THE MEANING OF HEALTH IN THE NURSE'S PRACTICE

by

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ABSTRACT

What is the meaning of health from the nurse's perspective? This question provided the focus for an interpretive study with four registered nurses. The aim of the study was to contribute to the understanding of health by approaching it from the perspective of the nurse.

Hermeneutic methodology was used for the study as it approaches the task of understanding and the methodology necessary to interpret a text. The study included indepth interviews and journal entries which were approached with the central question: "What are the experiences which shaped your understanding and meaning of health?" In keeping with the hermeneutic approach, the stories were carefully explored and statements were noted for their descriptions of health. Meanings were identified, developed and supported by excerpts from the text of the narratives.

For the nurses in this study the following aspects of health are considered in their meaning of health. Specifically; connecting, hope, peace, and empowerment were themes which were brought forward as key to their understanding of the concept. The nurses also described the following qualities of health: the presence of health within illness, the time-less quality of health, and the holistic aspect of health. The nurses defined their

understanding of health through their personal experiences and their client's experiences with health.

Implications this study has for nursing and recommendations for research are suggested. The impact of this type of interpretive methodology upon nursing education and nursing practice is considered. The contribution of this study in nursing includes the call for greater involvement of nursing practice in the development of nursing theory. The thoughtful approach necessary to develop a greater understanding of the meaning of health suggests nurses in practice can play a large role in defining our vision of health.

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CHAPTER 1

INTRODUCING THE STUDY

This study is an exploration on what four registered nurses understand to be the meaning of health. These nurses are or have been involved in various nursing settings such as medical and surgical nursing units, intensive care and home care. They were invited to reflect in a written and verbal form on their practice in order to understand their meaning of health. Interpretive methodology is used to develop meanings and an understanding of these nurse's texts.

The general aim of conducting this study is to contribute to the current knowledge of 'health' by investigating the views of those who promote health, practising nurses. A main task or responsibility of the registered nurse is often considered the promotion of health. The nursing profession acts within the health care system in order to achieve the goal of improvement in people's health. Although the concept of health is central to nursing practice, the images of health differ widely. Despite the fact that health appears in most nursing theoretical works, the meaning of health can be approached from many different perspectives.

DESCRIBING THE CONCEPT OF HEALTH

It ought to be possible to describe such an important concept such as health as it occupies a major emphasis in our population. We spend a great deal of money trying to

restore or improve it. We join health clubs, visit health resorts, and buy health food. Oddly enough when the question is put to people to define health, the majority can only define it negatively as 'freedom from disease.'

We know health well in its absence. When we are sick or injured, we have no trouble knowing how things should be. Freedom from disease is a common understanding of what health is, however, since "disease" is an old French word meaning "lack of ease," we are left with a doubly negative term. From this perspective, health is the absence of an absence of ease.

One might assume that after one hundred years of study within the nursing profession and clinical practice, nursing would have a commonly accepted definition of the term health. However, the concept of health continues to lack an appropriate operational definition (Ahemd & Kolker, 1979; Dolfman, 1973; Shaver, 1985; Benner, 1985). In fact, this term has proved to be an elusive concept in nursing, undergoing changes in meaning with various nursing theorists.

NURSING PERSPECTIVES ON THE CONCEPT OF HEALTH

Nursing's pursuit of promoting health has been documented in the literature of the Western hemisphere since the days of Florence Nightingale. Nightingale was the first nurse to publish her views on health in the 19th century.

This perspective reflected hygiene, the pervasive social challenge of the period (Nightingale, 1969). She encouraged the view of the individual's relationship to the environment where the goal of the nurse was to place the person in the best condition for the environment to support the individual's ability to heal.

Peplau was the first to emphasise health as a dynamic developmental process; defining health as the forward movement of the personality toward creative, productive living (1952). Theorists such as Hall (1966), Levine (1973), and Johnson (1980) emphasised health as a positive rather than a negative state. Roy's (1976), Orem's (1985) and King's (1981) definition of health (see Table 1) reflects a view of health that is a dynamic state of physical, social, spiritual and psychosocial well-being (Parse, 1987).

Paterson and Zderad (1976), Watson (1985) and Newman (1986) have also defined health to be closely linked to a second paradigm developed by Parse (1987). As indicated in Table 1, this paradigm advocates a view of human beings as unitary and health as an expression of the life process in which human participate in co-creation within the environment (Parse, 1987).

The challenge of accommodating the numerous views of theorists in nursing practice exists. What do nurses

TABLE 1

COMMON DEFINITIONS OF HEALTH

HEALTH IS DEFINED AS:	**THEORIST:**
- a complete absence of disease. It is the state of being free from signs and symptoms of disease and with complete physical, mental and social well-being.	World Health Organisation (1947)
- a state and a process of being and becoming an integrated and whole person. Lack of integration represents lack of health, a state of human perfection that includes continuing human development and adjustment to stressors in the environment to achieve maximum potential for daily living.	Roy (1984) Orem (1971) King (1971) Dunn (1961) Dubos (1961) Seyle (1959) Nightingale (1954)
- a synthesis of disease and non-disease. Disease conditions are part of the total pattern of the individual, and can be regarded as an integrating factor important for the integration of self. Health is viewed as the totality of the life process, which is moving toward the expansion of awareness to greater dimensions.	Newman (1986) Watson (1986) Parse (1981) Paterson & Zderad (1976) Rogers (1970)

believe and accept within their practice in the goal of promoting health? Upon questioning various nursing colleagues for their definition of health, the responses seldom included a theoretical understanding from nursing theorists. The practising nurse develops an unique, contextual understanding of what health means that is more often linked to the nurse's experiences than to theoretical explanations.

AN EXPERIENCE WITH HEALTH

When I first donned the uniform of a nurse, while a student, I, like most of my peers, knew very little about nursing yet alone about health. Most of my understanding about health developed over time throughout my nursing practice. In the ten years as a practising nurse, I confess, at times I have shared the prejudice of those in practice who questioned the validity of what academia had to say about such terms as health.

My interest in the meaning of health began early in my nursing practice. I had worked on a surgical unit and was becoming quite confident with my skills in this area. I was not until I encountered a particular client, Mr. Grayson, who was dealing with inoperable cancer that my meaning of health began to shift.

This man had undergone surgery to relieve a bowel obstruction, and upon his return he was informed his

intended surgery was unsuccessful. Given several weeks to a few months to live, he recovered from the surgery, and at the same time began to prepare for his death.

I felt fortunate, and at the same time burdened to share in many personal conversations which centred around his expectations. I recognised how this man regained a sense of hope as we conversed and communicated through thoughts and touch. When I had no words to reassure him, I held his hand silently for a time, eventually telling him I would return. Mr Grayson's manner and presence through this process instead began to reassure me.

Lying helplessly, this gentle and alert man seemed to be beyond my own distinctions of health and illness. He radiated a kind of "healthiness" even while moribund. I could not describe his condition then, but as I stood in the hallway thinking I was taken with a thought that made no sense at the time. "This man is healthy." A few hours later, amidst much nausea and copious emesis, he died, I am convinced, in good health.

The learning that came through this experience left me with a very different understanding of health than I previously had held. The notions of what I believed to be health continued to develop through various incidents with clients in my nursing practice. These events were rich and continued to be meaningful years after they occurred. I came to recognise that my meaning of health was no longer

grounded by definitions I had learned earlier in my formal education.

This perspective suggests the validity and importance one's clinical practice has in the formation of our understanding of concepts such as health. The clinical practice of the nurse unfolds to reveal truths which may be obscured within the planned curriculum for students in the classroom. What is the vision of health that is rooted in the lives of nurses who are no longer exposed to a formal curriculum? The nurses' experiences in the clinical practice setting determines a significant part of informing the nurses' views on health.

CURRENT NURSING PRACTICE

Nursing practice has worked alongside the medical profession almost since its inception in the Western world. The medical approach to health care has influenced the way nurses practise in many settings. For example, hospital based nurses work with an illness orientation as the hospital environment exists to treat disease and/or trauma with a curative approach. The health care system has recently increased the focus on preventative medicine. This shift is demonstrated by efforts in the medical community to screen for cancer, discourage smoking, promote exercise, lower cholesterol and counsel against risky sexual behaviour (Reisser, Reisser & Weldon, 1987). However, this preventative approach toward health has generally been

overshadowed by the holistic health movement in society.

For many in today's society the search for alternative forms of therapy signify an interest and concern for health that has not been met by traditional forms of medicine. Some of the approaches to meeting health needs include acupressure, biofeedback, iridology, homeopathy, applied kinesiology, and therapeutic touch. Western medicine is confronted with a new challenge as this movement argues that the health care system has lost touch with the human soul and spirit (Reisser, Reisser & Weldon, 1987). The leaders in this movement are suggesting a radical revision of underlying thinking about health and disease. These alternative approaches to health care have had an influence not only on Western medicine but on nursing practice.

Challenges for Nursing Practice

Understanding the meaning nurses hold about such a key concept as health is important to nursing because of the implications for practice and curriculum development. Beliefs about health shape and change the nurse's practice on many levels, and consequently influences the nurse's approaches when dealing with people's health. This understanding of health which is developed not only in the classroom but in the practice setting should also inform nursing education.

The challenge in current trends in the profession of nursing is to incorporate humanistic and holistic values and

to develop knowledge from practice. Although nursing has drawn on its own tradition of healing through care, to a certain extent the general acceptance of this approach to health resulted in shifting public perceptions of traditional approaches to health care (Benner & Wrubel, 1989). In this new context, nurse educators recognise that learning for nurses is subjective, contextual and values driven (Watson, 1988). This is a departure from the objective, reductionist approach often taken in nursing research and education (Bevis, 1989). Developing a sharing understanding about health from this new perspective needs to be explored.

In summary, the views and meanings the practising nurse has about "health" is grounded in the experiences of caring for and assisting people with health needs. The current decade for nursing is characterised by efforts to develop knowledge from a nursing perspective and also to respond to changes in societal needs in relation to health. An improved understanding of this key concept in nursing is important to nursing practice and nursing education.

STUDIES

Some of the ways health has been conceptualised in the field of nursing have been in the context of illness and in the context of how we understand the healing process. As my own study centres around the meaning nurses' hold on the attribute of health, literature with this view in mind is

explored.

The first formally trained nurse recognised for her impact in health care was Florence Nightingale. In her book, Notes on Nursing (1969), first published in 1859, she shared the essence of her knowledge on health. She called attention to the natural antidote to illness: fresh air, good lighting, the reparative importance of quiet, and a properly managed environment.

In the medical field, research on health developed through clinical studies of illness experiences. Flanders Dunbar, a psychiatrist in New York in the 1940's, analysed the relationship of personality type, stress, and physical illness with 1,600 patients over a period of 12 years. Dunbar found certain personality characteristics typical of the majority of people suffering particular disorders. Case histories of those with diabetes, cardiovascular disease, allergies, gastrointestinal disease, and fractures revealed stressful emotional situations prior to the onset of their illnesses.

Although Dunbar's work in the 1940's was sometimes criticised as speculative and nonscientific (Keegan, 1988), it led other researchers to explore the effect of stress on one's health. Hans Selye (1959) developed the theory of stress based upon what he termed the general adaptation syndrome, which is widely acknowledged today. Holmes and Rahe (1967) developed a questionnaire to document the

relationship between the occurrence of stresses of significant life events and the onset of illness. The researchers predicted that when the point value of each significant life event totalled to a certain level there was an increased likelihood for illness to occur. Findings revealed that the more changes individuals underwent, the more likely they would become ill.

Research conducted the area of formal beliefs about health, such as the Health Belief Model (Hochbaum, 1958; Kegeles et al, 1965; Rosenstock, 1966) and Bandura's Self Efficacy Model (1977) are examples of the view of health as a choice. The individual's belief in making healthy choices such as proper nutrition, rest and exercise are based on the notion of the person's ability to appraise a situation and decide on a course of action. This approach to researching health explains the use of formal beliefs in the choice of and deliberate planning of health, however it does not approach the meaning of health for the individual.

