reflection-in-action regularly if at all, and especially given that their inner space is already so compressed by the context in which they work.

Rolfe, Freshwater and Jasper (2001) discuss reflection-in-action above in relation to a process of nurses 'doing' and as such, it might not seem applicable to spiritual care giving as I have described it earlier within this section of my thesis. However as I will explicate later in this chapter, their 'doing' incorporates 'being' as 'doing' and employs all ways of knowing in nursing, therefore including (inter-)subjective knowledge. Thus they view reflection-in-action as being applicable to all domains of nursing practice.

I have discussed how nurses are embedded in a dualistic (or secular) as opposed to a nondualistic (or spiritual) reality and how this is problematic for individual nurses giving spiritual care. Additionally, the general working environment for nurses further contributes to the problem. However also as I have discussed, in a nondualistic reality there is no such thing as objectivity. In our dualistic, evidence-based practice reality, though, objectivity not only exists (along with (inter-)subjectivity), but is valued while (inter-)subjectivity is dismissed. Thus our evidence-based practice environment or culture, through the manner in which we have interpreted and adopted evidence-based practice within nursing, does not acknowledge the whole of our being, objective and (inter-)subjective, the latter of which is how we know and embody our spirituality. Further, it reinforces the secular and dismisses the spiritual, rendering it even more difficult for nurses to provide spiritual care.

8.5 An examination of the history of nursing to contextualize the difficulty in spiritual care giving

Thus far throughout my thesis, including this chapter, I have indicated how spiritual care giving is difficult to provide in relation to the 'spiritual' lens of nonduality versus duality as reality, and in relation to the environment and culture in which nurses work. As much of my thesis talks about just how powerful the culture in which nurses practise is in terms of making it difficult for them to provide (spiritual) care for patients, and as nurses live and work, as do we all, in a deeply secular world (the extent of which I have indicated earlier in this chapter), it might be useful to examine the subject further. Culture is shaped by history and we embody our culture. Thus I will briefly examine the history of nursing (Hallett 2010), focusing chiefly on Britain and in later years, nursing within institutions, to see how it has shaped a largely "uncaring" as opposed to caring nursing culture.

Nursing has existed in various forms since the earliest known civilizations. From the beginning, nurses sat with suffering. Also from the beginning, in so doing they employed a form of more 'technical' knowledge. Originally, nurses were women in society, caring for their families and employing a detailed knowledge about various plants, minerals and crystals which held healing properties which healers, or shamans, possessed and passed down to them.

In the dark ages, religious orders set up hospitals in which the sick and elderly were cared for, although salvation of people's souls was more on the agenda. Thus nurses continued to sit with suffering, with spirituality and spiritual care giving very much on the agenda.

By the middle ages, with the Catholic Church at the forefront of society, shamans, who dealt with warding off evil spirits and were considered a threat to the Church's spiritual power, were banished. Many religious orders established hospitals a little more like we know them today, caring for the sick, with nurses, cloistered from the rest of society, learning as they progressed up through the order. Meanwhile, chiefly in rural areas, women healers, with each village having a "wise woman", took over the healing role of the shamans with respect to prescribing herbal medicines and caring for the frail and sick. They practically applied their knowledge which they also handed down, although unlike the shamans who had been feared because they dealt with evil spirits, did not usually or openly engage in ritual and magic. While their work was valued, their lack of formal education gave rise to some suspicion. They managed to survive outside of the influences of the two powers of the time, the patriarchal family and the Church, as they passed down their knowledge in secret. Thus nurses continued to sit with suffering either in rural areas or in hospitals, and spirituality remained on their agenda. While nurses in rural areas continued to apply their 'technical' knowledge as above, though, the family and the Church were attempting to control nursing in terms of its 'technical' knowledge.

Later in the middle ages, secular orders, with their members living amongst the community, cared for the sick poor within cities in much the same way as members

of religious orders, but in their homes. Thus sitting with suffering and spirituality were still on the nurses' agenda.

During the crusades, with the rise of military nursing orders, nurses were celebrated for their courage and compassion. Men were now also adopting nursing roles. Women were allowed to nurse within the military, but were segregated and viewed as subordinate to their counterparts who additionally fought in wars. They also established hospitals within Europe and the Middle East. Thus sitting with suffering remained on the agenda, although there was no longer a direct link with spirituality. Also, women were devalued as nurses solely on the basis of their gender.

In the Early modern period (circa 1450-1800), nurses continued to learn via apprenticeships, passing the 'art' aspect of the role down from expert to novice through hands on experience. The study of medicine at universities was available only to an elite few who, once qualified, distanced themselves from their patients, and so nurses in rural areas were valued most highly for their practical role in society. These nurses were in great danger, as both the Protestant and Catholic churches led witch-hunts because they felt that their power originated from the devil. In the sixteenth century, the Protestant Reformation outlawed all Catholic institutions. In England, the Anglican Church was established and other religious institutions and their associated hospitals were abolished (just a few important ones remained which became secular led). Skilled nursing care was therefore scant. Thus nurses in Britain continued to sit with suffering either in hospitals, in towns and cities or in rural areas until the sixteenth century. Then spirituality was once again off the agenda as a result of the Protestant Reformation. The 'technical' knowledge of the nurses in rural areas was valued by their communities but threatened by the Churches.

In the first half of the nineteenth century, the industrial revolution meant the growth of cities with extremely poor, overcrowded living conditions for many people and cholera epidemics. In these circumstances, people were no longer in touch with the skilled healers who had cared for them in their rural life. Eventually, some wealthy people and politicians, influenced by their Christian calling to assist, arranged for nursing centres and training programmes, incorporating lectures by

physicians for nurses who were largely recruited from young, lower class women. Nursing was thus no longer associated with religion, but was more of a burgeoning profession as the training was founded on scientific principles. Also, it was no longer learned amongst women privately, but rather on hospital wards.

At the beginning of the nineteenth century, military nursing again came to the fore as various empires sought to expand. With more advanced weapons, large casualties ensued which were treated poorly.

Mid century, Florence Nightingale established a coveted place in history by bringing a group of professional trained nurses to the Crimean war and lowering the mortality rate (Hallett 2010), chiefly by the improvement of sanitary conditions, ventilation and lessening the hospital overcrowding. Nightingale's focus was on holistic healing, and it is considered that she incorporated spirituality, nursing's metaparadigm concepts of person, health, environment and nursing, and all of Carper's (1978) fundamental patterns of knowing (empirical (especially in relation to statistics and epidemiology (Kudzma 2006)), ethical, aesthetic and personal) in her practice during and after the war (Dossey et al 2005). Nightingale also established the first of many secular nurse training schools which proliferated in late nineteenth century Britain and improved nursing in 'poor law' infirmaries where nursing was carried out by pauper inmates.

Thus with the advent of industrialization and associated urbanization, the rural nurses who sat with suffering and applied their 'technical' skills were largely lost to the majority of the population. Nursing in hospitals no longer had spirituality on the agenda, but scientific principles instead. Nursing was beginning to professionalize itself and was learned chiefly on hospital wards. By the mid nineteenth century, though, and despite the birth of secular nurse training schools, Florence Nightingale managed to re-establish spirituality within hospital nursing and to establish a balance between sitting with suffering and the application of 'technical' or scientific knowledge.

The nursing schools grew over time to offering three year formal training programmes comprised of practical and theoretical components, with lectures given by doctors. There were two classes of nurses in the voluntary, wealthy

hospitals - philanthropists who engaged in charitable acts through nursing, and working class women who earned a living by nursing. The former, who undertook supervisory roles and carried out the more 'technical' or 'scientific' elements of the job (supposedly requiring greater knowledge and expertise) such as administering medications and undertaking complex dressings, were revered, and the latter, who did the more 'dirty work' and whose work incorporated domestic duties of ward maids, were held in some contempt by the public. In truth, both parties valued the 'dirty work' (they recognised the importance of keeping the body and environment clean) and undertook such work, at least during their training, although this was largely hidden from the public in the interest of promoting nursing as a respectable profession. Previously, nursing had promoted its reputation as a charitable service, but now, in a secular environment, this no longer captured the public's imagination. Instead, nurses latched on to what rapidly expanding modern, 'technical' science had to offer, even though this created the above mentioned schism within the profession. Their subsequent battle to gain professional recognition in the form of a register, led by the elite nurses and commencing in the last two decades of the nineteenth century, was won on these grounds in 1919. Many nurses, however, feared that this would mean turning nurses into mere 'technicians', and that the compassionate art of nursing, at its heart, would be lost. As Eva Luckes (1884, as cited in Hallett 2010: 89) wrote,

“The inevitable result of this is to concentrate attention chiefly on the mechanical side of Nursing and to regard the human side of the work as a secondary consideration. Those who aim to become nurses merely by book knowledge and examinations can, at best, only become machines. Their presence will bring no sense of comfort to those who are suffering, or to those who are anxiously watching every turn of their illness.”

Thus from the late nineteenth century into the twentieth century, nurses were formally trained in nursing schools, although under the heavy influence of medicine and its associated 'technical' and scientific knowledge. Sitting with suffering was still very much on the agenda, although in the name of professionalization, this was kept hidden from the public. Further, a schism in nursing developed which still exists today between those who see nursing as a 'technical' and scientific endeavour and those who see it as a service and caring endeavour (in terms of sitting with suffering) as well.

The twentieth century saw new chronic diseases occurring, with more affluent but unhealthier lifestyles and people living longer, and medical and surgical technology develop further. As a result, nurses felt that they needed to expand their medical and 'technical' knowledge enormously to understand and administer care to their patients. Initially, nurses largely followed doctors' orders in the delivery of such care. However later, particularly as specialisms emerged within nursing, largely based upon specialist, medical and 'technical' knowledge and skills thought to be required in caring for patients as a result of the aforementioned knowledge, they worked more in partnership with them, if not autonomously as appropriate.

As a result of the world wars, more men were entering nursing, and this, along with the increase in medical and 'technical' knowledge, was considered to enhance nursing's status as a profession. Britain had introduced a standard national training syllabus for all hospital training schools in the early part of the century and several decades later, there was a drive to further advance the profession by adopting a more academic approach to training and moving nurse training into universities. The first degree level course in nursing in the UK commenced in 1972 and more followed, although these courses were initially offered for the relatively few more academically able nurse candidates. Nurse education for most nurses, generally carried out at diploma level, has increasingly moved into higher education since the 1990's and degree level education will be introduced for all nurses seeking registration from September 2013 (Ford 2012). Prior to 1992, nurse education was generally provided in schools of nursing that were based at or very near hospitals where the nurses studied and carried out practical ward work. It was envisaged that degree level education for all nurses would expose students to the culture of higher education in general (in the vein of producing flexible, critical thinking, autonomous practitioners who could take nursing forward into the twenty first century (United Kingdom Central Council for Nursing, Midwifery and Health Visitors 1986)), and nurse training would no longer be an end to merely meeting workforce requirements of the NHS (Lord 2002). Meanwhile, close relationships with nursing practice, chiefly in the NHS, have been maintained as the courses are comprised of fifty percent theory and fifty percent practice, the equal split considered appropriate for a practice discipline within higher education.

Higher education at post-registration level has expanded tremendously within the late twentieth and early twenty-first centuries, particularly as this has been

recommended in preparing nurse specialists and nurse consultants (Hamric 1989, Manley 1997, Department of Health 2010b). The latter emerged by the last decade of the twentieth century as a result of increasing numbers of nurse specialists. Their role is to practise, teach and research in their expert, specialist field of nursing.

In the latter half of the twentieth century, nursing academics (who were formerly clinical nurses), chiefly in the United States, developed a range of nursing theories based on their largely past clinical nursing experiences and reflections on nursing, although generally not written about in relation to the former. These theorists sought to define nursing as a discipline distinct from medicine and one that should be practised in tandem with medicine, but under its own direction. These theories, like Nightingale's, were underpinned by the holistic metaparadigm of nursing mentioned above and stressed the importance of the environment, including the nurse, in the provision of healthcare. They also incorporated all of Carper's (1978) fundamental patterns of knowing in nursing and promoted the therapeutic use of self as a vital component of caring nursing practice. They considered nursing to be a valuable, unique, caring discipline that only nurses can understand and do, largely based on first hand nursing experience. An attempt was thus made to turn the tide in terms of the way forward for the professionalization of nursing, from alignment alongside the theoretical underpinnings and practice of medicine to the practice of a unique discipline with its own body of knowledge. Sadly, however, these theories have been marginalized within nursing, largely because they are viewed as esoteric theories for academics and not for the masses, especially as they are considered to demonstrate a gap between theory and practice within nursing due to the manner in which they were derived (as mentioned above, not directly from actual clinical nursing practice).

Meanwhile, as mentioned above, Carper's ways of knowing in nursing were explicated in 1978 and thereafter reflective practice was introduced into nursing as a means of nurses developing theory from their practice and applying that back to their practice, embracing all of these ways of knowing (Johns 1995). Thus the theory practice gap would also be closed (Rolfe et al 2011). Reflective practice was adopted by members of the profession following Schon's (1991: 21) work in which he critiqued technical rationality, or professional decision making and problem solving by "the application of scientific theory and technique". Schon

(1991) felt that the dominance of positivistic science and technology and the decline of religion, superstition and 'pseudoknowledge' over the previous few centuries gave birth to technical rationality. He (1991: 42) argued that technical rationality failed to account for a considerable amount of what professionals do, famously stating,

“In the varied topography of professional practice, there is a high, hard ground where practitioners can make effective use of research-based theory and technique, and there is a swampy lowland where situations are confusing ‘messes’ incapable of technical solution”.

Schon (1991) felt that the swampy lowlands were where people's unique problems of greatest human concern lay, for example, suffering and uncertainty (certainly, these problems would apply to spirituality), and that practitioners needed to go there, with their 'gut feeling' and employing trial and error to make a meaningful difference to people's lives with respect to those problems. Simply applying standardized solutions to such complex, context specific problems, he argued, would unlikely be helpful. He encouraged professionals to reflect in action, meaning that they employ tacit knowledge to uncover the theory in what they are doing, an inductive rather than deductive approach to theory development. Further, he advised that they adjust what they do in light of continuous assessments of their actions.

There are many nurses who have waded into the swampy lowlands of their practice and successfully helped patients through the process of reflection (for example, Lumby 1992, Madden 2002 and Johns 2004b). However it also seems that many nurses have experienced difficulty in doing so, particularly in that they have understood reflective practice to mean merely thoughtful, critical and/or innovative practice (Pierson 1998) rather than an actual activity in which to purposefully and seriously engage in order to learn. Of course, the problem may concern the reason why reflective practice was thought necessary for professions in the first place, specifically *because* tacit knowledge has not been valued historically within nursing for some time. Instead, nurses have done what doctors and/or science and technology have told them to do in practice situations.

At approximately the turn of the twenty-first century, evidence-based practice was introduced to the healthcare professions. At a time of severe financial pressures on the healthcare system and an ever increasing older population with chronic health problems (meaning that there would be ever continuing, increased healthcare spending required), it was felt that clinical decision making should be as effective as possible. The concept was first introduced into medicine as a means of using hard research evidence as the basis for clinical decision making rather than expert opinion and beliefs. In essence, in terms of knowledge, evidence-based practice was previously known as technical rationality or research-based practice.

Evidence-based practice has proliferated within nursing. Currently, it serves as the dominant discourse in terms of what comprises effective practice and excellent scholarship (Rolfe et al 2011). This is particularly worrying as while there are different views regarding what comprises best evidence, as I have stated previously, nursing has widely adopted the classic hierarchy of evidence based on the work of Petticrew and Roberts (2003) in which research based on quantitative methods is valued more highly than qualitative research or clinical experience or opinion or beliefs (Ellis 2010). In terms of knowledge, this means that factual knowledge (or 'knowing that') is valued way and above both practical knowledge (or 'knowing how') and knowledge by acquaintance (or 'knowing who') (the latter two of which comprise Schon's tacit knowledge). However all three types of knowledge are considered important in caring for patients (albeit some may be more appropriate than others in different practice situations) (Rolfe et al 2011), and especially in terms of Schon's (1991) swampy lowlands. Thus in terms of Carper's (1978) ways of knowing, empirical (objective) knowledge is valued over aesthetic and personal ((inter-)subjective) knowledge. This, then, poses somewhat of a problem for reflective practice as there is some conflict between the sources of knowledge which should be employed in nursing practice and what nurses should think and do in their practice. Should they generate learning and theory for the delivery of individualized care, or with perhaps less thought, apply pre-developed, generalized evidence? Rolfe et al (2011) fear that any strides that have been made in advancing reflective practice within the profession may be seriously eroded with the subsequent growth of evidence-based practice therein.

From the early twentieth century until the present, nursing has engaged in a process of professionalization based on its 'technical', scientific knowledge base and is now widely considered a profession on this basis. However the schism in nursing continues between those who consider that it should be a 'technical' and scientific endeavour and those who see it as a service and caring endeavour (in terms of sitting with suffering) as well. Within the profession, nursing theorists attempted to bridge the divide but failed. From outside the profession, nursing has adopted both evidence-based practice (for political and economic reasons) and somewhat less so, reflective practice (so that nursing's tacit knowledge might be valued and employed to solve patients' unique (more) complex problems, and the theory practice gap closed). However it has done so in a manner that reflects nursing as a 'technical' or scientific practice only, valuing empirical (objective) knowledge over personal, intuitive and aesthetic ((inter-) subjective) knowledge, which results in generalized rather than individualized care. (This is extremely ironic with respect to reflective practice as it was adopted precisely to achieve the opposite!)

The compressed nature of being in my thesis is a reflection of how nurses need to function within the society that we are in and what society values. This affects the theory that we use. Thus in adopting evidence-based practice and reflective practice, nursing has embraced those knowledge elements in relation to a 'technical' or scientific practice. In so doing, it has disregarded their underpinning philosophy of holism in terms of a knowledge base for helping professions and their objective to deliver individualized care as appropriate. Thus nursing is viewed by the majority of nurses who are employed in hospitals as a (more) 'technical' and scientific generalized approach to care giving, based chiefly on traditional, scientific or empirical knowledge. Meanwhile, personal, intuitive and aesthetic knowing applied individually to patients as appropriate and associated with nursing as a service and caring endeavour (in terms of sitting with suffering), has been relegated to the sidelines. As a result, sitting with suffering and spirituality are largely absent from professional practice as my findings demonstrate.

I set out to examine the history of nursing chiefly in Britain to see how it has shaped a largely "uncaring" as opposed to caring nursing culture. History has shown that while nursing has been a 'technical' (and later scientific as well) and also a service and caring endeavour (in terms of sitting with suffering) since the beginning of

recorded history, it has had a distinct tendency to be dominated by the hegemonic discourse of the time with respect to which path it has adopted. Thus while nursing has valued and delivered excellent patient care based upon all ways of knowing, both objective and (inter-)subjective, within its practice over time, various types of knowledge have been dismissed at various points in history, suggesting that nursing does not have the capacity to lead its own way forward. The dominant discourse at present is techno-rationality which embraces objective, traditional, scientific, empirical knowledge and results in generalized care giving. Meanwhile, (inter-)subjective knowing and individualized care have been pushed into the shadows. Thus we have moved from a place of nurses sitting with individuals who are suffering to taking on and performing medical tasks and roles.

8.6 Critical discussion of issues raised and possible ways forward

My research has added depth and understanding to some of the complexities and difficulties and limitations that nurses experience in providing spiritual care, both from a clinical practice perspective and the way that nurses are educationally prepared for practice. Nurses are already living, as is virtually everyone, in a dualistic (or secular) world that tends to overwhelm everything so that it is very difficult for them to surrender and get into a sacred space from which they may practise with true love or compassion. Their general working environment and its culture, through a variety of means, further contribute to their problem of being able to access their sacred space. Meanwhile, the profession has not for the first time succumbed to outside pressures and adopted an evidence-based framework for practice that devalues and dismisses the longstanding (inter-)subjective knowledge base that underpins (spiritual) caring as being at the very heart of the profession. Thus the secular world is further reinforced.

The nurses in my study want to be the nurses that they feel that they can be, and deliver compassionate care to their patients. However, as nurses we have been driven to do certain things, as opposed to what we would like to do. Nurses are trapped and are victims of the system, not just the healthcare system in which they are employed, but also by the educational system that prepared them for professional practice and which they continue to access in their continuing professional development. What, then, can be done to alter the system such that the transformational, sacred aspects of nursing that have been lost in the

development of the profession may be regained such that nurses are freed to practise spiritual care giving?

Foremost what is needed is to facilitate nurses to access their sacred space. The world of dualism will continue to exist for us because our consciousness has not evolved to a nondualistic level (Wilber 2000). However we may have glimpses of nonduality that may be fostered such that we may experience these more frequently. We may also bring (inter-)subjective ways of knowing more to the fore such that they are valued and employed equally with objective knowledge within nursing practice as appropriate. As these ways of knowing are how we know and experience spirituality, this will serve to reinforce the spiritual world as our ultimate reality.

8.6.1 Nurse education and practice

The remit of degree level education for nurses was, as I have stated previously, to promote the development of responsible, flexible, critical thinking and autonomous practitioners who could take nursing forward into the twenty-first century. Additionally, the code of conduct requires that nurses be beneficent, responsible and accountable for the care that they deliver (Nursing and Midwifery Council 2008).

I commenced my narrative with a short narrative about why I left clinical nursing practice. Fundamentally, I wanted to care for my colleagues and my patients, embodying the above qualities and employing all of my ways of knowing and being. However it appeared that this was surplus to requirement. More than that, it was neither appreciated nor wanted. It appears that Mrs. B. could not face the reality of a caring act based on perceived individual need (me leaving the ward briefly to drive my colleague to her ill mother-in-law's home) which is an amazing paradox. Also, she appeared to want a ward Sister who would merely accept her authority and follow her orders without question (or even discussion). For me, this meant that I would have to disregard my valued wealth of knowledge (much of it (inter-)subjective in this case) and ways of being (again (inter-)subjective in nature) that I had acquired by caring for patients individually, and behave irresponsibly and in an uncaring manner. I simply could not do that, and so I chose to leave.