Health researchers in nursing and other disciplines have also studied selective aspects of health promotion (Williams, 1946; Parson, 1958; Duffy & Pender, 1987), defined health behaviours (Bauer & Schaller, 1955; Hinkle, 1961; Orlando, 1961; Twaddle & Hessler, 1977; Black et al 1979), and defined health with various theoretical stances such as: role theory; stress; and adaptation frameworks (Dubos, 1965; Dunn, 1973; Bower & Bevis, 1979; Smith, 1981).

Each of the above investigations contributed to the overall view of health from a disease orientation. I did not, however, discover in my literature search any structured study exploring the meaning of health from the perspective of the lived experience. I did uncover autobiographical accounts of the direct experience of illness, pain and suffering. Examples such as Norman Cousins' (1979) Anatomy of an Illness, Michael Halberstan's (1976) A Coronary Event, Oliver Sacks' (1984) A Leg to Stand On, and Larry Dossey's (1984) Beyond Illness are only a few. Dossey's (1984) work is an exploration of the questions he raised about health from within his clinical practice. He examines assumptions made about health and its correlates, for example; what is meant by birth and death, health and illness, fear and hopefulness, and malaise and energy. He postulates that these correlates are inextricably intertwined, not just conceptually but as a matter of pure experience as well.

This study of the meaning of health from the perspective of the practising nurse has the potential to add to our understanding of what we mean in nursing when we simply use the term health. A major supposition underlying this study is that our present meaning of health is dependent on the evolution of the common use of the term. As one of the steps to aid my own understanding of the term, I undertook a historical review of our understanding of

health. It was helpful to glean an insight into how our views on health have been shaped over the centuries. A review of our historical understanding is therefore considered appropriate for providing the background to discern the meaning of the nurses' texts.

The Historical Understanding

The historical review of the term health reveals tow distinct themes. These are frequently termed the holistic and the positivist perspectives. The two divergent perspectives emerged from distinct world views. These are labelled the "old-world" and the "new-world" views (see Table 2). The old-world view's influence on health brought to us through English and Greek notions with the view of wholeness equated to health. The new-world view's started with the scientific revolution to suggest health was a problem which could be easily reducible to studying the body anatomically, whereby the sum of the results could then define illness, not health.

An Old-World Perspective

An analysis of the origins of the word health suggests an early English viewpoint; where it is described as being sound or whole. This viewpoint has existed for several thousand years. As early as 400 B.C. Greek notions of health also involve a positive attribute of wholeness; to which we are entitled to if we govern our lives wisely (Dolfman, 1973). The understanding of soundness or

TABLE 2

COMPARISON OF OLD AND NEW WORLD VIEWS ON HEALTH

Old-World View	**New-World View**
Holistic Model	Medical Model
- search for patterns and causes	- treatment of symptoms
- emphasis on human values	- emphasis on efficiency
- pain and disease may be valuable signals of internal conflict	- pain and disease are wholly negative states
- minimal intervention complemented with use of noninvasive techniques	- primary intervention with use of drugs and surgery
- body is seen as a dynamic system	- body is seen as machine in good or bad repair
- disease or disability seen as a process	- disease or disability seen as an entity
- an emphasis is placed on the achievement of maximum body mind health (mind is a primary or coequal factor in all illness)	- an emphasis is placed on eliminating symptoms and disease
- prevention in synonymous with wholeness which includes work, relationships, goals, and body-mind-spirit	- prevention seen as enviromental: exercise, rest, immunization

Adapted from: Ferguson, M., (1980). The Aquarian Conspiracy: Personal and Social Transformation, (p. 246-248).

wholeness has influenced the use of the term (see Table 2). However, variations in the theme of wholeness have altered subsequent views. For example, in the 14th century the word health came to represent moral soundness and spiritual salvation. This assumed a religious significance as opposed to strictly a physiological perspective.

A New-World Perspective

The meanings generated from the old-world view gradually shifted to accommodate a positivist perspective from the new-world view. The holistic view of health (the state of being whole) persisted until the Cartesian revolution in the 17th century (Simmons, 1989). The body then came to be seen by science as in intricate machine, and it became the doctor's task to repair the machine (Engel, 1979). This scientific approach dominated this field until the Renaissance introduced the biomedical model to the study of man.

The biomedical model only gained complete acceptance since the middle of the 19th century when the link between germs and disease became established (Ahemd, Kolker & Coelho, 1979). The model is referred to as positivist because it assumes that only objectively measurable phenomena are real, and reductionist as biochemical language is considered to be sufficient to explain these phenomena (Ahemd, Kolker & Coelho, 1979). Practitioners utilising this positivist model as the basis for their practice have

tended to focus on the pathological process of the disease rather than the whole person (see Table 2). The new-world view which reinforced a scientific focus on the cellular and tissue level has been widely accepted in the medical discipline.

Emerging Perspectives

This historical period not only developed the meaning of health, but it saw the term undergo a change from the concept of wholeness to a more restricted connotation. This shift in perspective also supports an illness orientation (see Table 2). As a result of significant development in 19th century classification and pathophysiologic mechanisms, medicine today emphasises specificity and subdividing man into organs and tissues in order to achieve a medical capacity to cure (Black, 1976). Well known literary works such as On Being Ill by Virginia Woolf (1928), The Death of Ivan Illych by Leo Tolstoy (1960), Cancer Ward by Aleksandr Solzhenitsyn (1968), and Heartsounds by Martha Weinman Lear (1980) reflect a perspective of an illness orientation in our society.

Individual-As-Object

Our current Western health ethic is built around the individual-as-object. At this level we continue to base our notions of health and illness separate from a knowledge that comes through the intimate or direct way of knowing, that of the lived experience. Thus we find ourselves with models in

medicine, and subsequently with nursing models, which are characterised by scientific and objective descriptions of the world that we live in.

Many of the predispositions in the Western world to an objective approach rest in the legacy of Rene Descartes (Barrett, 1978; Bowers, 1989; Jardine, 1990). The modern thought accepted the split between subject and object, and named such a division as the only methodological approach which could support human certainty. The method Descartes proposed set up an estrangement between persons, and between an individual and his or her own world (Smith, 1991). In this view, the notion of how people are in the world is represented through the subjective and objective. The individual's personal meanings are subjective and reality is objective. This assumption has influenced our conception of health and illness in the Western world (Benner & Wrubel, 1989).

Health As Adaptation

The increasing prevalence of disease in the 20th century prompted such notable authorities as the microbiologist Rene Dubos to claim that health is a mirage and ultimately an unattainable ideal (Ahemd, Kolker & Coelho, 1979). Dubos came to view health as the state in which the individual is able to adapt adequately to the environment (Dolfman, 1973). In this perspective, a healthy individual may actually become ill, but what is important to

the definition is that illness is adapted to, not resisted.

Dubos' concept of health as adaptability to one's environment, and Darwin's concept of adaptability as a criterion for the survival of the fittest have the same philosophical origin (Bower & Bevis, 1979). One is never in a state of perfect health or perfect sickness; one moves toward higher levels of health, stands still, or one moves nearer toward illness.

Health As A Norm

A model frequently employed in the medical system is the notion of equating health with normality. Norms have been developed on numerous biomedical measurements, where an individual can be deemed healthy if the individual's functioning levels fall within predetermined ranges. Proponents of this view therefore consider every organ and tissue has a natural range to its structure and function.

Disease-Free-State

The most popular and accepted idea of health which emerged in the 18th century equated the concept of health as a disease-free-state. Within this view, health and disease were regarded as extremes of a continuum, with the absence of one defining the presence of the other (Dolfman, 1973).

The view of health as a disease-free-state gave rise to the definition mandated by the World Health Organisation (1947) which states: "health is a state of complete physical, mental, and social well-being and not merely the

absence of disease or infirmity" (p. 83). This view of health provided distinct and positive qualities by enlarging on the concept defined earlier. Some would argue that this definition of health makes everyone feel diseased and consequently in need of diagnosis and treatment (Kothari & Mehta, 1988).

A Critique of Emerging Perspectives

The positivism which subtly infuses so much of modern health care renders its own fundamental definition of health problematic. Researchers with a positivist approach devise ways of conceptualising, organising and describing personal meaning as subjective. The data is often mistrusted or questioned as personal meanings are considered limited as it reveals nothing about people in general. More significantly, it leaves out the lived experience of health. Each culture gives shape to a "unique Gestalt of health and to a unique conformation of attitudes toward pain, disease, impairment and death" (Illich, 1979, p. 128).

For researchers from the positivist perspective the objective reality forms the basis for assessing health and adaptation (Benner & Wrubel, 1989). With the assumption that an objective world is the field of study, subjective meanings are left out of the communicated findings. This basis for studying a concept such as health limits the findings from forming a comprehensive and whole picture of health.

The notion of adaptation should also be expanded to include more than the positivist perspective of illness as a mal-adaptive mechanism. If polluted air is a factor in emphysema, for example, the disease is caused by adaptive mechanisms, not by any failure of the lungs to adapt. As illustrated through the person with emphysema, adaptation is often so effective that physical changes develop gradually to mask signs or symptoms of the illness. In fact, affected people often gradually and unconsciously change their lifestyle to accommodate changes in their lungs. The view that considers a healthy person as one who can adapt reflects a cultural ideal which upholds the qualities of mastery, control and autonomy. If we hold that adaptive mechanisms are necessary for health, the type of adaptation must be clarified. The type of adapting can assume many different and varying forms, for which we need to understand the nature of what healthy adaptation would mean.

Dunn (1959) also conceptualises health as a disease-free-state, but introduces a new concept which he calls "high-level wellness" (p. 786). This concept includes the individual's ability to function in an environment as well as the ability to cope with environmental stress. In this notion of health, Dunn relegates health to a secondary position while emphasising the notion of wellness equating that to a quality of life. This notion extends far beyond the early understanding of health as being sound and whole,

and "eliminates the idea of health being a state or condition" (Dolfman, 1973, p. 496). In addition, a problem with Dunn's definition is the matter of introducing words that have little or no meaning. The word wellness does not exist in the English language, and even where some authorities consider this possibility, the meaning differs from Dunn's usage (Dolfman, 1973).

Much of the confusion and ambiguity which has surrounded the use of the word health is apparent to many health practitioners. Illness and disease have overshadowed our focus on health. The medical community directs its attention to the treatment and mastery of disease. It is an inescapable fact that health care providers have concentrated on disease as a reducible and objective focus. Given this orientation, very little research directly questions the meaning of health from the lived experience of the patient or the health practitioner.

In summary, the literature review provided an historical overview of the concept of health, and more specifically reviews the shift of health from a concept of wholeness to hat of an illness orientation. Understanding of the direct experience of health, both from the health practitioner's and the client's perspectives is clearly lacking.

CHAPTER 2

METHODOLOGY AND ITS RATIONALE

The purpose of this study is to understand what health means to the practising nurse. To achieve this purpose, an interpretive approach was chosen for this study in order to uncover the meaning of health as it is experienced by nurses.

The use of a qualitative methodology to view health developed out of my desire to utilise a language that could convey the meaning of health by those who live with and observe aspects of health in their practice. To understand the underlying meaning of health, it is necessary to explore the experiences and beliefs which informs the reality of health for the nurses in this study. Such exploration requires a specific kind of qualitative research methodology: the hermeneutic inquiry. This inquiry can sift out the deeper meanings contained within the stories and incidents which have influenced the nurses' practice.

Underlying the Task of Interpretation

Intentions

The interpretive process includes the intentions and hopes of both the speaker and listener as they share the particular context. A dialectic exists between the speaker and listener in much the same way as a reader shares with a text in a particular context (Palmer, 1969; Polkinhorne, 1983). The reader's or interpreter's own intentions, hopes

and pre-interpretations are brought to bear on the text itself as the interpreter brings his/her own understanding to the interpretive process.