Thus if more 'caring' nurses are to remain within the profession and fewer 'caring' students to leave before obtaining their nursing qualification, personal, aesthetic and intuitive ((inter-)subjective) knowledge and caring ways of being need to be valued as much as empirical (objective) knowledge and 'technical' skills within the profession, including nurse education, and taught in the latter. Additionally, there needs to be a balance in nurse education between 'doing', 'knowing' and 'being'. Currently, the first is given huge priority over the latter two; in line with the evidence-based practice paradigm, students are filled with 'technical' and scientific knowledge befitting more a 'training' than an education, and then expected to generally apply that knowledge to all patients. 'Being' is virtually nonexistent. Also, the educational process needs to develop the above mentioned qualities that the profession believes that nurses should possess in order to practise. Thus all of the ways of knowing in nursing (objective and (inter-)subjective) should be embraced such that individualized care such as spiritual care may be delivered as appropriate.

In the current target driven culture, the 'doing' as we have traditionally known it, is easy to teach and the outcome may be seen and displayed (for example, in the form of the achievement of clinical competencies with respect to various practical skills and knowledge). However alternative epistemologies (other than empirical (and ethical) ways of knowing) and ontology have been squashed out of nursing because we cannot demonstrate their value within the evidence-based practice paradigm as the profession has adopted it. (We can demonstrate their value, but not in that paradigm. My thesis, for example, does this.) Therefore, in order to bring them back into the profession, we need to expand our consciousness and re-consider how we have adopted evidence-based practice and for what purpose, coming to understand and appreciate its underpinning holistic philosophy rather than simply dismissing it.

Moreover, new evidence is emerging, demonstrating the value of (inter-)subjective ways of knowing and 'being' on patient outcomes. In a great deal of literature (for example, Davenport & Keeley 2005, Niu et al 2010, Moore et al 2011) and in line with the evidence-based practice paradigm as it has been adopted by nursing, 'doing' is professed as the action that makes the difference in healthcare (for example, what type of dressing to apply to a particular type of wound to promote best healing). Meanwhile, in psychological or spiritual literature (for example,

Zuroff & Blatt 2006, Duncan et al 2010, Norcross 2011), the act of 'being' with the person or engaging in a therapeutic relationship with the person in the *process* of 'doing' whatever you are 'doing' is what is considered to make the difference. In other words, it does not matter what therapy you are 'doing' with a patient, but rather the fact that you are intentionally dedicating your entire attention to that person in that context and 'being' with them, totally present, as you are 'doing' whatever you are 'doing'. Further, increasingly, it is being proven that the *meta-intervention* of 'doing', the therapeutic relationship or environment in the context that the patient is in, is what makes the difference in healthcare (for example, Anderson 2007, Friese et al 2008, Gunnarsdottir et al 2009, Aiken et al 2011, Jarrin 2012).

Thus as Halldorsdottir and Hamrin (1997) demonstrated in their research and which I cited earlier in my thesis, it is the *manner* in which nurses 'do' something to a patient which may render the 'doing' to be perceived as either therapeutic or an initiation of suffering, the latter potentially even 'soul destroying'. Yet these new findings indicate more than this; it is the entire contextual circumstances and wider environment, including the therapeutic relationship (encompassing (inter-) subjective knowing and 'being'), that make the difference. My own study findings appear to support this, and if All is One and inter-connected (Wilber 2000), this would follow logically. In our dualistic culture in which things are separate from each other rather than as One, I have been discussing 'doing', 'knowing' and 'being' as though they are three separate entities. Unsurprisingly, then, this new research appears to indicate that they may all be embodied as One.

In the current healthcare culture that values evidence-based practice and healthcare outcomes, this 'scientific' evidence that indicates that 'being' and 'knowing' are vital components of the 'doing' that make a difference in healthcare outcomes may help to bring 'being' and (inter-)subjective knowing (and thus spirituality) out of the shadows to which they have been relegated in the dominant techno-rationality discourse. Thus it may assist nurses with their current difficulty in delivering spiritual care as indicated by my findings. For example, if staffing levels and staff-patient ratios are improved such that nurses are facilitated to engage (more) in this new meta-intervention of 'doing', nurses may be provided with more opportunity to connect with their sacred space. Additionally, more attention may be given to the understanding and development of this 'doing' skill (encompassing (inter-)

subjective 'knowing' and 'being'), thus also bringing personal, aesthetic and intuitive knowledge and caring ontology out of their current shadows. There should also be consideration and the creation of (more) empathetic practice environments to provide sacred space for nurses such that they are facilitated to undertake this new 'doing' (Rankin 2009, Choiniere 2011) and such that the environment itself is more conducive to spiritual care giving. This would include consideration of the people employed therein and the behaviour which they model to the rest of the staff. My experience with both Lydia and Kathy supports this recommendation.

To further bring 'being' (caring ontology) and (inter-)subjective knowing (and thus spirituality) out of the shadows to which they have been relegated in the dominant techno-rationality discourse, we might usefully focus our attention on how we may teach these additional ways of knowing and caring ontology. As above, the use of narrative, such as mine, which demonstrates how these ways of 'knowing' and 'being' are embodied in nursing practice might be useful. Storytelling, for example, in the form of patients' experiences such as Ben's, might also be useful (for example, Liehr & Smith 2000, Leight 2002, Terry 2012), as might various other forms of art, such as visual art, dance, film and poetry (for example, Holmes & Gregory 1998, Wikstrom 2001, Hunter 2002, Raingruber 2003, Northington et al 2005, Pardue 2005, Wagner 2005, Picard & Landis 2007, Jensen & Curtis 2008, Wilby 2011). In terms of assessing learning in relation thereto, students might usefully produce various forms of art which demonstrate this. Of course, whole new criteria for assessment would need to be developed for this, underpinned by these ways of 'knowing' and 'being'.

Perhaps, though, if 'doing', 'knowing' and 'being' are One as I have suggested above, we should bring this notion into our education and practice systems. Rather than teach or discuss academic subjects, practical skills, alternative epistemologies and ontology separately (the latter two would need to be added to the curriculum), we should teach and discuss them as one metaparadigm of 'doing' as above. In other words, in everything that we teach and discuss in relation to nursing practice, we should adopt a holistic approach, for it is only by adopting a holistic approach that we may come to realistically expect nurses to deliver holistic care.

As part of the aforementioned proposed new process, guided, critical reflective practice (Johns 2002 & 2006) might also be usefully implemented (individually, in groups or both) both as part of students' educational experience and in clinical practice after qualification. Whilst analyzing my data and writing up my thesis, I was engaged in critical reflective practice, employing (inter-)subjective knowing and considering caring ontology, and that is what has enabled me to learn what I have. The value of my thesis is that it is *through* this process and of placing myself in care giving situations (in the thick of 'messy' nursing practice, so to speak) that I have been able to display and examine spiritual care giving in clinical nursing practice and come to understand it as I have; I reflected on my 'doing', my 'knowing' and my 'being' as One. Students and qualified nurses may be able to achieve this similarly through their clinical placement or practice experiences.

As above, the employment of critical reflective practice has the potential to expand consciousness. As expressed in Chapter Seven, one of the difficulties that Kathy experienced was that like me in my clinical practice on my last ward, she was "not encouraged to think for herself or employ her intuition and personal knowledge". Thus her potential for learning did not appear to be recognized. If students and qualified nurses engage in critical reflective practice, they may experience and appreciate expanding consciousness for themselves. Thus they may better understand and appreciate the potential for expanded consciousness in others in relation to spirituality.

A further point about the employment of a holistic teaching and learning approach including critical reflective practice is that by encouraging students and nurses to additionally embrace all of the ways of 'knowing' in nursing and caring ontology, they may deliver individualized care based thereon. Thus it will promote all of the qualities that degree level nurse education seeks to embody in students – responsibility, flexibility, critical thinking, beneficence, autonomy and accountability. Additionally, it will offer opportunities for students and nurses to process their emotions and recognize aspects of restricted consciousness which may impede them accessing their sacred space. It will also offer them opportunities to consider the (wider) caring environment, its impact on practice and how it may be improved, if appropriate. This is important, for as indicated above, the practitioner and the environment are part of the whole in holistic care giving and thus students and qualified nurses will be better equipped to deliver such care.

Both parties should also understand the theoretical underpinnings of evidence-based practice and critical reflective practice so that they may make (more) informed choices about how they practise in relation thereto. A better understanding of these concepts and (more) experience as students in their engagement may also assist future qualified nurses to be more confident and effective in engaging them after they have completed their nurse education.

In line with this, the nursing profession as a whole might also usefully examine these same theoretical underpinnings with a view to considering how the profession, having adopted evidence-based practice as it has done, may have contributed to nursing practice having become so “uncaring” in nature. The profession might then consider what may be done to turn the situation around, such as implementing the recommendations that I have made above. In this process, nursing might also usefully consider its place as a profession in line with the traditional criteria on which professionalization is based and to which it has conformed through its attempts to be more traditionally ‘scientific’ or empirical. Perhaps it is more than time for nursing to stand up and proudly accept its more feminine epistemology and its ontology as a caring profession and determine its own, appropriate criteria for the profession in relation thereto.

To further facilitate spiritual care giving, nursing might usefully consider adopting a holistic framework for practice which is underpinned by the transformational, sacred aspects of nursing. I have discussed what it means to surrender into suffering and why it is so important in spirituality and spiritual care giving. As stated previously, the goal of spiritual care giving is to surrender into others’ suffering and connect with them with a view to potentially expanding their consciousness (and potentially ours as well in the process). Through suffering, there is hope and transformation because God is in us all, is in all suffering, and so we can move through that suffering.

Parse, a contemporary nursing theorist, developed ‘the humanbecoming theory’ (‘humanbecoming’ is meant to be one word), underpinned by the ethical tenet of human dignity, in which the goal of nursing is to promote the individual’s quality of life from their own or their group’s perspective (Parse 2007). She believes that

people are free and that they select ways of being with situations in which they find themselves. A key concept within her theory is that of transcendence about which she states (2007: 309) “cotranscending with possibles is the powering and originating of transforming” and she speaks of a key nursing role as mobilizing transcendence. This means that the nurse facilitates the patient to move beyond the ‘now’ to create a unique, personal path for him/herself, in line with his/her values whilst in the middle of ambiguity, mystery (in that nothing may be completely known) and constant change. The possibilities (including within the patient and the nurse as well) are considered limitless. Parse views the employment of her theory as a way for patients to quest, moving through their suffering. Thus the aim of her theory is, in a sense, for patients to become fully human (everything that they can become, with limitless possibilities). Parse’s theory would appear to be worthy of consideration to adopt for spiritual care giving as it is very much in line with how I have come to understand and have described the latter. Also, it is very much in line with nurse-patient, I-Thou relationships. Further, the nurse’s ability to connect with his/her sacred space seems primary to Parse’s theory in action.