Collaboration

This inquiry encompasses ideas of collaboration and participation between speaker and listener. The reciprocal relationship between the researcher and the participating nurses is important to the trust and collegiality necessary to facilitate sharing one's stories. With this cooperative interaction and participation, both the interpreter and the participant are considered co-researchers.

The Co-Researchers

In this study, four co-researchers were selected on the basis of specific criteria, with not attempt at randomisation. The choice of participants in this type of research is important as they provide the text for interpretation. Each person was chosen because they had experience in a nursing context, they could articulate their experience, and could thereby contribute understanding to the research question. The nurses who agreed to participate were assured that their names and any distinguishing descriptions would be altered in all reports and records in order to ensure confidentiality and anonymity (see Appendix A).

The nurses involved in this research had reached the stage of Benner's (1984) description of proficient if not

expert, clinical practice. The four nurses, Lauren, Christine, Jill and Lucy are women aged 32 to 38 years and have an average of ten years in nursing practice. What is paramount with the involvement of these participants is their ability to participate in the reflective methodology of this research orientation. Experienced or expert nurses can readily bring to mind clinical situations which altered their approach to meeting health and patient care issues (Benner, 1984). The stories about clinical situations provide descriptions to illustrate the nurses' own understanding of health.

In reflecting on and sharing past experiences which impacted on notions of health through the narrative accounts and journals, the co-researchers were encouraged to provide stories which were oriented to the topic. This caused the nurses to look deeply and seriously into their experiences and to be as perceptive and discerning as they could be. This process provided a text which was reflective and often evocative.

The Reflexive Process

An assumption that underlies this method includes the interaction which exists between a person's experience and the expression of that personal experience in dialogue and the reflective understanding of this experience. The richest source of material is from the person's self knowledge. This knowledge develops from the ability to

formulate meanings. To discover something about the meaning of health in entering the world of the co-researcher; one must ask them about their experiences and seek to identify their understanding.

Polkinhorne (1983) elaborated on the nature of this reflexive process:

> "As we interact with the other person our experiences become interlocked. In these 'we-relationships', one person comprehends the other person's subjective meaning" (p. 209).

In this atmosphere of dialogue and reflection it is important to acknowledge the influence and interaction that ideas and assumptions have for both the researcher and co-researchers. The focus of the process is to arrive at a greater understanding of the term health through the recovery of meaning behind our awareness.

The search for the understanding of the term health will focus the interpretation on:

a) the reflexive process which reveals patterns of meaning,

b) the view that our understanding is developed through reflection and dialogue,

c) the relevance of the context and the situated perspective for each of the co-researchers,

d) the underlying definition of reality about health for each co-researcher,

e) the ontology (way-of-being-in-the-world) of the co-researchers.

Understanding Through Dialogue

Through the description of events and the nurses' dialogue on health, the research process attends to the meanings and understanding held for the co-researchers. In uncovering what nurses hold to be true about their meaning of health, it is the vehicle of shared stories and interwoven connections that is necessary to the discovery of meaning.

An interest in stories of the narrative has existed for some time (Propp, 1928; Barthes, 1974) with emerging theoretical literature (Spence, 1982; Sarbin, 1986; Bruner, 1986; Polkinhorne, 1988). These studies support the belief that human understanding can be shaped through a kind of storied relationship to events, characters and situations (Smith, 1990). This is seen through the act of storytelling, which encourages the unity of experience to include our context, our history and our beliefs. It is our personal language in narration through which we are able to relate to our own connection in the world.

Co-researchers were invited to reflect on and write about incidents in their practice which have shaped their understanding of health (see Appendix B). As we draw our subconscious thoughts into our awareness in dialogue, the written form extends this initial process since writing involves the ordering of one's thoughts into the organised

pattern of written language. As Moffet (1984) explains "the deliberate selecting of images and ideas, and of words themselves, not only breaks up routine and random inner streaming but sustains the development of a subject beyond what we have thought or imagined about it before" (p. 62). By narrating the understanding of health into words, and making the meaning available to the co-researchers' scrutiny and manipulation, writing encourages further thought development.

The interviews and journal entries provided the source for this study's interpretation. By asking searching and open-ended questions the stories were constructed in the telling and in the written reflections of each nurse. Some reduction of the journal entries and interviews were necessary to capture the context, timing and intentions of the nurses' stories in its entirety while remaining concise for the reader to follow. In wishing to let the nurses' voice speak through the stories, the stories were rearranged only where necessary. It was hoped that the meanings the stories offered would then have a sense of transparency for others as well. The co-researchers were interviewed a second time to check whether or not the edited account represented what they had intended to communicate about their experiences. The four agreed and elaborated only very slightly on the text itself.

The Context

Acknowledging the context of the co-researchers is necessary to provide openness and insight into this type of inquiry. In terms of any experience, we are situated in a particular time and culture. The context can never be replicated but by including a description of the events, the comprehension of meanings of health can be pursued. This also advocates the inclusion of the context for the co-researchers in order to identify and clarify their own understanding. Rowan (1981) suggests that "hermeneutics is an art of interpretation that is aimed toward a deeper comprehension of a phenomenon by recognising that understanding is an historical process" (p. 132-133).

Interview Strategies

Each co-researcher was invited to tell stories and relate incidents from her nursing practice in conversations which averaged up to two hours. Interviews for the study were framed by the core question: "What are the experiences which shaped your understanding and meaning of health?" Further questions focused on gaining a clearer picture of what happened and what this meant to the nurse. There were very few formal questions. Further exploration of this topic came through clarification questions, reflective silences, and nonverbal cues such as nodding affirmatively. Through these stories and incidents which the participants shared, their meaning of health emerged.

Journal Entries

The four co-researchers were invited to journalize while reflecting on their intentions and interpretations of the events, as well as document the chronology of the action and outcomes. As Moffet (1984) indicated previously, the act of writing encourages reflection and the ordering of one's thoughts. Involving journal entries in this study, therefore, developed and sustained a focus on the topic and acted to provide an opportunity for silent thought before and/or after the interview. Co-researchers were encouraged to journalize in ways which were helpful to them, and the timing and content of their entries were not specifically directed.

The Interpretive Process

In trying to hold to the question of what is involved in the event of understanding the nurses' meaning health, the assumptions about "understanding" are provided. Palmer (1969), Schleiermacher (1977), and Polkinhorne (1988) are sources for this study's assumptions:

a) understanding a text is more than providing an explanation or a rational theory,

b) understanding involves language and occurs <u>through</u> language,

c) we understand by constant reference to our personal experiences,

d) just as the interpreter's own experiences of the world is involved in the process of understanding, the stance (ontology) of the interpreter will influence the understanding that is developed,

e) the interpreter must have knowledge of the topic being discussed before a shared understanding emerges.

The intent in utilising hermeneutics in interpretation is to move to an increasingly deeper level of meaning. The encompasses the "relationships between whole and parts, between what is known and what is unknown, between the phenomenon itself and its wider context, between the knower and that which is known" (Rowan, 1981, p. 134). One must know the timing, the meanings, and the intentions of the particular situation in order to understand the specific context and impact of the incident for the individual. Schleiermacher (1977) also contends "the interpreter needs some talent for 'feeling' or 'divining' how language as a living, organic power has affected the fabric of thought and the mode of presentation" (p. 5).

Hermeneutics addresses both the task of understanding and the methodological principles to interpret and explain a text (Palmer, 1969). In order to achieve an understanding of health, much of what is fruitful in hermeneutics is through the medium of language. For Palmer (1969) "understanding (a literary work) therefore is not a scientific kind of knowing which flees away from existence

into a world of concepts; it is an historical encounter which calls forth personal experience of being here in the world" (p. 10).

From this perspective, hermeneutical understanding is a subjective experience of a text rather than an objective analysis of it. What is expressed in words involves the process of interpretation, to simplify and explain a text. It is also true that meaning is a matter of context, whereby it is only in a particular context that an event is meaningful (Palmer, 1969).

As a nurse listening to the stories of other nurses, I shared a glimpse into the dynamic, temporal and personal world of each of the co-researchers. What became clearer to me as this study developed was how natural and supportive my own experiences as a nurse were to the process of understanding. My previous understanding of health was pushed still further as I entered each of the co-researcher's world. Like pieces of a puzzle, the understanding of health began to emerge into a whole picture. Palmer (1969) illustrates this process:

> "For the interpreter to 'perform' the text, he must 'understand' it: he must preunderstand the subject and the situation before he can enter the horizon of its meaning. Only when he can step into the magic circle of its horizon can the interpreter understand its meaning" (p. 25).

Through this hermeneutic process, a sentence cannot be understood in isolation, but is understood as part of a larger whole. As the interpreter, I needed to enter the

horizon of each co-researcher, understand the context, timings, and intentions from the perspective of the speaker, and remain in peer relationships with each nurse throughout the process of interpretation. The kind of open process to include the nurses in the review of their stories led to collaborative relationships as I documented their view of reality.

In raising the research question of "what is the meaning of health for the practising nurse," I needed to be in a true peer relationship to be open to what comes through real sharing. By listening attentively I encouraged co-researchers to share their stories in a way that enabled reflection and openness to their potential meanings. This is an underlying premise of the I-thou encounter described by Martin Buber.

The I-Thou Relationship

In seeking to remain congruent with the I-thou relationship (by listening to the co-researchers without judgments or suggestions) I enabled an open dialogue. This ensured that I adequately heard the co-researcher's story, rather than screening my own judgments of the events. I was aware that body language, eye contact and affirmative nods are also important factors to encourage dialogue. The openness in the I-thou relationship with co-researchers was also supported through sharing my research agenda with each nurse (see Appendix A & B).

In a translated edition of I and Thou, Buber (1970) describes the elements necessary to the I-thou relationship:

> "The basic word I-You can be spoken only with one's whole being. The concentration and fusion into a whole being can never be accomplished by me, can never be accomplished without me. I require a You to become; becoming I, I say You. All actual life is encounter" (p. 62).

The encounter presented here is an essential act in life for Martin Buber. In his notion of persons and things, he presents his notions of relational processes and states:

> "Relation is reciprocity. My You acts on me as I act on it. Our students teach us, our works form us....How are we educated by children, by animals! Inscrutably involved, we live in the currents of universal reciprocity" (p. 67).

Given the understanding that this study is an encounter of an interpreter and co-researcher involved in the process of understanding health, the notion is pushed further to include the reader. This study does not seek to provide an explanation of health, but invites the reader to bring a personal experience to bear on this work. It is intended in the presentation of this research to have the reader share in the original context as much as possible. This process invites further meaning to develop for the reader, as the nurses' experiences and understanding about the concept of health is rich in depth and substance.

Considerations for this Study

Because the key focus of this study was to add to our understanding of health, attempts to discern or attribute

meanings to other issues were not made. Issues surrounding patient care and the limits in the health care system are potentially areas for future research.

The understanding of health presented in this study are also acknowledged as a collaborative work of two parties, that of the interpreter and the co-researchers. Thus the meanings of health are examined, articulated, re-interpreted or reformulated through both the co-researchers and the writer. It is on the basis of the descriptions of events surrounding health for the co-researchers that views on health were shared.

The findings of the study are intended only to portray the meaning of health from the perspective of the nurses who participated in the study. The nature of this inquiry therefore does not stress generalizability but is an appeal to each one of us to understand how we are aware of health personally, biographically and situationally.

In summary, the methodology and its rationale is discussed in order to support its use in this study. Hermeneutics, the reflexive process, the co-researchers, the context, and the interpretive process is described. The goal of this methodology is to develop an understanding of health from within the nurses' practice.

CHAPTER 3

THE STORIES

The stories that are presented are the conversations and journal entries shared by each of the co-researchers. The stories are presented as they are expressed and edited only to facilitate the flow of the story. I have chosen to present the order of the separate stories chronologically, in order to capture meaningful moments which may elaborate on earlier events. Each of the co-researchers is introduced briefly to let their voices speak through their stories.