As I have partially indicated above, it is no coincidence that I have advocated the above educational and clinical proposals for nurses to regain access to spirituality and spiritual or holistic care giving. They are the same means (storytelling, poetry, employment of the metaparadigm of ‘doing’, (guided) critical reflective practice, and a framework for spiritual or holistic care giving (my own theoretical framework underpinned, as Parse’s theory, by a relational, (inter-)subjective approach to spirituality)) that I have employed in the process of conducting my research in order to regain and reaffirm my own access to spirituality and spiritual and holistic care giving. The outcome of my having adopted these means is that as my narrative testifies, I have become increasingly better able to access my spirituality via my sacred space and deliver spiritual care as a result. I set out to learn about nurses’ spiritual care giving and I have done so, but primarily, I have experienced a self spiritual transformation. I have given birth to my new more spiritually aware self, and have experienced all the pain and joy that accompanies the birthing (or learning) process. However as I stated above, I will continue to exist in a world of dualism, rendering it difficult for me to remember and embody all that I have learned. Therefore, if I wish to be able to embody my spirituality more, I will need to regularly exercise mindfulness of my spiritual self and the need to surrender to what is, and I will need to practise surrendering. Practices such as regular meditation, immersion in nature and the arts (Kulananda 2003) and reflection may

assist me on my continuing journey. Likewise, if we expect nurses to access and embody their spirituality, they too should regularly engage in such practices.

I have made quite a few recommendations for education and clinical practice such that spiritual care giving may become more of a reality and less of a myth within nursing. While my data reveal that it *is* possible for nurses to be compassionate and provide spiritual care at times within the current educational and practice systems, unless changes are made, the best that we can expect is that spiritual care giving will continue to remain largely absent, although not necessarily nonexistent.

8.6.2 Nursing research

As I have indicated, difficulty in surrendering into the “suffering” that I was exposed to, or being able to be in those situations in the moment, permeated virtually the whole of my experience as a researcher in my study. I struggled with academic and healthcare convention as I have described above and detailed in my first few Chapters (especially Chapters Two, Three and Four in relation to Betsy and Bethan, Lydia and Raymond) and this continued throughout the whole of my thesis. As my experience progressed, though, and as I have indicated, my consciousness expanded in relation thereto, and I became more able to deal with the various issues that impeded my surrendering (for example, in the subsequent cases of Ben, Brenda and Malcolm, and Kathy in Chapters Five, Six and Seven respectively and as I have detailed therein). The more conscious I became, the more interconnected my reality became. The spiritual world of nonduality was always there, but because of my education as a professional and an academic and the culture in contemporary Western society, I was not able to see it.

My consciousness had been severely restricted and I had not been engaging in critical reflection within the metaparadigm of ‘doing’ (for all of the reasons that I have outlined earlier within my thesis) such that my consciousness might have been raised as a result. Instead, as I analyzed my data and wrote and re-wrote my thesis, I now realize that I engaged in critical reflection within the metaparadigm of ‘doing’ increasingly throughout (facilitated by my theoretical framework) and my consciousness expanded through these processes. In essence, I began to surrender to my own suffering as a researcher (my struggle between my conscious

reality of dualism and my unconscious, sometimes briefly glimpsed reality of nondualism) and in those moments, I was able to spot opportunities to assist me in my struggle and have gestalt insights into my struggle. For example, as I described in Chapter Five, I recognized immediately that a television programme that I was watching about a researcher studying wild turkeys had relevance to my data analysis (and research methodology later, after I read about Goethean science). Additionally, as I described in Chapter Six, my more conscious awareness of nonduality as reality led to my realization that in caring for Brenda and Malcolm, I needed to work on overcoming the restrictions on *my* consciousness which might have hampered the care that I was able to offer in relation to their potential expansion of consciousness (as well as on facilitating the same process in relation to all of the *other* healthcare professionals who cared for them).

In short, my methodology became more in the vein of holistic Goethean science as I have described in Chapter Four, and less in the vein of traditional empiricism. Thus as a nurse, I have come to research spirituality and spiritual care giving in a different manner from others - by the increasing process of surrendering to All (Bortoft 1996). In the Goethean science vein, as I have examined the relationships and interactions between the *parts* of my thesis (my 'doing', my 'knowing' and my 'being' - an examination "of qualities and conscious awareness of the relationships and interactions between the parts out of which the whole emerges and which are dependent on the whole" (Wahl 2005: 68) (the metaparadigm of 'doing')), I feel that I have come to know the *whole*, as I hope that the reader has as well.

As a researcher of spiritual care giving, I have been on a most challenging journey, as I have outlined throughout my thesis. When I read about Goethean science as a research methodology, it immediately resonated deeply with me, in terms of being an appropriate methodology with which to explore spirituality and spiritual care giving. I now realize that this is because its methodology comprises 'knowing' (epistemology), 'being' (ontology), and 'doing' (including engaging in critical reflective practice) as One. As spirituality is All as One (nonduality) and one must surrender to this to embody spirituality (or All, love or compassion), it follows that the research process or methodology for researching spirituality should be similarly holistic. It too should be a holistic process (a metaparadigm of 'doing') of surrendering to All and thus embodying spirituality. When I watched the

programme about the researcher investigating wild turkeys which I described earlier, I wondered how we would know differently about nursing (not to mention the universe and everything therein) if we had adopted or were to adopt this research methodology as opposed to others. My thesis is a testament to how much more, by the increasing employment of Goethean methodology, we now know about spirituality and spiritual care giving in clinical nursing practice (and there is so much more to learn, I am sure, if Goethean science were to be *fully* embraced) .

Gary Rolfe (2006), as I have alluded to earlier, has contributed to the debate amongst nursing scholars as to how we should research nursing, proposing a 'science of the unique'. Rolfe asserts, as I have stated previously, that as a result of the rise of evidence-based practice in the 1960's and 1970's, technical rationality is nursing's dominant discourse. He (2006: 39) describes how the term evidence-based practice, coined by Habermas (1970), was used by Schon (1983) to refer to theory dominating over practice, with a "one-way flow of information from research and researchers, through academic journals and textbooks, to nursing practice and practitioners". Rolfe (2006: 39) argues that this illuminated a theory practice gap within the profession, as the research methodologies employed were largely "positivist and/or quantitative", in line with the paradigm of technical rationality. Also, the nursing researchers at the time were largely drawn from the social sciences in which these methods were regularly employed, with a view to studying large social groups and being able to generalize the research findings to the population. (The desire to employ research methodologies which would generate findings that could be so generalized had arisen from the early social philosophers who sought to reproduce the large scale successes that the physical sciences, such as chemistry and physics, had made in the nineteenth century). Rolfe further argues that in the main, social scientists have not deviated significantly from these methodologies over time, right up to the present day.

The problem, as Rolfe (2006:39) sees it, is that "clinical nursing practice is (or, (he) would argue, should be) a series of unique encounters, each of which is different from all others", again as I have suggested previously. Hence applying generalized findings to specific, unique individuals is blatantly inappropriate. He proposes that instead, nursing research should sever its association with the paradigm of technical rationality, and clinical nurses should develop nursing theory based on

their practice. In this manner, research would be reflection or experimentation in action, and it would be integrated with and more relevant to practice. Hence the theory practice gap could be eliminated. Nursing would thus have informal, largely instrumental theories which are constantly being tested, revised and applied back into practice.

I have explicated the 'doing' of Rolfe's research methodology for nursing. In this earlier publication than the one that I have drawn from previously (Rolfe et al (2011)), Rolfe (2006: 41) specifies the various ways of 'knowing' in clinical nursing slightly differently, as personal knowledge ("knowledge the nurses have about individual patients they are working with, gained mostly from the therapeutic relationships they have built up with patients. Personal knowledge also includes knowledge that the nurses have about themselves"), experiential knowledge ("knowledge that the nurses bring to the clinical encounter from other, similar (but never identical) situations from their past experiences" (Benner's (1984) "nurse's repertoire of past paradigm cases")) and propositional knowledge ("knowledge from research findings and textbooks that affirms information about general situations in which the nurses find themselves"). Rolfe considers the most important and relevant knowledge in nurses' theorizing to be in the order in which I have presented them above. He points out that propositional knowledge may play a particularly important role for nurses in caring for patients when they do not have personal knowledge about them, and when they have a repertoire of not many like past paradigm cases. Rolfe mentions 'being' in his methodology, in terms of the nurses 'being' in therapeutic relationships with their patients.

I agree with Rolfe that a 'science of the unique' is appropriate for nursing. I feel that my own theorizing with respect to my data employs the three types of knowledge which he advocates, and that I have employed them (largely) in his same proposed order of relevance, albeit I have employed reflection largely *on-* rather than *in-*action. As a result, my data analysis, I hope, demonstrates that I have given relevant care to unique patients in unique situations. I also feel that a shift away from the dominant paradigm of technical rationality is highly appropriate (parts of my thesis, as I have indicated previously, may be considered nothing short of an indictment of its inappropriate employment for developing nursing theory). An appropriate methodology for a professional practice should, as I have expressed, embrace the relevant 'doing', 'knowing' and 'being' as well as being a science of

the unique, as I think that Goethean science does for nursing. Goethean science proposes coming to 'know' through the ('doing') process of surrendering to All (or 'being' as One with All) (a way of 'being') (Steiner 1911, Wahl 2005). In contrast, Rolfe's science proposes a very limited but important mode of 'being', 'being' in therapeutic relationships with patients (in a sense as One with them) as a means of coming to 'know' them. While this would undoubtedly be a huge step forward for nursing science and practice (it certainly does not occur very often in practice, at least according to my data, and it does not seem to occur as often as it should according to the media and patient groups of late (for example, BBC One 2011b, Smith 2011, The Patients Association 2011, BBC One 2012)), it falls far short of the holistic 'being' as a means of coming to 'know' proposed by Goethean science.

Finally, I wish to make it clear that similar to Rolfe in relation to his proposed methodology (2006), I am not suggesting that Goethean science should be employed to research all aspects of nursing practice. There remains an appropriate place for maintaining technical rationality within nursing, but not with respect to coming to know patients as unique individuals and not with respect to spirituality.

8.7 Conclusion

When I set out to research spiritual care giving in clinical nursing practice, I could never have imagined what lay ahead. I envisaged that I would simply collect my data and then analyze it. I knew that this process would be work intensive in terms of hours spent in the field and time spent writing my data up and then analyzing it, but I never suspected the tumultuous roller coaster ride upon which I would be embarking, as evidenced by all of the emotional and spiritual angst that I experienced.

With hindsight, I do not know what I was thinking. Spirituality and spiritual care giving belong to another paradigm. How is it possible to live in one paradigm and regularly operate in another with any kind of ease? It is not, and hence, of course, the wild roller coaster ride!