TABLE 3

DEMOGRAPHIC CHARACTERISTICS OF CO-RESEARCHERS

Name	Age	Occupation	Educational Background
Christine	34	Head Nurse	Registered Nurse (1979) Operating Room Diploma (1983) Bachelor of Science in Nursing (1988)
Lauren	32	Home Care Agency (Supervisor)	Registered Nurse (1981) Community Health Bachelor of Science in Nursing (1990)
Lucy	35	Student	Registered Nurse (1979) Bachelor of Science in Nursing (1992)
Jill	36	Acute care Nursing	Registered Nurse (1980) Bachelor of Science in Nursing (1988)

CHRISTINE'S STORY

Christine is a brunette woman of 34 who shares her world with two very loved cats. Her blue eyes sparkle as she discusses their antics as they play together. This suggests a great capacity to enjoy life's moments.

Following two years at university to complete her BSN, she now finds herself in a busy and challenging role as head nurse after working the last 11 years in various medical and surgical settings. In the future she plans to be pursuing a new challenge in the area of Psychology with a Master's program. These interests in acute care and in the area of mental health have long been a part of Christine's way in the world. She is very intuitive in dealing with people's needs, both personally and professionally.

Connecting

> I can think of a patient when I was a student nurse. Tom had a whipple pancreaticoduodenectomy. He was not doing well. He had a number of leaks in his anastomosis. The bile leak was essentially eating up on his inside, he had massive amounts of drainage from this and was in a lot of pain. I did everything I could possibly do to think of how to help him with his pain. Even when he was uncomfortable he was a very stoic man. But Tom was very, very pleasant too and I remember feeling very compassionate towards him. I wished I could do more; and wrestled within myself

knowing that I couldn't do more. I knew that just being there could be helpful, but wasn't sure of that. I said to him, "I wish there was something more I could do. "Tom said, "oh you've done all you can dear."

When he said this I touched his hand and it was like something really connected. He just looked at peace and it felt like energy flowed through both of us. It was very spiritual. He did calm and sleep after that. What touched me deeply was not what he said, but the way he said "you've really helped." I could see that, that touch had connected for him as well. I connected on that emotional-spiritual level that is hard to describe exactly...it's more of an experience... and I just knew he was OK and he knew. It was like he had a trust in me and was able to let go, relax and trust me to take care of him.

What I received from him somehow made both of us whole, and I felt I had really made a difference. Having done that little extra, and staying open to receiving from him instead of just giving made the difference for me. I knew I wanted to desperately make him comfortable, and yet he was uncomfortable until we went through this. That lessened the trauma of the pain and he was able to be at peace even though I knew the medication wasn't taking all the pain away. It was one of the most beautiful times in my career as a nurse.

Christine's text discloses the feelings which helped her resolve her wish to help Tom deal with intractable pain. It was the nature of the connection of the nurse and the patient which is articulated clearly by Christine. Her words point us toward understanding the essence of connecting with others and invite us to reflect on what it means to help others in our presence.

Control

> Sometimes when someone has had a really rough time they need to pick on every little thing. It's just the shock of having to go through an illness and that's just their way of expressing "I don't like feeling out of control." I think it's important for us as nurses to be able to accept that that's just what they're saying. Seeing that as a barometer check and then to look for things to help them.
>
> Control issues often come up with patients. I'm sure I would have a hard time with control issues as a patient myself. I think it makes me even more aware that we put them in a hospital gown, take their clothes away and give them a band with a number on it. We don't even let them control when they get their meds, and we take all of that away from them and wonder why they look for ways to control their environment. They don't necessarily say I'm trying to control my environment but if you really listen to what's going on

and step back it can help you understand. It can also get at the real problem and help the person feel more in control.

There's Earl who came to our unit with a long history of vascular problems. Although he is just 57, he was in for a last ditch effort to save his legs. That involved the joint effort of three vascular surgeons who were to do an extensive bypass graft involving the descending aorta through the axilla area and down to his femorals, with a cross femoral graft and a femoral-popliteal graft.

Preoperatively Earl was very inappropriately suggestive with nurses and very controlling of his environment. He then told the Social Worker about his fears of surgery. When he was given his Demerol before surgery he began to laugh loudly and hysterically over trivial things. He kept singing jovially "Hang down your head Tom Dooley, hang down your head and cry, hang down your head Tom Dooley, poor boy you're going to die."

Postoperatively he came back to us after a few days in the Intensive Care Unit. Earl's disposition was much better and his surgery is so far a success. He still likes as much control as possible, for example, he chooses when to have his morning bath and when the lab technician can draw a blood sample.

Earl has been told over and over to quit smoking and has had a healthier lifestyle explained to him. Yet here he is again. He has been labelled "non-compliant" and criticised widely for the fact that he still smokes even after all these years of vascular surgery. It seems that what fuels our criticism is that somehow people should be able and willing to just change when they have the knowledge of what is best. I have to wonder how this attitude biases our approach to truly helping Earl to change and to support him through his pre and post-op fears as a person!

Dependence

I wondered at the time, what about those patients who don't know and maybe are afraid when suddenly they have to depend on someone? That rests on issues, like can you depend on someone...can you even trust someone. Denying illness seems to be our biggest barrier to achieving health; and that feeds the illness. We just expect people to act differently because if there is no illness, there's no need to be acting inappropriately. We accuse each other of not trying, thus perpetuating the negative environment and greatly inhibiting our healing process.

When you take the time to reach the patient wherever they are personally you get better responses. There's less anxiety and more trust. Recognising

what's been happening as unhealthy behaviours as a result of illness, both gives the needed hope for recovery and the needed direction to take to reach it. It tends too, to provide the needed tolerance of the process of getting there. When we believe we can change; we do.

For Christine, helping is more than a selfless act of the nurse. She demonstrates how the action of helping embodies doing what is fitting for another, and this ensures their well-being. Christine seeks to bring a sense of wholeness and peace to her patients.

The Nonverbal Message

When I think of health, I find it difficult to really give that a definition. It's really more something I sense as much as I understand intellectually. I tend to use my intuition to understand what I'm doing. I do see it as a holistic thing where it's very much the whole person. I can see it with a recent patient who complained about his nursing care. His experience in the hospital was not positive and even though he healed from his laminectomy I believe he is still working through much of this. Even though he wrote a letter of complaint, it indicated he is still healing from that and he is not there yet. So in terms of health he is not healthy yet and I don't know how long that is going to take him.

This is going to affect other things, his next hospital stay, and it's going to affect his whole attitude towards being healthy. It's difficult to describe health without describing its opposite; what's unhealthy.

There is something more and deeper than just the physical language and the verbal language. If you let the person know that you really are listening, and that you care in a nonjudging kind of way. Even if it is with something I totally disagree with, I find that a challenge in nursing, in working with people anywhere, is to be able to help them to express and accept themselves. It often helps them to see whether they really believe in what they're saying and often they can see the gaps themselves. It's important to feel accepted just the way they are and where they're at.

How do these convictions about doing what is necessary in Christine's nursing practice take root and grow? What are the insights and influences which forge this belief in her work? It is further in the text of what Christine discloses about her experiences with her own health which sheds light on these questions.

Care of the Self

It's a very important part of my own life in going from unhealth to being more healthy. It's OK to be me, even with all my faults. Yet as part of that paradox

with a weight problem, it is in focusing on the weight that I'm unhealthy. I used to fight very hard with that, constantly dieting and constantly upset. That was even more unhealthy than the weight itself. Now I can be more accepting that I am not my weight, my weight just happens to be and it still needs to be worked on, but the me inside the body is a lot healthier than I was a few years ago. That's been a part of the emotional and spiritual growth that I have grown to be more healthy.

A big change was in separating attitude from behaviour. That is a more healthful way to approach it. To say "I am not that behaviour" I just happen to have certain behaviours that I want to change. Behaviours are learned things and when I can learn a different way it gives me hope. You can replace it with something else, instead of going back to old behaviour, it tends to really undo all the negative feelings and responses. I responded very negatively to my whole world, with my unhealthy image where everybody was reading between the lines and assuming that everyone was critical.

Now that doesn't stop me from doing things in life, whereas before it would stop me, and that's what I consider being more healthy and whole, because now I'm not inhibited by what others believe. I'm seeing

how I choose to limit my life by what others were saying to me. Now it's not attached to my person and I can look at it more in perspective and accept myself.

We strive towards a perfect world, whatever we are ready for and growth helps encourage us to work on growth in other areas of our lives. It tends to be a positive circle, the better I feel about myself, the better I take care of myself. I had to care for myself before I started to care about my health. I know that so much of myself is reflected in the way I care for patients, and to understand what they are going through. It makes me a better person, more healthy for it.

Christine's experiences with her struggles with a health concern beckons us to gaze thoughtfully upon her experience.

Interdependent Relationships

We can be very independent and yet very interdependent at the same time. That's a unique paradox in life. That's part of being healthy when one can accept being part of that and to appreciate that. In terms of any health condition that is interrupting someone's well-being, then there are certain types of interventions for whatever type of condition it is which guides what we do towards health. Health seems to be different for every person, and they have a

different perception of what that is. There are healthy people who happen to be paralysed and in a wheelchair. I like to think it's there if they are happy and well adjusted in their life with the presence of independence and autonomy.

Being in touch with yourself spiritually is a very important aspect of my life. Healthiness is again my relationship with my God. That denotes a lot of unhealthiness when I see I am out of sorts in my relationship with my God. That affects everything else in my life. Often that's when I get a cold, or when I'm not coping well in decision making. It seems so intertwined that everything works better when I'm more in balance, that's when I'm healthy again. I don't know if anyone is ever purely healthy because we're all dealing with something. So in a pure sense health is never achieved. Maybe that's why it's so difficult to define something that is perfect, and we're not perfect.

Throughout Christine's narrative we are able to discern a moral: that of interrelating and connecting with others in achieving health. Christine's text calls into question the present alienation of human kind and bids us to recognise the importance of commitment to dwelling in a respectful relationship with one another. It is in the act of being drawn in to these relationships, both with others

and her God, that Christine gains a strong sense of self. Health is an elusive goal in Christine's view, where she describes it as "something that is perfect, and we're not perfect." If we understand what this ideal relationship is between us, we may understand this glimpse of health in her orientation to the world.

LAUREN'S STORY

Lauren is a tall, slim woman whose easy grace and poise hides a buoyant exuberance for life. Only the mischievous twinkle in her blue eyes and a ready laugh hint at this. While only in her early 30's, Lauren has worked everywhere from surgical, intensive care and to home care nursing settings. She responds to her nursing career with an appreciation and understanding for the many patients she encounters. This deep awareness of others is transferred to her present role with those involved in home care services.

Lauren looks forward to her future involvement in her nursing practice in the community, while expecting her first child. Her eyes reflect pride as she and her husband remodel their home and plan for this new addition.

Loss of Identity

> I had worked in an Intensive Care Unit in a large, downtown hospital in Toronto. I remember this as a very unhappy time as it was so far removed from the way I wanted to practice. Somehow I found myself taking an ICU course when I had wanted a change in my job. I stayed to work in the ICU for almost two years because I had a hard time giving this job up even though I didn't like it.
>
> I had a patient I remember very well. Mark had many MI's, with a lot of arrhythmias which were life threatening. His cardiologist/surgeon wanted to

perform a procedure called cardiac mapping, which at this point was experimental. A piece of netting, similar to what you would have over a roast, is placed onto the heart, and then they take out chunks of the myocardium. In trying to find the irritable part of the myocardium that is setting off the life threatening arrhythmias, they stimulate the areas and take out any bad area they find.

After the surgeon had taken out a lot of his myocardium, Mark had an incredibly long pump run, and he continued to have arrhythmias. He wasn't even all there mentally anymore because he'd been on the pump run so long that he had some air in his system. He was placed in one of the end rooms, where we place the ventilated patients or those who had failed surgeries and were going to die.