So what hope is there for spiritual care giving to become more of a reality? Well, the 'highs' of spiritual care giving, as, for example, I experienced with Aiden, Lydia

and Ben, are nothing short of awesome! They put the 'life', joy and real meaning in living. Most of us know this, at least at some level of our consciousness. The problem, of course, and as I have stated before, is that we simply keep forgetting it.

And therein lies the answer – we need to try to keep remembering! We need to create a new and radically different culture and environment of care (and education and research and beyond), both within and outside of ourselves (because, of course, everything is One) that helps us to remember. It will be no easy task, but it will be worth it for all of us!

List of References

Aiken, L.H., Sloane, D.M., Clarke, S., Poghosyan, L., Cho, E., You, L., Finlayson, M., Kanai-Pak, M. & Aunguroch, Y. (2011) Importance of work environments on hospital outcomes in nine countries. *International Journal for Quality in Health Care* 23(4): 357-364.

Anderson, J.H. (2007) The impact of using nursing presence in a community heart failure program. *Journal of Cardiovascular Nursing* 22(2): 89-94.

Anema, C., Johnson, M., Zeller, J.M., Fogg, L. & Zetterlund, J. (2009) Spiritual well-being in individuals with fibromyalgia syndrome: relationships with symptom pattern variability, uncertainty, and psychosocial adaptation. *Research & Theory for Nursing Practice* 23(1): 8-22.

Avey, D. & Broomby, R. (2011) *The Man who Broke into Auschwitz*. Hodder and Stoughton, London.

Bailey, M.E., Moran, S. & Graham, M.M. (2009) Creating a spiritual tapestry: nurses' experiences of delivering spiritual care to patients in an Irish hospice. *International Journal of Palliative Nursing* 15(1): 42-48.

BBC One (2011a) My Life as a Turkey: Natural World Special. *BBC One*. TV. November 23. 02:35 hrs.

BBC One (2011b) Panorama. Undercover Care: The Abuse Exposed. *BBC One*. TV. May 31. 21:00 hrs.

BBC One (2012) Panorama. Undercover: Elderly Care. *BBC One*. TV. April 23. 20:30hrs.

Benner, P. (1984) *From Novice to Expert: Excellence and Power in Clinical Nursing Practice*. Addison-Wesley, Menlo Park, CA.

Bortoft, H. (1996) *The Wholeness of Nature – Goethe's Way of Science*. Floris Books, Edinburgh.

Brindle, D. & Curtis, P. (2011) *Care Home Abuse: Ministers Move to Restore Confidence*.

<http://www.guardian.co.uk/society/2011/jun/01/care-home-abuse-ministers-move>

Accessed: 07/10/2012.

Brook, I. (1998) Goethean science as a way to read landscape. *Landscape Research* 23(1): 51-70.

Buber, M. (1970) *I and Thou* (Kaufmann, W. Trans). Touchstone, New York.

Care Quality Commission (2011) *Dignity and Nutrition Inspection Programme: National Overview*.

http://www.cqc.org.uk/sites/default/files/media/documents/20111007_dignity_and_nutrition_inspection_report_final_update.pdf

Accessed: 10/10/2012.

Carper, B.A. (1978) Fundamental patterns of knowing in nursing. *Advances in Nursing Science* 1(1): 13-23.

Casement, P. (1985) *On Learning from the Patient*. Routledge, London.

Chase, S.E. (2005) Narrative inquiry: multiple lenses, approaches, voices. In *The Sage Handbook of Qualitative Research*, 3rd edn (Denzin, N.K. & Lincoln, Y.S., eds), Sage, Thousand Oaks, CA, pp. 651-679.

Choiniere, J.A. (2011) Accounting for care: exploring tensions and contradictions. *Advances in Nursing Science* 34(4): 330-344.

Christians, C. G. (2005) Ethics and politics in qualitative research. In *The Sage Handbook of Qualitative Research*, 3rd edn (Denzin, N.K. & Lincoln, Y.S., eds), Sage, Thousand Oaks, CA, pp. 139-164.

Clandinin, D.J. & Connelly, F.M. (2000) *Narrative Inquiry: Experience and Story in Qualitative Research*. Jossey-Bass, San Francisco.

Clarke, J. (2009) A critical view of how nursing has defined spirituality. *Journal of Clinical Nursing* 18(12): 1666-1673.

Cody, W.K. (2007) Bearing witness to suffering: participating in cotranscendence. *International Journal for Human Caring* 11(2): 17-21.

Cohen, A. (2002) *Living Enlightenment: A Call for Evolution Beyond Ego*. Moksha Press, Lenox, MA.

Connelly, F.M. & Clandinin, D.J. (1988) Narrative meaning: focus on teacher education. *Elements* 19(2): 15-18.

Creel, E. & Tillman, K. (2008) The meaning of spirituality among nonreligious persons with chronic illness. *Holistic Nursing Practice* 22(6): 303-311.

Cummings (2009) *Invictus: A Study Guide*.

<http://cummingstudyguides.net/Guides7/Invictus.html>

Accessed: 08/10/2012.

Dalmida, S.G., Holstad, M.M., Diiorio, C. & Laderman, G. (2009) Spiritual well-being, depressive symptoms, and immune status among women living with HIV/AIDS. *Women & Health* 49(2-3): 119-143.

Davenport, K. & Keeley, F.X. (2005) Evidence for the use of silver-alloy-coated urethral catheters. *Journal of Hospital Infection* 60(4): 298-303.

Deal, B. (2008) *The Lived Experience of Giving Spiritual Care*. Unpublished PhD thesis, Texas Woman's University, Denton, TX, USA.

Department of Health (2010a) *Front Line Care: The Future of Nursing and Midwifery in England. Report of the Prime Minister's Commission on the Future of Nursing and Midwifery in England 2010*. Department of Health, London.

Department of Health (2010b) *Advanced Level Nursing: A Position Statement*.

<http://www.aanpe.org/LinkClick.aspx?fileticket=Q%2BhJMeQpKKU%3D&tabid=1051&mid=2816&language=en-US>

Accessed: 12/10/2012.

Dossey, B.M. & Keegan, L. (eds) (2009) *Holistic Nursing: A Handbook for Practice*. 5th edn, Jones and Bartlett, Sudbury, MA.

Dossey, B.M., Keegan, L., Guzzetta, C.E. & Kolkmeier, L.G. (eds) (1995) *Holistic Nursing: A Handbook for Practice*. Aspen, Gaithersburg, MD.

Dossey, B.M., Selanders, L.C., Beck, D.-M. & Attewell, A. (2005) *Florence Nightingale Today: Healing, Leadership, Global Action*. American Nurses Association, Silver-Spring, MD.

Duncan, B.L., Miller, S.D., Wampold, B.E. & Hubble, M.A. (eds) (2010) *The Heart and Soul of Change: Delivering what Works in Therapy*. 2nd edn, American Psychological Association, Washington, DC.

Ellis, P. (2010) *Understanding research for nursing students*. Learning Matters, Exeter.

Emblen, J. & Pesut, B. (2001) Strengthening transcendent meaning: a model for the spiritual nursing care of patients experiencing suffering. *Journal of Holistic Nursing* 19(1): 42-56.

Faull, K., Hills, M.D., Cochrane, G., Gray, J., Hunt, M., McKenzie, C. & Winter, L. (2004) Investigation of health perspectives of those with physical disabilities: the role of spirituality as a determinant of health. *Disability & Rehabilitation* 26(3): 129-144.

Ford, S. (2012) *Degree nurses 'not too posh to wash', says Willis Commission*.

<http://www.nursingtimes.net/nursing-practice/clinical-zones/educators/degree-nurses-not-too-posh-to-wash-says-willis-commission/5048142.article>

Accessed: 08/10/2012.

Freshwater, D. (2000) *Transformatory Learning in Nurse Education: A Reflexive Action Research Study*. Nursing Praxis International, Southsea, Hants.

Fretwell, J.E. (1982) *Ward Teaching and Learning: Sister and the Learning Environment*. Royal College of Nursing, London.

Friese, C.R., Lake, E.T., Aiken, L.H., Silber, J.H. & Sochalski, J. (2008) Hospital nurse practice environments and outcomes for surgical oncology patients. *Health Services Research* 43(4): 1145-1163.

Gergen, M.M. & Gergen, K.J. (2002) Ethnographic representation as relationship. In *Ethnographically Speaking: Autoethnography, Literature, and Aesthetics* (Bochner, A.P. & Ellis, C., eds), Altamira Press, Walnut Creek, pp. 11-33.

Golberg, B. (1998) Connection: an exploration of spirituality in nursing care. *Journal of Advanced Nursing* 27(4): 836-842.

Greene, J.C. (1998) Qualitative program evaluation: practice and promise. In *Collecting and Interpreting Qualitative Materials* (Denzin, N.K. & Lincoln, Y.S., eds), Sage, Thousand Oaks, pp. 372-399.

Greenstreet, W.M. (1999) Teaching spirituality in nursing: a literature review. *Nurse Education Today* 19(8): 649-658.

Guba, E.G. & Lincoln, Y.S. (2005) Paradigmatic controversies, contradictions, and emerging confluences. In *The Sage Handbook of Qualitative Research*, 3rd edn (Denzin, N.K. & Lincoln, Y.S., eds), Sage, Thousand Oaks, CA, pp. 191-215.

Gunnarsdottir, S., Clarke, S.P., Rafferty, A.M. & Nutbeam, D. (2009) Front-line management, staffing and nurse-doctor relationships as predictors of nurse and patient outcomes. A survey of Icelandic hospital nurses. *International Journal of Nursing Studies* 46(7): 920-927.

Habermas, J. (1970) *Toward a Rational Society: Student Protest, Science and Politics* (Shapiro, J.J. Trans). Beacon Press, Boston.

Hall, B.A. (1998) Patterns of spirituality in persons with advanced HIV disease. *Research in Nursing and Health* 21(2): 143-153.

Halldorsdottir, S. & Hamrin, E. (1997) Caring and uncaring encounters within nursing and health care from the cancer patient's perspective. *Cancer Nursing* 20(2): 120-128.

Hallett, C.E. (2010) *Celebrating Nurses: A Visual History*. Fil Rouge Press, London.

Hamric, A. (1989) A model for CNS evaluation. In *The Clinical Nurse Specialist in Theory and Practice*, 2nd edn (Hamric, A. & Spross, J., eds), W.B. Saunders, Philadelphia, pp. 83-104.

Hawks, S.R., Hull, M.L., Thalman, R.L. & Richens, P.M. (1995) Review of spiritual health: definition, role, and intervention strategies in health promotion. *American Journal of Health Promotion* 9(5): 371-378.

Heidegger, M. (1927/1962) *Being and Time* (Macquerrrie, J. & Robinson, E., Trans). Blackwell, Oxford.

Highfield, M. F. & Cason, C. (1983) Spiritual needs of patients: are they recognised? *Cancer Nursing* 6(3): 187-192.

Holloway, I. & Freshwater, D. (2007) *Narrative Research in Nursing*. Blackwell, Oxford.