He was being sustained on many different drugs in order to maintain his blood pressure up, on the ventilator and to keep him comfortable. His family were there every day and were very supportive, but really there was no hope that he would come off these medications.

Then, I have never seen anything like this, but his body wasn't able to manage fluids at all and his whole body became extremely edematous. Mark ended up

with systemic herpes and he really looked terrible with herpes all over his face and body. I mean he really looked like a monster.

I remember how awful this was, but what was worse was how focused the nurses were on the routine, they were very organised and meticulous. I felt that we were removed from the people that were there. The coldness of having a purely technical view of that person and getting wrapped up in that technical stuff and forgetting about people. It had to be technical there because their condition was so labile. You had to concentrate on the blood pressure going up and down, and there is a place for that, there definitely is, but it wasn't my place. Mark was not treated like a person, with respect. He was more an object that lost his identity. This was somebody's father, and somebody's brother.

I wondered why he had this procedure. Was the surgeon thinking about her research at the time or about the quality of what Mark's life would be like? It was hard seeing that family come in day in and day out, and try to keep their heads up. You have to be brought back to that sometimes.

I feel the unhappy times there in the ICU were because it was even more impersonal than I could imagine. I just didn't feel that I was like the other

nurses. The other nurses tended to keep the patients sedated, and they were highly organised, smart, technical nurses. When somebody died and someone had to go tell the family many of them would just fall apart. They couldn't cope with this. For me this was my strength, I liked to be able to relate to people and really talk to them. This was the part of nursing that I felt good about.

Lauren's narrative shifts to recount events in her move to practice nursing in the community. There her descriptions evoke a holistic encounter as she sees people in their homes on a daily or periodic basis. Although this nursing setting is far removed from her earlier experiences in acute care nursing, the health problems and concerns share remarkable similarities.

Dignity

One of the first cases that I had in the community was Mr. Moore. He had pancreatic cancer and was dying. His wife was a nurse administrator with one of the big downtown hospitals, and she knew what was going on. Caring for a dying client was not new to me as I had worked on a surgical floor which often had up to 20% oncology and palliative care patients.

I remember going in the house and just having a really nice talk with Mrs. Moore. She explained how they had set up their home with oxygen, a hospital bed,

a commode, a bedpan and everything else. Their four sons had all taken a leave of absence from work so that they could be with their father.

When they took me upstairs to see Mr. Moore, I could see he looked really end stage, and I knew he wasn't going to be around for a long time. It was beautiful to see the care and the set up, they really had everything they needed as they were together. I told Mrs. Moore "why don't you go lie down or something as I'm going to give him a bath." I was there for about an hour, I finished my assessment and care and made a few recommendations for mouth care. I was ready to go when Mrs. Moore came out of her room and she told me she had fallen asleep. She said "I knew that when you were here I could relax and felt that he was going to be OK and be taken care of."

I just remember walking out of the door and I just almost started to cry. I think I did a bit thinking, 'my God, that's what I have wanted to do all these years and it wasn't like that in the hospital.' That I was able to get across to others that I'm there to help them 100% and that I'm not there for my own reasons was really important. It was important to me to be able to connect with a person; to have them know you are listening, that you respect them, and that you are a very trustworthy person there to help them.

That's when I thought back to this one patient that I looked after on the surgical floor where it was more of a team approach and we were looking after everybody. Douglas was dying of cancer and on Morphine. The nurses weren't going in to see Doug much except to give him his medication because there was nothing they could really do for him; we knew he was dying.

I remember going in when Douglas was very short of breath and hallucinating. He was picking at the air and it was obvious he was going to die within the hour. I sat down on his bed and I started stroking his forehead and saying "its OK, just let it go." You know I thought 'this is somebody's father, or somebody's brother and look at the way this guy is passing out of this world. In this sterile room, he's got no family here, he's hallucinating and he's in some uniform that the hospital has put him in.' It just seemed so wrong.

To see the other situation in the community made me feel so good, you know this is how it is supposed to be. With Mr. Moore there was so much more respect shown for him. Considering him, giving him dignity, and to have his family there. People seem to loose all that when they come into the hospital. When somebody is dying its all the more important somehow because they're vulnerable, and you want to treat them right.

People are very complex, and there are so many things that we can do to make them have the best death possible, the healthiest death.

Lauren shares how her encounter with Mr. Moore and his family marked a turning point in her ability to practice nursing in a different way. It is her stance on how she wants to be in her nursing practice which identifies much of her meaning and understanding of health.

Making Choices

I recall caring for Greg, a guy in his late 20's. He had a massive GI bleed due to a gastric ulcer. The staff in emergency nearly lost him as his haemorrhage was so severe. He was transfused and quite a skilful surgeon saved his life with surgery. The only reason I had occasion to meet him was that he developed a wound infection which needed treatment and monitoring at home.

Greg was on my caseload for almost a month until the wound completely healed and I discharged him from home care. In my first few visits I attended to his wound and concentrated on building a rapport, explaining my actions. He was a very shy person and I knew this was particularly important.

I read up on gastric ulcers, the etiology, preventative measures and the forms of treatment. When he was more comfortable with me we began to talk about

the incident in emergency and gastric ulcers in general. There was a rapport we were able to develop. I think if that hadn't happened I wouldn't have understood details about his life and that he wanted to change but didn't know what to do. I learned that he actually knew very little about what caused the ulcer or that he needed to make any lifestyle changes, or indeed that his actions contributed to his health at all. If there was no follow up to help him understand how his lifestyle could affect his health, it was only going to happen again.

I began to teach him in my visits. We talked about nutrition, smoking, drinking, and stress as Greg's lifestyle contained some very important risk factors for ulcers. I left him information to read, drew pictures and urged him to obtain a book on stress from his local library. We then discussed portions of this book at each visit. I felt it was important to have Greg start to seek out information for himself to increase his knowledge of caring for himself.

It really hit home; it's just amazing what a difference it makes to a person if there is someone coming in as an extra support. There was time in the community to analyse the situation, problem solve and sort our way through. Greg taught me about the system and how it had failed him. Just how important elements

other than the physical element can be, and how important it is to recognise and deal with them. Our relationship was respectful and trusting and brought out all those things that I found was really satisfying.

A big part about health is that people are looking after themselves. When they are able to take control and learn from a situation, perhaps they may not be able to do everything for themselves, but they would know to ask for help. There are situations where you can't survive on your own and there are times in order to stay healthy you need a good support system. I think that's important. That has a huge affect on someone. So many of the patients that I see have no idea that the way that they are thinking or that the choices they have made, have contributed to their health. I think I would see someone who is healthy has got to be very open minded.

Lauren's narrative portrays a connection with others that is rich in scope and depth. For Lauren, her way of holding each person in high regard is evident through the text and within her nursing practice. We are brought back to her emphasis in how she wishes to be understood; "it was important to me to be able to connect with a person; to have them know you are listening, that you respect them and that you are a very trustworthy person there to help them." It

is this way to be in the world which becomes the hallmark of what is meaningful in realising health in Lauren's nursing practice.

LUCY'S STORY

Lucy projects a cheerful and happy persona with a facial expression that suggests she is anticipating a humorous punchline. She delights with everything life offers, and although often quiet, can in a voluble manner speak of those things that are meaningful to her. Along with her humour, Lucy shares herself with others in a very caring manner. In a calm approach she brings a sense of comfort and a deep interest in the lives of others.

Lucy's inner strength and determination in dealing with a chronic health challenge are evident in her achievements. Having worked on various medical units in Canada and in the United States, Lucy has spent the last years in school completing her BSN. The future possibilities in her nursing practice are just beginning to be realised.

Hopeful Expectations

> I still I remember the situation with Wilma, this patient in her 60's. She was a diabetic and had had her left leg amputated at the hip. Wilma was in pain no matter what we did. It didn't matter how much Demerol we gave her, even if it was a half hour before we were to do the dressing change, it didn't do enough. I still remember having to soak the dressing off with saline and then having to pull away any dead tissue that was gangrenous. It was green and black and pink in a couple of places and the dressings were always

saturated with serosanguinous, pus and purulent stuff.

I just felt so sorry for her because to me she was a real hero. Wilma would lie on her right side and she wouldn't cry out but occasionally she would just gasp during these procedures. I would try to not take too long because I didn't want to prolong her agony or cause more pain. I always hated this.

One day she was in tears after this procedure and she said to me "do you think I'm going to live?" I was surprised and I didn't know what to say because her incision was gangrenous and I think she was starting to become septic at the time.

I knew Wilma was religious. I answered her and said "I don't know, it's in God's hands." She was still in tears. I don't know what prompted me but I asked her if she would like me to pray. I didn't even know what to pray, but she said "Yes that would be very nice." So I prayed for a few minutes, she was so grateful for this. I told her I really hoped that whatever happened was what she wanted.

I think that basically people know what they need and what they want in life. Their understanding of health may be totally different from ours. In some ways people reach what they think health should be for them. I think it varies at different points in your life depending on your situation.

Obviously if you are fairly well then optimum health would mean keeping a nice balance between the social, psychological, spiritual and everything else. If you were well then I think that's what everybody's ideal would be, but I think it depends on what state of health you are in at the time. But no matter what your health is like, everybody needs to have hope.

I felt Wilma's health at the time would have been just to feel comfort and at peace. I knew she needed some hope and to be at peace with herself and with what was going on. If she did improve then that would probably change as she improved. You start out for what is possible within your reach.

The proposition that health can vary depending on the time in one's life is echoed in Lucy's personal experiences with health challenges. She describes her struggle with a chronic health challenge to detail what she needed at different times to experience health.

Giving up Control

I think control and health are tied together at least at some level. For me control has been very important. The healthier you are, the more control you do have about what you can do and how you can maintain your health. The sicker you are the less energy you have to think about how you can make things different,

and how you can help yourself. This is true with my own experiences as a patient. I have been in and out of hospitals since I was one when I was diagnosed with asthma.

The worst time in my life was in January of 1986. I had spent several months in hospital, and my chest specialist told me I would never get off the ventilator if I even lived. I couldn't think of any way to have a healthy thought, although I tried to be positive in front of my family. Once I tried to commit suicide. I tried two nights in a row to commit suicide and I was so angry with God for not letting me die when I wanted to die. It was difficult to do in the intensive care unit, because of all the monitors and everything.

After giving up on this, I started to want to prove my doctors were wrong. At that point all I wanted to do was to heal. I was determined that I would get off my ventilator at least for part of the day. I think at that time what I needed for health was to have someone to talk to, so that I could feel some sense of peace. My Mom had gone through a lot of strain and couldn't carry any more stress. She knew I was depressed, but I couldn't tell her I had tried to commit suicide. I think the biggest thing that helped me was having someone who could be objective and listen. I knew the basic thing I needed was to feel

some semblance of peace, so that I could at least unburden everything that was troubling me.

Lucy's experience of dealing with a chronic respiratory disorder has at times created serious health challenges. These experiences in Intensive Care and in Respiratory Units shape her image of health and of what is important in restoring health. Lucy describes her personal struggle to make her choices for her life.

Growing Strong

> In a way, health does become everything. I agree with that WHO definition of health, where I forget what the wording is, but it is not just the absence of disease, it's the whole general well-being. I just believe in the holistic definition of health. It has to encompass everything about that person, spiritual, physical, psychological, social and even economic aspects. A big stressor I had recently was money. It got to the point that I didn't know how I would pay the bills for the end of the month. Sometimes it was almost better to be in the hospital because I didn't have to pay for food, that helped to reduce the financial stress but I'm sure it didn't help me to be in hospital either. I can see how everything needs to be considered because it all affects health in a person.
>
> I don't think people can be healthy unless they

feel good about themselves. I feel so strongly about that. Sometimes they can't learn to feel good about themselves unless they have an advocate. My doctor influences me in how I feel about myself. He has always told me to stop being hard on myself. Often he tells me "be kind to yourself" or "be gentle to yourself". He always respects me and talks openly with me. Its taken me years to get to this point because I had such a poor self esteem and self image. In fact I'm still not where I want to be but at least I can accept myself and forgive myself.