Holmes, V. & Gregory, D. (1998) Writing poetry: a way of knowing nursing. *Journal of Advanced Nursing* 28(6): 1191-1194.

The Holy Bible, New International Version (1984) *I Corinthians, Verse 13*.

http://niv.scripturetext.com/1_corinthians/13.htm

Accessed: 10/10/2012.

The Holy Bible, New International Version (1984) *Psalm 41, Verse 3*.

<http://niv.scripturetext.com/psalms/41.htm>

Accessed: 10/10/2012.

The Holy Bible, New International Version (1984) *Romans 8, Verse 28*.

<http://niv.scripturetext.com/romans/8.htm>

Accessed: 10/10/2012.

Hoover, J. & van Ooijen E. (1995) Back to basics? *Nursing Times* 91(33): 42-43.

Humphreys, J. (2000) Spirituality and distress in sheltered battered women. *Journal of Nursing Scholarship* 32(3): 273-278.

Hunter, L.P. (2002) Poetry as an aesthetic expression for nursing: a review. *Journal of Advanced Nursing* 40(2): 141-148.

Ironson, G. & Kremer, H. (2009) Spiritual transformation, psychological well-being, health, and survival in people with HIV. *International Journal of Psychiatry in Medicine* 39(3): 263-281.

Jacobs, M. (1998) *The Presenting Past: The Core of Psychodynamic Counselling and Therapy*. 2nd edn, Open University Press, Buckingham.

Jarrin, O.F. (2012) The integrality of situated caring in nursing and the environment. *Advances in Nursing Science* 35(1): 14-24.

Jensen, A. & Curtis, M. (2008) A descriptive qualitative study of student learning in a psychosocial nursing class infused with art, literature, music, and film. *International Journal of Nursing Education Scholarship* 5(1): 1-9.

Johns, C. (1995) Framing learning through reflection within Carper's fundamental ways of Knowing. *Journal of Advanced Nursing* 22(2): 226-234.

Johns, C. (2002) *Guided Reflection: Advancing Practice*. Blackwell, Oxford.

Johns, C. (2004a) *Becoming a Reflective Practitioner*. 2nd edn, Blackwell, Oxford.

Johns, C. (2004b) *Being Mindful, Easing Suffering: Reflections on Palliative Care*. Jessica Kingsley, London.

Johns, C. (2006) *Engaging Reflection in Practice: A Narrative Approach*. Blackwell, Oxford.

Johnstone, B. & Yoon, D.P. (2009) Relationship between the brief multidimensional measure of religiousness/spirituality and health outcomes for a heterogeneous rehabilitation population. *Rehabilitation Psychology* 54(4): 422-431.

Judith, A. (2002) *Wheels of Life: A User's Guide to the Chakra System*. Llewellyn Publications, St. Paul, Minnesota.

Kirby, S.E., Coleman, P.G. & Daley, D. (2004) Spirituality and well-being in frail and nonfrail older adults. *Journals of Gerontology Series B-Psychological Sciences & Social Sciences* 59(3): 123-129.

Kitson, A. (1997) Using evidence to demonstrate the value of nursing. *Nursing Standard* 11(28): 34-39.

Koslander, T. & Arvidsson, B. (2007) Patients' conception of how the spiritual dimension is addressed in mental health care: a qualitative study. *Journal of Advanced Nursing* 57(6): 597-604.

Kudzma, E.C. (2006) Florence Nightingale and healthcare reform. *Nursing Science Quarterly* 19(1): 61-64.

Kulananda (2000) *The Wheel of Life*. Windhorse Publications, Birmingham.

Kulananda (2003) *Principles of Buddhism*. Windhorse Publications, Birmingham.

Kuuppelomaki, M. (2001) Spiritual support for terminally ill patients: nursing staff assessments. *Journal of Clinical Nursing* 10(5): 660-670.

Kuuppelomaki, M. (2002) Spiritual support for families of patients with cancer: a pilot study of nursing staff assessments. *Cancer Nursing* 25(3): 209-218.

Lather, P. (1992) Post-critical pedagogies: a feminist reading. In *Feminisms and Critical Pedagogy* (Luke, C. & Gore, J., eds), Routledge, New York, pp. 120-137.

Lawton, J. (2000) *The Dying Process: Patients' Experiences of Palliative Care*. Routledge, London.

Leight, S.B. (2002) Starry night: using story to inform aesthetic knowing in women's health nursing. *Journal of Advanced Nursing* 37(1): 108-114.

Levi, P. (2007) *Survival in Auschwitz: If This is a Man* (Woolf, S. Trans). 2nd edn, BN Publishing, www.bnpublishing.net.

Levine, E.G. & Targ, E. (2003) Spiritual correlates of functional well-being in women with breast cancer. *Integrative Cancer Therapies* 1(2): 166-174.

Lewin, D.C. & Leach, J. (1982) Factors influencing the quality of wards as learning environments for student nurses. *International Journal of Nursing Studies* 19(3): 125-137.

Liehr, P. & Smith, M.J. (2000) Using story theory to guide nursing practice. *International Journal for Human Caring* 4(2): 13-18.

Liehr, P. R. (1989) A loving center: the core of true presence. *Nursing Science Quarterly* 2(1): 7-8.

Lo, R. & Brown, R. (1999) Holistic care and spirituality: potential for increasing spiritual dimensions of nursing. *Australian Journal of Holistic Nursing* 6(2): 4-9.

Logan, J., Hackbusch-Pinto, R. & De Grasse, C.E. (2006) Women undergoing breast diagnostics: the lived experience of spirituality. *Oncology Nursing Forum* 33(1): 121-126.

Lord, M. (2002) Making a difference: the implications for nurse education. *Nursing Times* 98(20): 38-40.

Lumby, J. (1992) *Making Meaning from a Woman's Experience of Illness: The Emergence of a Feminist Method for Nursing*. Unpublished doctoral thesis, Deakin University, Geelong, Victoria, Australia.

McCauley, J., Tarpley, M.J., Haaz, S. & Bartlett, S.J. (2008) Daily spiritual experiences of older adults with and without arthritis and the relationship to health outcomes. *Arthritis Care and Research* 59(1): 122-128.

McSherry, W. & Draper, P. (1998) The debates emerging from the literature surrounding the concept of spirituality as applied to nursing. *Journal of Advanced Nursing* 27(4): 683-691.

Madden, B. (2002) Working with women following traumatic childbirth. In *Guided Reflection: Advancing Practice* (Johns, C.), Blackwell, Oxford, pp. 187-212.

Mahoney, M.J. & Graci, G.M. (1999) The meanings and correlates of spirituality: suggestions from an exploratory survey of experts. *Death Studies* 23(6): 521-528.

Manias, E. & Street, A. (2001) Rethinking ethnography: reconstructing nursing relationships. *Journal of Advanced Nursing* 33(2): 234-242.

Manley, K. (1997) A conceptual framework for advanced practice: an action research project operationalizing an advanced practitioner/consultant nurse role. *Journal of Clinical Nursing* 6(3): 179-190.

Maslow, A. (1970) *Motivation and Personality*. 2nd edn, Harper and Row, New York.

Mellor, P. (1993) Death in high modernity: the contemporary presence and absence of death. In *The Sociology of Death* (Clark, D., ed), Blackwell, Oxford, pp. 11-30.

Menzies, I.E.P. (1970) *The Functioning of Social Systems as a Defence Against Anxiety*. Tavistock, London.

The Mid Staffordshire NHS Foundation Trust Inquiry (2010a) *Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust January 2005-March 2009. Volume I*. Chair Robert Francis QC. The Stationery Office, London.

The Mid Staffordshire NHS Foundation Trust Inquiry (2010b) *Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust January 2005-March 2009. Volume II*. Chair Robert Francis QC. The Stationery Office, London.

Mok, E., Wong, F. & Wong, D. (2010) The meaning of spirituality and spiritual care among the Hong Kong Chinese terminally ill. *Journal of Advanced Nursing* 66(2): 360-370.

Moore, Z., Cowman, S. & Conroy, R.M. (2011) A randomised controlled clinical trial of repositioning using the 30 degree tilt, for the prevention of pressure ulcers. *Journal of Clinical Nursing* 20(17/18): 2633-2644.

Moss, M.M. (2007) *Nursing Students' Perceptions of Clients' Spirituality, Spiritual Needs, and Spiritual Care in Faith Communities*. Unpublished PhD thesis, George Mason University, Fairfax, VA, USA.

Moustakas, C. (1990) *Heuristic Research: Design, Methodology, and Applications*. Sage, Newbury Park.

Murray, R.B. & Zentner, J.P. (1989) *Nursing Concepts for Health Promotion*. Prentice Hall, New York.

Murray, R.P. (2010) Spiritual care beliefs and practices of special care and oncology RNs at patients' end of life. *Journal of Hospice & Palliative Nursing* 12(1): 51-58.

NHS Future Forum (2011) *Summary Report on Proposed Changes to the NHS*. Chair Professor Steve Field. NHS Future Forum, London.

Niu, Y.-X., Tan, J.-P., Guan, J.-Q., Zhang, Z.-Q. & Wang, L.-N. (2010) Cognitive stimulation therapy in the treatment of neuropsychiatric symptoms in Alzheimer's disease: a randomised controlled trial. *Clinical Rehabilitation* 24(12): 1102-1111.

Norcross, J.C. (ed) (2011) *Psychotherapy Relationships that Work*. 2nd edn, Oxford University Press, New York.

Northington, L., Wilkerson, R., Fisher, W. & Schenk, L. (2005) Enhancing nursing students' clinical experiences using aesthetics. *Journal of Professional Nursing* 21(1): 66-71.

Nursing and Midwifery Council (2008) *The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives*. Nursing and Midwifery Council, London.

Oakley, A. (1981) Interviewing women: a contradiction in terms. In *Doing Feminist Research* (Roberts, H., ed), Routledge, London, pp. 30-61.

Ogier, M.E. (1982) *An Ideal Sister: A Study of the Leadership Style and Verbal Interactions of Ward Sisters with Nurse Learners in General Hospitals*. Royal College of Nursing, London.

Orton, H.D. (1981) *Ward Learning Climate: A Study of the Role of the Ward Sister in Relation to Student Nurse Learning on the Ward*. Royal College of Nursing, London.

Paley, J. (2008a) Spirituality and secularization: nursing and the sociology of religion. *Journal of Clinical Nursing* 17(2): 175-186.

Paley, J. (2008b) Spirituality and nursing: a reductionist approach. *Nursing Philosophy* 9(1): 3-18.

Pardue, K.T. (2005) Blending aesthetics and empirics: teaching health assessment in an art gallery. *Journal of Nursing Education* 44(7): 334-337.

Parliamentary and Health Service Ombudsman (2011) *Care and Compassion? Report of the Health Service Ombudsman on Ten Investigations into NHS Care of Older People*. The Stationery Office, London.

Parse, R.R. (1998) *The Human Becoming School of Thought: A Perspective for Nurses and Other Health Professionals*. 2nd edn, Sage, Thousand Oaks, CA.