As a nurse, sensitive to the facets of her chronic condition, Lucy's story is poignant and yet it remains hopeful. Having come to the point of rediscovering control, Lucy sets out to prove the predictions are incorrect.

Rediscovering Control

People get tied up with physical health and yet there's so much with psychological health that's affecting what's going on and is so important to a person. There were times when I was in the hospital and the thing I needed most was something simple like having my hair washed. Some of the nurses didn't want to wash it because they felt I was not well enough. This made me angry. There were times where the head nurse would get really cross with me because I had my doctor write the order to have my hair washed.

I can understand that the nurses felt that this could set me in the wrong direction and I would have to return to ICU, but I knew it would make me feel so much better about myself. If it's important to someone's well-being then I think even if it looks risky, it's more important to do it. That's the way I wish they had viewed it with me.

The only times I didn't like being a nurse were times when I couldn't give patients what I felt he or she needed most to feel better about their situation. If someone was really upset and I was too busy to spend the time with that patient, whatever their problem was, I would want to get someone to help them.

Knowing Best

In general I think people live the way they know best, and the way they know how, whether it meets our values, beliefs and expectations or not. People come from different environments and different situations and I don't feel there should be any judgmental statements made for any reason. It does more harm than good.

The more success you have, the happier you feel about yourself. The better you feel about life the more you are able to cope with things that come your way. You know you've got those successes behind you which builds more confidence. I've been praying for

> years for improved health. At one point I was so weak that somehow it felt constructive when I didn't know if I was going to live or die because I just couldn't cope with the way things were at the time. Self acceptance may need to be a prerequisite for self advocacy. I know the stronger one's sense of self is, the more likely that you will have more than the average amount of good health.

Lucy's words disclose the deep tension she experiences in her attempts to support others in their health. The morality of intruding and interfering in the choices of another is brought into question. Lucy seeks to have an environment which creates success for others by encouraging and supporting those in acts of self advocacy. For Lucy the only way to be in the world is to have a position in life that builds on success. It is this that has been meaningful in realising health for Lucy and those within her nursing practice.

JILL'S STORY

Jill is a 36 year old woman who shares her world with an exuberance and vitality that is hard to miss. Jill's warmth and ardent approach to life is evident in her friendly smile. She talks freely of a busy and rewarding home life with her husband and her teenaged niece. Her eyes reflect pride as she talks about others and their abilities, suggesting a great capability to support and build others up.

Jill has worked in various medical and surgical areas over the past 9 years, and took time off to complete her BSN four years ago. Jill continues to practise her nursing at the bedside on a busy surgical unit. Her nursing practice reflects a deep sense of honour and commitment in dealing with others. She shares a warm and personal approach with patients, and often considers them part of her larger family.

Self Acceptance

> We had a young fellow, Terry, who was in a motorcycle accident. He lost three of his limbs. He lost a leg and two arms and the surgeon was able to reattach the opposite arm onto the opposite stump, only because the other arm wasn't viable. In some ways this was done for cosmetic reasons. Terry wasn't expected to get much function back afterwards.
>
> I cared for him a few months while he had a number

of surgeries. He then left to go to Vancouver to get fitted with prosthetics and to learn to walk again.

I remember Terry came back to the ward around Christmas time to visit us. We just had carollers who had come to sing for patients on the unit. Terry wanted to show us how he was doing and he came up in a wheelchair without any of his prosthetics on. He stood up and with one pant leg folded up and although he had a jacket on, if you looked closely you could see he didn't have a hand there. He looked kind of unusual.

The carollers happened to come the moment Terry stood up out of the wheelchair. He leaned over against the wall and the children came around us. I felt definitely not ashamed, but I felt embarrassed for him. At first I stood really, really close to Terry, almost as if to hide his missing arm and leg so that the children wouldn't see his deformity.

But Terry wasn't upset about his situation at all, he was happy. From the outset he had never looked back. It was as if he said "this is the way it is and lets get on with life." I still have that memory of how I stood there to hide him, but Terry was OK with it all. I learned the importance of self acceptance that day.

Jill's text relates her impressions and her experience in dealing with deformity and loss. A considerably

different life and set of challenges faced Terry as he progressed through the stages of healing from the loss of his limbs.

Changing Perceptions

I also remember a young fellow in his early thirties who has been on our unit a number of times with very bad decubitus ulcers. Harold is from a reservation along the West Coast. He had grown up in an environment where there was no future for him, except that he was a very good soccer player. His whole world ended when he was in an accident and became a paraplegic. When I first met him he was a very angry person.

When I first saw Harold he had open wounds to his buttocks that I could put both my arms and elbows in. He had these very bad ulcers from spending most of his time sitting in his wheelchair in the same position. I'm not sure how young he was when he began drinking, but Harold would spend most of his time sitting in the bar. There he would neglect his bowel and bladder functions. With his lack of bladder function he would wear a leg bag but would let this bag become too full so that the pressure eventually created a huge ulcer on his leg. He also would be incontinent of his bowels and would continue to sit at the bar for hours. I don't know how he could neglect himself so much.

The fact that Harold never went septic or anything was amazing with the ulcers he had. Eventually these ulcers were repaired and he had to have a colostomy. Over the nine months on our unit we got to know him and understand him, but I still remember when he first came to us how angry he would get. He would tell us off, swearing and throwing things in his reach. I learned it was better to go in and do your work around him and be done quickly. He was very strong, and could take a cart and throw it against the wall when he was angry.

I realised we wouldn't change everything about Harold's situation but I remember near the end of his hospitalisation when I had been sick and felt quite nauseated. I was working in his room and I had told him I didn't feel well. Harold said "oh, when I get like that I take a couple of Tylenol. You should do that." I had leaned over on the supply cart, and here was Harold trying to make me feel better! It was the first time that I saw him care about anybody at all. When he left he had written a message to us. It said "you don't realise what you did for me, you all made a difference." It's not like we ever cured him or solved all his problems but these were real changes.

Reassurance Through Touch

A story that has always been significant to me is a moment I shared with Marian, a patient I had almost

two years ago. Marian was a very thin, frail lady. She was admitted with chronic obstructive pulmonary disease and she also had a history of cholelithiasis. Marian was a very interesting lady from New York where she used to be a jeweller. She had no family here and in a sense we were her family.

Marian was in a private room down at the end of the hall. Many of the nurses didn't want to go in her room 'cause she looked awful, sounded awful, and you felt very helpless. She had a difficult time sleeping with her nausea and with the COPD she was also very, very breathless. Unfortunately they [physicians] were not able to do anything because she had serious heart problems. I remember I was giving her as much medication as I could but there was nothing else that I could possibly do to make her breathing more comfortable. So I asked her if she would like a hug.

This frail, little lady raised herself out of the bed with all the strength she could muster, to give me this wonderful hug. It was more than I could give her. I think, in her way of knowing, we both needed this hug together and she helped me as much as I helped her. After the hug she looked much more at peace and actually went to sleep. I think she felt more reassured. She felt that somebody cared.

We are still technically oriented in many ways and

often times we forget the simplest things. It's actually the little things that are important too. It's not just the medical side of things, but it's looking after the spiritual side, the emotional needs, and including talking and touch which is so important.

Jill's reflections relates a very moving moment in her practice as she experiences the reciprocal richness of human touch.

Rest

One of the most important aspects of what I see is necessary for health for my patients and myself is sleep. I believe that rest is really very important. I do everything I can to ensure my patients get a really good night's sleep. The things I do to encourage this is quite simple and nothing earth shattering. It is something that I've done for years, and I find that it really makes a difference.

It's not something I do to make my load during the night lighter because these patients never wake to ring the call bell, but I know there has to be benefits. The research shows that rested patients do better, and I think their stay in the hospital is shorter. They have a much better recovery.

The things I do to achieve this with my patients is simple. I don't encourage them to stay in bed

during the day, unless they really need total bed rest. If they want to take a nap, I suggest they lay on top of the covers because I feel that if you lay on top of the bed with blankets there is a difference between napping and sleeping. I think once you're under the covers you're actually sleeping and that should be during the normal times you're used to at home. Sometimes I find that by eight o'clock in the evening patients have been sleeping most of the day. This can lead to chemical dependency on sedatives.

I don't have a problem with giving patients sleeping pills but I find there are often other measures which should be tried first as they're more helpful. Our ward policy is not to give HS sedation after 0200, so if I have a patient who is awake then I first ask them to walk. I've gone to several sleep disorder clinics and they suggest that you should walk and not lay down if you can't sleep. It works to do this instead of taking more sedation. When I have patients who really require sedatives to sleep, then I give it and encourage them to be active during the day and only nap if they need to.

The first thing I do in the evening is that I go around and speak with every patient. I take the time to ask them how their day was. We talk about the tests and procedures which went on for them, and I ask them

how they feel about things. I then ask them if they have any concerns or worries and I just try to provide the reassurance that somebody is listening, somebody cares. I take a few minutes and just listen to them.

It's easy to see with these patients, whether they are preop or postop; they need to relax and be reassured. I think these patients benefit, and I think they go home sooner. Just the fact that I've listened, and taken an extra bit of time to settle them at night makes the difference.

I also offer all my patients a snack and a back rub in the evening because they actually rest better. I know that some of the nurses that I work with think it's crazy to give back rubs. I've been told that if we give back rubs all the patients will expect it, but it's not something I could give up for patients. Some patients may not want it and that's quite all right. Other nurses who try this all agree that it helps and it has always seemed to work for me.

It seems like something so basic that I learned years ago when I was in my LPN training. I remember as far back when I was in grade three being concerned to get enough sleep at night. We had a teacher who had this thing up on the board which said every student should have 12 hours of sleep every night. Ever since

then I have counted every single night to get the hours I needed. So sleep has always been important to me.

Jill's words and actions illustrate her awareness of the qualities that sleep and rest have had for her patients. In this narrative she details the nursing activities which have become important to her practice with her patients.

Peaceful Transitions

One of the most difficult times I've experienced in nursing was a few years ago with a patient who I became very attached to. Violet stayed on our unit for 7 months, and I got to know her well. In fact, she made us little Christmas ornaments, which are wonderful because the material she used was the same as her housecoat which she also had made.

Violet had surgery to her mandible, and after a slow recovery, she then had two strokes a week apart. I just loved her, and although I was her nurse I couldn't see that she could die soon. I kept thinking that we could do things to bring her around.

But soon after her second stroke she coded. I didn't want to see her die, I wanted everything done to resuscitate her. With her earlier surgery around her neck area, the scar tissue and a skin reaction to the tape used caused a rigid neck position because the skin had become so tight. I knew intubation would be very

difficult so I brought in a tracheostomy set because I wanted the anethetist to trach her. I thought that was the only way she could be resuscitated in time.

The anethetist had a lot of difficulty intubating her, and I was very upset when he didn't attempt to perform a tracheostomy. He let the intern practice on her, and I knew she was gone. It was a long code, and it was an awful, awful time. I wished they would stop. I was upset and crying through this code. I wanted it to be over.

Violet's family called me to tell me they knew the day before that she was going to die. They were able to see that her condition was so poor, but I couldn't see it, I was too attached. On Monday, I was at home and I knew Violet was there. I never saw her, but she was in the room. Violet was a very kind person, who loved us all very much. I got the sense that she was there to make sure I was OK. When I phoned the family to tell them, each family member had all had the same experience. That was a very special experience.

That brings me to the time when my dad died. I had taken a course on grieving, and we learned that the 52nd day is the hardest. This is the time when you have been surrounded by all the support from others, but people get back into their own lives again. You're left alone to cope and you're not ready to cope.

My dad had told me earlier that year that he was ready to die, but he died very suddenly. He was an avid golfer and only 68, but I felt comforted because I knew he was ready to die. We had a very close family time after my dad died, but there was a point when I had a very difficult time dealing with it. I had dealt well with my dad's death, but on the 50th day I got very angry and I was angry for 3 months. I thought I would never get through it. It was a very taxing experience and I felt very alone.

While at work one day, I was in a room with Frannie helping to wash her hair. It was entirely phenomenal that I would inquire into where this lady was born, to discover she grew up in the same small town as my dad. Amazingly enough they were next door neighbours. Frannie talked about her life, and how my father and his family had influenced her. My anger and grief changed that day. I could see there was so much to be thankful for. It was so timely for me. I came to really appreciate Frannie. In many ways she helped me to feel at peace after the death of two people I loved very much.

Jill's account goes on to divulge the deep sense of commitment she experiences with those who are dying. Within the resolution of accepting the loss of loved ones, Jill continues her engagement in the lives of others.

> Saying goodbye is really important to someone who is dying. I think it can be done tastefully if you know the person isn't going to live and you don't know if you'll see them again. I'll go to the patient and depending on whether or not they are conscious or not I would tell them goodbye. It's really a privilege to be there.

Jill's practice reflects a personal philosophy which values a person's achievement of peace, rest, and acceptance in order to reach one's potential of health. She is able to draw alongside in support through difficult transitions. Her willingness to connect with her patients through touch and maintaining emotional and spiritual links, portrays her awareness of the impact this contact has for others. For Jill the only way to be in the world is to respond to these transitions in order to bring a sense of peace and affirmation toward health in the lives of others.

CHAPTER 4

FINDING THE MEANING OF HEALTH

The original question, What is the meaning of health?, is considered and explored through the context of the narratives of four nurses. The voices of each of the co-researchers offer various answers to this question. Although Lucy, Jill, Christine and Lauren share commonalities as nurses, they are diverse in their professional pursuits and life experiences. This diversity in experiences provides a dialogue rich in meaning and scope. The aspects of connecting with others, peace, hope, and empowerment are brought forward through the narratives to express the nature and meaning of health for these nurses.

The end product of what is 'meant' by health for these nurses is approached from within the horizon of the reader's environment. The stories and reflections help us to understand that the personal meaning of health is reflected in individual insights. Through reflection on the context and content of the narratives, a clearer understanding of what health means to these nurses emerges. The orienting question throughout the reading of these texts therefore has been "What is going on in the nurses' experiences which describes the meaning of health for each nurse individually?"

The experience of the narratives does not differ much

from real life. The life encounters that happen in these nurses' practices occur alongside the multitude of the nurses' life experiences. The reader therefore must approach the narratives mindfully and sympathetically to glean the full range of meanings and intentions nuanced in the text.

Although particular attention is paid to the uniqueness of individual values and meanings, themes emerge as they develop through the orienting question. Thematic understanding is employed to illuminate the glimpses of meaning contained in each of the nurses' experiences.

Connecting with Others

The nature of health for these nurses becomes symbolised in the very way they characterise their relationship to their clients. As we can see in the accounts of these women, the nature of health is not primarily biological or measurable in quantifiable terms. Health is reflected in the active participation and engagement in the lives of others which promotes a rich quality of life.

Lauren, Jill, Lucy and Christine are often seen drawn to take actions which promote a connection with their clients. A careful look into their narratives shows that it is the ability to connect which signifies the presence of health for their clients. The possibility for health exists therefore, in communication and relating to others in a peer

relationship.

A closer look at what this relationship means to our understanding of health reminded me of what I learned in medical anthropology. It was Margret Mead, in studying primitive cultures, who considered the earliest sign of civilization. To her, evidence of the earliest true civilization was a healed femur. Such healings were not found in more savage societies (Brand & Yancey, 1980), but the healed femur showed that someone must have cared for that injured person. Just as someone must have hunted on the behalf of this person, this service was possible through the ability for two individuals to connect.

The possibiity of health exists with contact with others, a dependable relationship, and someone to trust. The co-researchers reflect this aspect of health in their stories, arriving at this understanding of health in different ways.

Lucy tells us of her own struggle for health following several months with respiratory difficulties. She describes her state of utter despair and her eventual recovery. "I think at the time what I needed for health was to have someone to talk to so that I could feel some sense of peace." Her response to regain health is to connect with another.

For Jill, the way to be in the world is to be involved and to connect through touch and maintaining emotional and

spiritual links with others. Jill shares her challenges with Harold whose angry and hostile reactions set the tone for his hospitalisation. She continues with this personal commitment to connect with others despite difficulties. The human condition of defeat and resignation with life is starkly evident in Jill's narrative. It is only when Harold attempts to identify with the needs of another person and communicates kindness and concern that health becomes evident to Jill.

Lauren looks beyond physical elements when her caseload includes Greg. She recognises the value of building a rapport and earning his trust over time. Greg teaches Lauren how the system had failed him as they problem solve and deal with his risk factors. Lauren's respectful and thoughtful approach in connecting with Greg is present in all her interactions with clients. Lauren's response to helping others achieve health is not to focus on the routines of her work in intensive care, but to seek changes where she could meet and connect with the 'real' needs of her clients.

Christine sets the bottom line for herself as she recognises the importance of the connection between herself and a client while a student nurse. Although new to the relationship of nurse and client, Christine reflects on the experience with Tom as a crystallising one for her nursing practice.

> "I touched his hand and it was like something really connected. He just looked at peace and it felt like energy flowed through both of us. It was very spiritual. He did calm and sleep after that. Having done that little extra, and staying open to receiving from him instead of just giving made the difference for me."

Given these stories, the meanings that these women ascribe to the ability to connect are consistent with the values implicit in their personal orientation to health. While there may be people who are content with the absence of connection with others and while the health care system may not always provide opportunities to connect, it is a goal that these nurses pursue. Connecting in itself is both the object and the reward that provides Lucy, Jill, Lauren and Christine with the understanding and achievement of health.

The Presence of Peace

The presence of peace emerges as a central theme in the accounts of both Lucy and Jill. In the face of real suffering, those of us standing by are left in shock at the sight of agony in others. We fight back lumps in our throats, look for words to create a resolution, and think about our inabilities to help. Providing a presence in order to reach peace is portrayed in Lucy's story about Wilma, and in Jill's own story of how she was brought to peace through Frannie's presence.

The answer to the question of how these people were helped in their suffering is curious and seems imprecise.

The way to bring peace in the midst of someone's suffering doesn't have smooth answers nor does it require a winsome personality. It is the quiet, understanding presence of someone who listens more than talks, someone who does not judge or even offer advice. The narratives suggest the best we can offer others is to be there, to see and to touch. Taken together, these stories provide a sense of the presence of peace.

There are definite elegant qualities that we recognise in others as peace. We sense it in those who know it the deepest. The nurses speak of this awareness where suffering and illness exist. Smith (1983) considers the experience of peace in the following account.

> "If anything, a realised soul is more in touch with the grief and sorrow that is part and parcel of the human condition, knowing that it too needs to be accepted and lived as all life needs to be lived. To reject the shadow side of life, to pass it by with averted eyes - refusing our share of common sorrow while expecting our share of common joy - would cause the unlived, rejected shadows to deepen in us as fear, including the fear of death... The peace that comes when a man is hungry and finds food, is sick and recovers, or is lonely and finds a friend - peace of this sort is readily intelligible; but the peace that passeth understanding comes when the pain of life is not relieved. It shimmers on the crest of a wave of pain; it is the spear of frustration transformed into a shaft of light" (p. 269-270).

Within the texts themselves, the aspect of peace becomes apparent in the accounts of Lucy and Jill. Lucy's story about Wilma portrays an awareness of the importance of connecting with her patient in order to reach peace. Lucy's practice attempts to draw alongside Wilma in support. She

describes her attempt to pray; an act that may not have been familiar to her, but in doing so, she brought peace to Wilma.

> "I knew Wilma was religious...I don't know what prompted me but I asked her if she would like me to pray. I didn't even know what to pray...so I prayed for a few minutes. I told her I really hoped that whatever happened was what she wanted. I felt Wilma's health at the time would have been just to feel comfort and peace. I knew she needed some hope and to be at peace with herself and with what was going on."

The narrative discloses Lucy's openness to meet her patient beyond the physical dimension of her nursing practice. Although Lucy concedes that she doesn't understand what prompted her in this attempt to pray, she does this for her patient's need for peace and comfort. The text takes us from the feelings of helplessness with Wilma's dressing changes to that of human strength and empowerment.

Lucy's tears and the deep expression of helplessness in her own health struggles convey difficult times. Her attempt to build a way of peace and honesty with others is demonstrated in Lucy's candid account. She finds room for dealing with her own discomfort and turns to discover a deeper awareness of how she and others could triumph with health.

> "I think at that time what I needed for health was to have someone to talk to, so that I could feel some sense of peace. My Mom had gone through a lot of strain and couldn't carry any more stress. She knew I was depressed, but I couldn't tell her I had tried to commit suicide. I think the biggest thing that helped me was having someone who could be objective and

> listen. I knew the basic thing I needed was to feel some semblance of peace, so that I could at least unburden everything that was troubling me."

Jill's account reflects her struggle to achieve peace for her patients and herself. Her story about Violet speaks of her frustration and unease in witnessing the efforts to resuscitate a patient she had come to love. Emotionally attached to Violet, Jill was unable to anticipate or prepare for Violet's death. Following shortly on the heels of this loss, Jill's father unexpectedly dies. Another patient, Frannie, helps Jill to come to a sense of peace.

> "Frannie talked about her life, and how my father and his family had influenced her. My anger and grief changed that day. I could see there was so much to be thankful for. It was so timely for me... In many ways she helped me to feel at peace after the death of two people I loved very much."

A significant part of Jill's nursing practice is also illustrated in her approach to consider her clients' need for rest. Jill undertakes the practical steps necessary to ensure adequate rest for those she cares for. These are the deliberate activities in her practice which portray her philosophy that achieving restful sleep is intertwined with achieving health.

Peace is also recognised through its absence in Lauren's story about Mark. Following cardiac surgery Mark is placed in the intensive care unit to die. Lauren speaks as someone whose intensive care training mattered very little to those she nursed. What mattered was her presence and her willingness to respond by reaching out to Mark.

> "I remember how awful this was, but what was worse was how focused the nurses were on the routine, they were very organised and meticulous. I felt that we were removed from the people that were there...getting wrapped up in that technical stuff and forgetting about people. You had to concentrate on the blood pressure going up and down, and there is a place for that, there definitely is, but it wasn't my place. Mark was not treated like a person, with respect. He was more an object that lost his identity."

Following some time later and distanced from this experience with Mark through other experiences, Lauren goes on to describe what is necessary for a 'healthy death.'

> "I remember going in when Douglas was very short of breath and hallucinating. He was picking at the air and it was obvious he was going to die within the hour. I sat down on his bed and I started stroking his forehead... When somebody is dying it's all the more important somehow because they're vulnerable, and you want to treat them right. People are very complex, and there are so many things that we can do to make them have the best death possible, the healthiest death."

The Encouragement of Hope

The meaning of health for these nurses becomes realised in the act of offering hope to others. Hope, as suggested in the narratives, is different from wishes. While this aspect of hope awaits fulfillment, it does not dictate the outcome. Instead we see in the stories told by Lucy, Jill, Christine and Lauren how hope is something that is open-ended. Health for these women is realised through the process of encouraging hope.

The basic thrust of inspiring another to have assurance and to feel good about themselves is to offer hope. Within the texts themselves, the act of offering hope becomes apparent in the giving and receiving of encouragement. When

defined by Webster's Dictionary (1984) encourage means to strengthen, inspire, reassure, fortify, incite, and advance. It is in the actions within the nurses' practice which demonstrates the many ways hope can be achieved. Hope is a common thread in the stories of all four participants.

The quality of hope permeates so much of what Lucy understands about health. Lucy considers the need for advocacy when she states "I don't think people can be healthy unless they feel good about themselves. I feel so strongly about that. Sometimes they can't learn to feel good about themselves unless they have an advocate." Lucy's narrative underscores the importance she sees in acting to support and strengthen one another.