Parse, R.R. (2007) The humanbecoming school of thought in 2050. *Nursing Science Quarterly* 20(4): 308-311.

The Patients Association (2011) *We've Been Listening, Have You Been Learning?* The Patients Association, Harrow, Middlesex.

Pesut, B. (2010) Ontologies of nursing in an age of spiritual pluralism: closed or open worldview? *Nursing Philosophy* 11(1): 15-23.

Petticrew, M. & Roberts, H. (2003) Evidence, hierarchies and typologies: horses for courses. *Journal of Epidemiology and Community Health* 57(7): 527-529.

Picard, C. & Landis, E.M. (2007) Creative movement: embodied knowledge integration. In *Innovative Teaching Strategies in Nursing and Related Health Professions* (Bradshaw, M.J. & Lowenstein, A.J. eds) Jones and Bartlett, Boston, USA, pp. 183-196.

Pierson, W. (1998) Reflection and nursing education. *Journal of Advanced Nursing* 27(1): 165-170.

Pinar, W.F. (1981) 'Whole, bright, deep with understanding': issues in qualitative research and autobiographical method. *Journal of Curriculum Studies* 13(3): 173-188.

Polkinghorne, D. E. (1995) Narrative configuration in qualitative analysis. In *Life History and Narrative* (Hatch, J.A. & Wisniewski, R. eds), The Falmer Press, London, pp. 5-23.

Raholm, M.-B. & Eriksson, K. (2001) Call to life: exploring the spiritual dimension as a dialectic between suffering and desire experienced by coronary bypass patients. *International Journal for Human Caring* 5(1): 14-20.

Raingruber, B. (2003) Integrating aesthetics into advanced practice mental health nursing: commercial film as a suggested modality. *Issues in Mental Health Nursing* 24(5): 467-495.

Raingruber, B. & Milstein, J. (2007) Searching for circles of meaning and using spiritual experiences to help parents of infants with life-threatening illness cope. *Journal of Holistic Nursing* 25(1): 39-49.

Rankin, J. (2009) The nurse project: an analysis for nurses to take back our work. *Nursing Inquiry* 16(4): 275-286.

Reed, P. (1992) An emerging paradigm for the investigation of spirituality in nursing. *Research in Nursing and Health* 15: 349-357.

Roach, M.S. (1992) *The Human Act of Caring: A Blueprint for the Professions*. Revised edn, Canadian Hospital Association Press, Ottawa.

Rogers, M.E. (1986) Science of unitary human beings In *Explorations on Martha Rogers' Science of Unitary Human Beings* (Malinski, V.M., ed), Appleton-Century-

Crofts, Norwalk, CT, pp. 3-8.

Rolfe, G. (2002) Reflexive research and the therapeutic use of self. In *Therapeutic Nursing: Improving Patient Care through Self-awareness and Reflection* (Freshwater, D., ed), Sage, London, pp. 179-194.

Rolfe, G. (2006) Nursing praxis and the science of the unique. *Nursing Science Quarterly* 19(1): 39-43.

Rolfe, G., Freshwater, D. & Jasper, M. (2001) *Critical Reflection for Nursing and the Helping Professions: A User's Guide*. Palgrave Macmillan, Basingstoke.

Rolfe, G., Jasper, M. & Freshwater, D. (2011) *Critical Reflection in Practice: Generating Knowledge for Care*. 2nd edn, Palgrave Macmillan, Basingstoke.

Rosenberg, W. & Donald, A. (1995) Evidence based medicine: an approach to clinical problem solving. *British Medical Journal* 310(6987): 1122-1126.

Ross, L. (2006) Spiritual care in nursing: an overview of the research to date. *Journal of Clinical Nursing* 15(7): 852-862.

Ross, L.A. (1997) *Nurses' Perceptions of Spiritual Care. Developments in Nursing and Health Care* 13. Avebury, Aldershot.

Royal College of Nursing (2003) *Defining Nursing*. RCN, Publication Code 001 983, London.

Royal College of Nursing (2010) *RCN Spirituality Survey 2010: A Report by the Royal College of Nursing on Members' Views on Spirituality and Spiritual Care in Nursing Practice*. Royal College of Nursing, London.

Rumbold, B. (2012) Compassionate care: engaging the spirit in care. *Progress in Palliative Care* 20(2): 106-113.

Rykkje, L., Eriksson, K. & Raholm, M.-B. (2011) A qualitative metasynthesis of spirituality from a caring science perspective. *International Journal for Human Caring* 15(4): 40-53.

Salvage, J. (1985) *The Politics of Nursing*. Heinemann Nursing, London.

Schon, D.A. (1983) *The Reflective Practitioner*. Temple Smith, London.

Schon, D.A. (1991) *The Reflective Practitioner: How Professionals Think in Action*. Avebury, Aldershot.

Sellers, S.C. (2001) The spiritual care meanings of adults residing in the Midwest. *Nursing Science Quarterly* 14(3): 239-248.

Sky News (2012) Live: Whitney Houston's Funeral. *Sky News*. TV. February 18. 17:00 hrs.

Smith, P. (1992) *The Emotional Labour of Nursing: Its Impact on Interpersonal Relations, Management and the Educational Environment in Nursing*. Macmillan, Basingstoke.

Smith, R. (2011) *Dementia Patients Ignored by Hospital Staff: Report*.

<http://www.telegraph.co.uk/health/healthnews/8957970/Dementia-patients-ignored-by-hospital-staff-report.html>

Accessed: 15/10/2012.

Steiner, R. (1911) *The World of the Senses and the World of the Spirit* (Unknown Trans). Lecture 1, December 27, Hanover, Rudolf Steiner Archive.

<http://wn.rsarchive.org/Lectures/WorlSensSpir/19111227p01.html>

Accessed: 26/01/2012.

Stockwell, F. (1984) *The Unpopular Patient*. Croom Helm, London.

Swinton, J. & Pattison, S. (2010) Moving beyond clarity: towards a thin, vague, and useful understanding of spirituality in nursing care. *Nursing Philosophy* 11(4): 226-237.

Tanyi, R.A. (2002) Towards clarification of the meaning of spirituality. *Journal of Advanced Nursing* 39(5): 500-509.

Tanyi, R.A., McKenzie, M. & Chapek, C. (2009) How family practice physicians, nurse practitioners, and physician assistants incorporate spiritual care in practice. *Journal of the American Academy of Nurse Practitioners* 21(12): 690-697.

Terry, L.M. (2011) Service user involvement in nurse education: a report on using online discussions with a service user to augment his digital story. *Nurse Education Today* 32(2): 161-166.

Theodosius, C. (2008) *Emotional Labour in Health Care: The Unmanaged Heart of Nursing*. Routledge, Abingdon, Oxon.

Tolle, E. (1999) *The Power of NOW: A Guide to Spiritual Enlightenment*. Hodder & Stoughton, London.

Topping, A. (2006) The quantitative-qualitative continuum. In *The Research Process in Nursing*, 5th edn (Gerrish, K. & Lacey, A., eds), Blackwell, Oxford, pp.

157-172.

United Kingdom Central Council for Nursing, Midwifery and Health Visitors (1986) *Project 2000: A New Preparation for Practice*. United Kingdom Central Council for Nursing, Midwifery and Health Visitors, London.

Vallurupalli, M., Lauderdale, K., Balboni, M.J., Phelps, A.C., Block, S.D., Ng, A.K., Kachnic, L.A., VanderWeele, T.J. & Balboni, T.A. (2012) The role of spirituality and religious coping in the quality of life of patients with advanced cancer receiving palliative radiation therapy. *Journal of Supportive Oncology* 10(2): 81-87.

Van Dover, L. & Pfeiffer, J.B. (2007) Spiritual care in Christian parish nursing. *Journal of Advanced Nursing* 57(2): 213-221.

Vivat, B. (2008) "Going down" and "getting deeper": physical and metaphorical location and movement in relation to death and spiritual care in a Scottish hospice. *Mortality* 13(1): 42-64.

Vrij, A., Mann, S.A., Fisher, R. P., Leal, S., Milne, R. & Bull R. (2008) Increasing cognitive load to facilitate lie detection: the benefit of recalling an event in reverse order. *Law & Human Behavior* 32(3): 253-265.

Wagner, A.L. (2005) The embodiment of nursing art: understanding the caring-self in nursing practice through reflective poetry-writing and art-making. In *Creating Connections Between Nursing Care and the Creative Arts Therapy: Expanding the Definition of Holistic Care* (Le Navenec, C.L. & Bridges, L. eds) Charles C. Thomas Publishers, Springfield, IL, pp. 229-258.

Wahl, D.C. (2005) "Zarte Empirie": Goethean science as a way of knowing. *Janus Head* 8(1): 58-76.

Walsch, N.D. (1998) *Conversations with God: An Uncommon Dialogue*. BCA, London.

Walsch, N.D. (1999) *Conversations with God: An Uncommon Dialogue, Book 2*. Hodder & Stoughton, London.

Watson, J. (1999) *Postmodern Nursing and Beyond*. Churchill Livingstone, Edinburgh.

Watson, J. (2005) *Caring Science as Sacred Science*. F.A. Davis, Philadelphia.

White, G. (2000) An inquiry into the concepts of spirituality and spiritual care. *International Journal of Palliative Nursing* 6(10): 479-484.

Wikstrom, B.-M. (2001) Works of art: a complement to theoretical knowledge when teaching nursing care. *Journal of Clinical Nursing* 10(1): 25-32.

Wilber, K. (2000) *Sex, Ecology, Spirituality: The Spirit of Evolution*. 2nd edn revised, Shambhala, Boston.

Wilby, M. (2011) Teaching others to care: a case for using the humanities in nursing education. *International Journal for Human Caring* 15(4): 29-32.

Williams, J.A., Meltzer, D., Arora, V., Chung, G. & Curlin, F.A. (2011) Attention to inpatients' religious and spiritual concerns: predictors and association with patient satisfaction. *Journal of General Internal Medicine* 26(11): 1265-1271.

Wink, P. & Dillon, M. (2003) Religiousness, spirituality, and psychosocial functioning in late adulthood: findings from a longitudinal study. *Psychology & Aging* 18(4): 916-924.

World Health Organization (1993) *WHOQOL Study Protocol: The Development of the World Health Organization Quality of Life Assessment Instrument*. Division of Mental Health, World Health Organization, MNH/PSF/93.9, Geneva, Switzerland.

Zuroff, D.C. & Blatt, S.J. (2006) The therapeutic relationship in the brief treatment of depression: contributions to clinical improvement and enhanced adaptive capacities. *Journal of Consulting and Clinical Psychology* 74(1): 130-140.

Appendix A

Nurse Information Sheet

Please note that the title of the research study as below was the initial title of my study.

Dear Nurse,

An invitation

You are being invited to take part in a research study exploring “**The perceptions and experiences of patients and nurses in relation to spirituality and spiritual care**”. Before you decide whether or not you would like to participate, I wish to tell you a little more about why the study is being undertaken and what your participation will involve. Please take time to read the following information carefully. You may then ask any questions that you might have and discuss it with others if you wish. Take as much time as you need to decide whether or not you wish to take part.

What is the purpose of the study?

The study will examine spirituality and spiritual care from the viewpoint of nurses and patients and explore how patients experience spiritual care. A number of things may influence patients’ experience of spiritual care and the study will also try to gain an understanding of these. It is now generally agreed that in order to be healthy and have a sense of well being, there needs to be a balance of mind, body and soul. During times of illness, this balance may be upset, and patients, as well as the nurses caring for them, may find themselves dealing with spiritual issues that they hadn’t felt the need to deal with before, or perhaps not in the same manner. Traditionally, the focus of nursing has been on caring for patients’ physical needs. As a result, little is known about how nurses may deliver spiritual care to patients, if indeed, patients want such care. The study will also fulfil the

requirements of a postgraduate degree of Doctorate of Philosophy in Nursing, being undertaken by the researcher who works as a lecturer in xxxxxxxx University. This research will be undertaken over the period of a year, commencing in September 2003.

Why have I been chosen?

You are working as a qualified nurse on one of the two settings which the researcher has selected for the study. Each setting is considered typical of other care giving units of its kind. All qualified nurses delivering direct patient care on the two units between September 2003 and August 2004 will be asked to participate in the study.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part, you will be asked to sign a consent form and be given a copy of that form and this information sheet to keep. If you decide to take part, you are still free to withdraw at any time and without giving a reason. There will be no adverse consequences for a decision to withdraw at any time or a decision not to take part.

What does taking part in the study involve?

The researcher, who is a qualified nurse, will work as a supernumerary unqualified nurse for one day per week on the unit where you are working. As she has not practised for some time and is not competent to perform many aspects of the qualified nurses' work, she will generally help out, assisting with the bathing and feeding of patients, sitting and talking with patients, and fetching and carrying. While she is assisting, she will also be observing how patients experience spiritual care. On occasion, she may observe less practical activities, such as the nursing handover process. She may also read nursing documentation of care. At times, she may have questions about you and your care delivery or what she has observed and may wish to chat with you privately so that she can gain a better understanding. Wherever possible, such conversations will occur in the course of the researcher assisting you with the nursing care that you would normally deliver. If this is not possible, she will arrange a time to speak with you that is convenient for you. Such conversations will never interfere with any professional care duties that you have.

What are the possible disadvantages and risks of taking part?

While no disadvantages or risks are anticipated, it is possible that talking about caring for patients in regard to spiritual issues may cause you to have some

feelings or thoughts that make you feel uncomfortable. If this occurs, the researcher will offer to stay with you for a while, if you wish. If you feel that further support would be useful, she will advise you about available counselling services.

What are the possible benefits of taking part?

It is not anticipated that you will gain directly from participating in this study. However, you may find that it makes you feel better to talk to the researcher about caring for patients in regard to spiritual issues. The information that is obtained from this study will help to teach nurses how to deliver this important aspect of care, and future patients may benefit as a result.

Will my taking part in this study be kept confidential?

If you consent to take part in the research, your nursing documentation may be looked at by the researcher. All information that is collected about you during the course of the research will be kept strictly confidential. Any information written about you will not use your real name so that you cannot be recognized from it.

What will happen to the results of the research study?

A research report will be presented to the nurses involved in the study. The results will be written up as part of the researcher's postgraduate degree and may also be published in various health care journals. As above, you will not be personally identified in any report or publication.

Who has reviewed the study?

This study has been reviewed and approved by the xxxxxx Local Research Ethics Committee.

Contact for further information

Should you require any further information about this study, please contact the researcher, Janice Hoover, on telephone: (xxx) xxxxxxxx, or leave a message with her secretary, Mrs. xxxxx xxxxxx, on telephone: (xxx) xxxxxxxx.

Thank you for taking the time to read this information sheet.

I appreciate that in the present nursing climate, your time is at a premium.

Appendix B

Patient Information Sheet

Please note that the title of the research study as below was the initial title of my study.

Dear Patient,

An invitation

You are being invited to take part in a research study exploring “**The perceptions and experiences of patients and nurses in relation to spirituality and spiritual care**”. Before you decide whether or not you would like to participate, I wish to tell you a little more about why the study is being undertaken and what your participation will involve. Please take time to read the following information carefully. You may then ask any questions that you might have and discuss it with others if you wish. Take as much time as you need to decide whether or not you wish to take part.

What is the purpose of the study?

The study will examine spirituality and spiritual care from the viewpoint of nurses and patients and explore how patients experience spiritual care. A number of things may influence patients’ experience of spiritual care and the study will also try to gain an understanding of these. It is now generally agreed that in order to be healthy and have a sense of well being, there needs to be a balance of mind, body and soul. During times of illness, this balance may be upset, and patients may find themselves dealing with spiritual issues that they hadn’t felt the need to deal with before, or perhaps not in the same manner. Traditionally, the focus of nursing has been on caring for patients’ physical needs. As a result, little is known about how nurses may deliver spiritual care to patients, if indeed, patients want such care. The study will also fulfil the requirements of a postgraduate degree of Doctorate of

Philosophy in Nursing, being undertaken by the researcher who works as a lecturer in xxxxxxxx University. This research will be undertaken over the period of a year, commencing in September 2003.

Why have I been chosen?

You have been admitted as an inpatient to one of the two settings which the researcher has selected for the study. Each setting is considered typical of other care giving units of its kind. All patients admitted to the two units between September 2003 and August 2004 will be asked to participate in the study.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part, you will be asked to sign a consent form and be given a copy of that form and this information sheet to keep. If you decide to take part, you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time or a decision not to take part will not affect the standard of care that you receive in any way.

What does taking part in the study involve?

The researcher will work as an unqualified nurse for one day per week on the unit where you are a patient. She will generally help the other nurses out, either working alongside them or on her own. While she is assisting, she will also be observing how patients experience spiritual care. At times, she may have questions about you and your care experience or what she has observed and may wish to chat with you privately so that she can gain a better understanding. Wherever possible, such conversations will occur in the course of the researcher providing the nursing care for you that you would normally receive. If this is not possible, she will arrange a time to speak with you that is convenient for you. Such conversations will never interfere with any other care that you are receiving as a patient or with any other plans that you have for spending your time, for example, visiting with your family and friends or taking a nap.

What are the possible disadvantages and risks of taking part?

While no disadvantages or risks are anticipated, it is possible that talking about spiritual issues may cause you to have some feelings or thoughts that make you feel uncomfortable. If this occurs, the researcher will offer to stay with you for a while, if you wish. If you feel that further support would be useful, she will advise you about available counselling services.

What are the possible benefits of taking part?

It is not anticipated that you will gain directly from participating in this study. However, you may find that it makes you feel better to talk to the researcher about spiritual issues of concern to you. The information that is obtained from this study will help to teach nurses how to deliver this important aspect of care, and future patients may benefit as a result.

Will my taking part in this study be kept confidential?

If you consent to take part in the research, your nursing records may be looked at by the researcher. All information that is collected about you during the course of the research will be kept strictly confidential. Any information written about you will not use your real name so that you cannot be recognized from it.

What will happen to the results of the research study?

The results of the study will be written up as part of the researcher's postgraduate degree and may also be published in various health care journals. As above, you will not be personally identified in any report or publication.

Who has reviewed the study?

This study has been reviewed and approved by the xxxxxx Local Research Ethics Committee.

Contact for further information

Should you require any further information about this study, please contact the researcher, Janice Hoover, on telephone: (xxx) xxxxxxxx, or leave a message with her secretary, Mrs. xxxxx xxxxxx, on telephone: (xxx) xxxxxxxx.

Thank you for taking the time to read this information sheet.

Appendix C

Nurse Consent Form

Please note that the title of the research study as below was the initial title of my study.

Title of Study: The perceptions and experiences of patients and nurses
 in relation to spirituality and spiritual care.

Name of Researcher: Janice Hoover, Lecturer,
 xxxxxxx University,
 xxxxxxx xxxx, xxxxxx xxxx xxx

Please initial box

1. I confirm that I have read and understand the information sheet dated 21 July 2003 (Version 2) for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without recrimination.

3. I understand that sections of any of my nursing documentation may be looked at by the researcher, Janice Hoover, where it is relevant to my taking part in the research. I give permission for this individual to have access to this documentation.

4. I agree to take part in the above study.

Name of Qualified Nurse (BLOCK LETTERS)	Date	Signature
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Name of Researcher (BLOCK LETTERS)	Date	Signature
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Appendix D

Patient Consent Form

Please note that the title of the research study as below was the initial title of my study.

Title of Study: The perceptions and experiences of patients and nurses
 in relation to spirituality and spiritual care.

Name of Researcher: Janice Hoover, Lecturer,
 xxxxxxx University,
 xxxxxxx xxxx, xxxxxx xxxx xxx

Please initial box

1. I confirm that I have read/had read out to me and understand
 the information sheet dated 21 July 2003 (Version 2) for the
 above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am
 free to withdraw at any time, without giving any reason,
 without my nursing or medical care being affected.

3. I understand that sections of any of my nursing records may be looked at by the researcher, Janice Hoover, where it is relevant to my taking part in the research. I give permission for this individual to have access to these records.

5. I agree to take part in the above study.

Name of Patient (BLOCK LETTERS)	Date	Signature
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Name of Researcher (BLOCK LETTERS)	Date	Signature
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Appendix E

A Breakdown of the Composition of my Research Data

Part I of my data consists of forty-two storied accounts of witnessed observations of patients or patient care delivered by nurses (generally, the 'stories' involve one patient, although sometimes they involve several) and interviews of nurses regarding spirituality and spiritual care giving (usually these form a 'story' each, although not always). Storied accounts in relation to the hospice generally include data in relation to the 'grand round'. There are twenty-four storied accounts in relation to the general medical ward and eighteen in relation to the hospice.

Part II of my data comprises twelve and fifteen storied accounts in relation to the general medical ward and hospice respectively, one per shift in each area. This is because I shadowed one nurse per shift and I have attempted to write the storied account in the full context of the shadowing experience. These storied accounts consist of the same general material as above, although they always include storied accounts of witnessed observations of patient care delivered by nurses, at least the nurse whom I have shadowed. Also, as above, storied accounts in relation to the hospice generally include data in relation to the 'grand round'.

During the whole of my data collection, I more formally interviewed five patients, all on the general medical ward, for twenty to forty-five minutes each. During the first half of my data collection, I more formally interviewed four nurses (three on the general medical ward and one at the hospice) for twenty to thirty minutes each and during the second half, eight nurses in each area for between ten and thirty minutes each. Overall within the data, I opportunistically questioned patients at the hospice about their care needs or nursing care on ten occasions and patients on the general medical ward on thirteen occasions. Similarly, I opportunistically questioned nurses at the hospice on forty occasions (and a social worker on one occasion) and nurses on the general medical ward on thirteen occasions.