Jill's text reflects the strong presence of encouragement and reassurance in her nursing practice as well. She defines a moment of sharing a hug with Marian as something that brought hope and comfort to both participants.

> "This frail, little lady raised herself out of the bed with all the strength she could muster, to give me this wonderful hug. It was more than I could give her. I think, in her way of knowing, we both needed this hug together and she helped me as much as I helped her."

Christine relates her experience with Tom as she discovered how important her contacts with patients were. She states "Tom was very pleasant too, and I remember feeling very compassionate towards him. I wished I could do more and wrestled within myself knowing I couldn't do more.

I knew that just being there could be helpful, but wasn't sure of that." With the advantage of hindsight, Christine is able to recognise how important her presence and her touch was for both Tom and herself. In seeking to bring a sense of wholeness and peace, Christine offers her encouragement in the life of another.

Lauren also deliberates about the importance of a good support system in order for health to be realised. She discusses her wishes for a different way to nurse in the realm of intensive care, and her response to the opportunities in home care to be a support and advocate for others. She states "It really hit home it's just amazing what a difference it makes to a person if there is someone coming in as an extra support. There was time in the community to analyse the situation, problem solve and sort our way through." It is this tact in Lauren's nursing practice which expresses that aspect of offering hope to another.

The potent impact of Lucy's narrative about her own health challenge helps us to understand the impact of despair and hope upon one's own health. In confronting the prediction of a future of never living without the use of a ventilator, Lucy is unable to speak of hope when the present seemed so bleak. When there is hope, the energies of life continue to stir. Hope pushes us toward the future and

provides confidence for the present. Lucy knows the best possible judgments may turn out differently. Generalisations or predictions cannot guarantee accuracy when they deal with people. The salient point Lucy makes is how difficult such statements or predictions of outcomes as generalisations were for her self esteem and her sense of control.

As Lucy expresses her hope by looking toward that which was not yet, she began to return to health. For Lucy, hope pushed her to visualize a future where she could see her freedom from the ventilator, if even for only a few hours. It is this measure of hope which demonstrates a return to health in Lucy's situation.

Empowerment

The issues of empowerment, control and dependency are also contained within the nurses's texts. Their narratives capture messages of the struggle and conflicts surrounding their patient's need for empowerment, control and respect.

Lucy's checklist for health would also include the ability to exert control and obtain respect in one's situation. As a nurse and as a patient herself, Lucy identifies her reservations with seeing the lack of choices offered to patients. "In general, I think people live the way they know how, whether it meets our values, beliefs and expectations or not."

As disclosed in her narrative, Lucy's experience in the

hospital illustrates her loss of control and what became important factors in restoring her health. She describes her personal struggles to make her own choices. Lucy goes on to disclose the meaning that this has had for her own health.

> "The better you feel about life the more you are able to cope with things that come your way. You know you've got those successes behind you which builds more confidence... I know the stronger one's sense of self is, the more likely that you will have more than the average amount of good health."

Christine eloquently describes Earl's context and condition following many years of a lifestyle choice. Although many efforts had been made through vascular surgery to improve Earl's health status, he continued to assert his independence through non-compliance. She states "He has been labelled non-compliant and criticised widely for the fact that he still smokes even after all these years of vascular surgery. I have to wonder how this attitude biases our approach to truly helping Earl to change and to support him through his pre- and post-op. fears as a person!"

Christine goes on to explain the reason behind offering this type of support.

> "Denying illness seems to be our biggest barrier to achieving health; and that feeds the illness. We just expect people to act differently because if there is no illness, there's no need to be acting inappropriately. We accuse each other of not trying, thus perpetuating the negative environment and greatly inhibiting our healing process."

As we see in this account, Christine is unsettled by the approach which may bias the nursing care provided to a

non-compliant person. She muses about the surgical efforts to overcome Earl's deteriorating vascular condition in light of his continued resistance to change his lifestyle. For Christine, this act of resistance strikes a cord into what it must mean to lose control. She goes on to elaborate on the meaning that independence and control have had in her own experience with health.

It is Christine's experiences as a patient and the opportunity to reflect on such a patient as Earl which supports her deliberations on the results of losing control with a health issue. "I remember myself as a patient...and I wondered at the time what about patients who don't know what will happen, and maybe are afraid that this is it. Maybe they don't even know consciously but rather suddenly they have to depend on someone."

Christine's narrative calls into question what it means to be dependent. Depend comes from the Latin word "dependere" which means 'to hang from.' While depend retained the notion of being literally suspended, in its more modern usage it has come to include a broader definition. Webster's (1986) defined it as resting entirely on or upon for maintenance, support, supply, or what is needed; to have to rely upon; to be a burden upon; and to be sustained by.

Jill strives to understand Harold's anger and

frustration as he sought to control his environment.

> "Harold's whole world ended when he was in an accident and became a paraplegic. When I first met him he was a very angry person... The fact that Harold never went septic or anything was amazing with the ulcers he had. Eventually these ulcers were repaired and he had to have a colostomy. Over the nine months on our unit we got to know him and understand him, but I still remember how angry he would get. He would tell us off, swearing and throwing things in his reach... I remember near the end of his hospitalisation when I had been sick... Harold was trying to make me feel better! It was the first time that I saw him care about anybody at all."

Harold's attempt to care about Jill demonstrated his transition as he began to see beyond his present situation to focus on others. This text contributes to a perspective of how detrimental an overemphasis on control was for Harold during the major portion of his hospitalisation.

The more Harold attempted to control his environment and health, the more he compounded his problems. His angry outbursts intimidated his care givers and increased his isolation. His frustration with his setbacks with his health may have hindered his ability to articulate his needs and be heard by others. Jill's story describes a person who was alone, hurt and angry. The turning point occurred for Harold when he let go of some of his own concerns, and began to take interest in the lives of others.

From this text and others, the reader is also drawn to consider the impact of dependency and the loss of respect existing for many in the hospital system. This view is shared by Lauren as she expresses her frustration while

nursing Douglas who was short of breath and hallucinating. She states:

> "You know, I thought this is somebody's father, or somebody's brother and look at the way this guy is passing out of this world. In this sterile room, he's got no family here. He's hallucinating and he's in some uniform that the hospital has put him in. It just seemed so wrong."

Lauren reflects on the startling differences present for Mr. Moore, dying at home. "With Mr. Moore there was so much more respect shown for him. Considering him, giving him dignity, and to have his family there. People seem to lose all that when they come into the hospital."

Achieving dignity and respect throughout the course of one's hospitalisation is important to the nurses who share their stories. It is this aspect of empowerment that motivates these nurses in the care they provide for their clients. Their stories allow us to see moments that their clients were empowered, an aspect which underpins their meaning of health.

There are clues that with the rigid search for complete control health does not seem to materialise. If obtaining control was actually the guarantor of empowerment, the consequences would be much different from what is demonstrated in these stories. Christine describes the non-compliant behaviour of Earl who is determined he will exercise control. Jill discusses her awareness of Harold's anger and frustration as he sought to control his

environment. Why then, when it comes to these and other clients, should those who strive for control over their health experiences be the very ones who seem denied it?

What if an overbearing emphasis on control were actually a guarantor for illness? The individual who most fears "the big one" can indeed succumb to heart disease. The person who reacts most to the loss of control does appear to be the most dependent. One gets the impression that some people actualise their fears, -by becoming what they fear the most.

From these narratives, empowerment is different than the purposeful behaviour of control. It is something that comes paradoxically with ease, through lack of struggle. The liberation experienced in empowerment is an event more easily attained by letting go than by hanging on. It is in this complex combination of liberation without seeking control that peace is actualised. Tillich (1952) describes this phenomenon "It is the force of human existence and underpins the courage to be" (p.3). When we face the future imagining the possibilities, we then experience the power which reveals an understanding of health.

Qualities of Health

In listening to the narratives about health experiences and the experiences of others, the qualities of health unfold. Health is not found through objective parameters. It is not the qualities of normal lab test results,

successful surgical interventions or even in the absence of illness. The emerging understanding of health has the following qualities: the presence of health within illness, the time-less aspect of health, and the holistic quality of health.

Presence

The first requirement to understanding health from the perspectives offered by the nurses in this study is that health does not begin when the individual achieves a recovery from an illness. Health can be present in the midst of illness or disease (see Appendix D). Illness, the common denominator in these nurses' stories, is real. Illness leads us onward to perceive health in existence. Health can be present long before treatment controls symptoms and healing becomes evident to others.

Time-less

The second requirement to understanding health is in its reference in time. Just as illness can change dramatically over time, health may reflect vast differences from moment to moment. Health is an essence that is not easily identified or grasped. The co-researchers shared stories which showed an acceptance of changes in health, and they held no determination of how health must specifically exist for others. Their stories demonstrated a recognition that nothing is permanent.

The nurses' texts suggest that while pain, suffering

and grief will continue to be felt, health is not seen in time bound language. Health is reached through the stillness of peace, hope, quiet acceptance and the expression of knowing that things are all right. Health in its fullest form is the capacity to 'be' in the present.

Health is not time-bound, nor is it constant and unchanging. The fluidity and changing nature in the texts (see Appendix E) suggest health cannot be measured in time. We often truncate health into a few acceptable moments when we consider health at the peak of physical performance, ideal body weight, or even with positive attitudes. However, the observations made by the co-researchers hold out for something beyond this type of health perspective. Their stories do not suggest that an endless repetition of health events was necessary to their view of health. An enduring state of unchanging health is not portrayed through their stories.

Holistic

Third, the understanding of health offered through the stories incorporates a holistic perspective (see Appendix F). Even if the health care system isolates the person, and reduces their individuality, the texts provide a vision of health which does not exist in isolation. Health is part of the person's life experience and does not exclude the presence of significant others and the environment and the contextual factors present at the time.

The health perspective offered in these narratives provides a more comprehensive view than the absence of a disease process. The nurses's view of the health experience overcomes the limitations of the medical model. Acknowledging that people are more than physiological entities, and integrating the mind and body within the social context ensures that clients are treated as persons, not as objects. Despite the fact that the medical model (see Table 2) offers insights for health care professionals, as well as a basis for the planning and implementation of care for clients in the health care system, it does not provide a satisfactory understanding of health. The medical model necessitates that the practitioner focus solely on the disease rather than on the client, on cell and tissue function rather than on the individual (Benner & Wrubel, 1989).

Consequently, these nurses' responses to understand health moves beyond the purview of medical science and traditional approaches to health care. The co-researchers consider aspects of health as terms such as connecting, hope, peace, and empowerment are key to their understanding of health.

The specific actions within the nurses' narratives also allow for the expression of the dynamic nature of health based on their perspective of health. Jill's nursing

practice offers an insight into her holistic approach as she considers all aspects of her clients' world in order to support peaceful rest. Lauren articulates her need to provide respect and dignity for clients within her reach. Christine seeks to understand how she can better connect with those who are non-compliant with existing health treatments. Lucy advocates success for her clients as she seeks to promote their self esteem in many small ways.

Sources of Commonality

This chapter presents the meanings of health for four nurses who illustrate their understanding of health through their experiences. The fact that they chose to speak about experiencing the presence of peace, hope, empowerment and connecting with others reflects where they stand in the world and in their nursing practice. Through this exploration of health, the nurses described several qualities of health. These qualities are: the presence of health within illness, the time-less and changing aspect of health, and the holistic quality of health. In understanding health, the narratives offer a glimpse of health as the nurses share their vision and commitment to their nursing practice.

A pattern of meaning for health emerged which is similar to the theoretical work by Parse (1981), Newman (1986), and Watson (1986). These nursing theorists view health as something that is a synthesis of disease and non-

disease, is multidimensional, lived uniquely by each person, and is an expansion of one's awareness or consciousness (Parse, 1981; Newman, 1986; & Watson, 1986). This view of health is acknowledge to have emerged from principles and concepts put forward by Martha Rogers in 1970 (Parse, 1981) and supported with work by Paterson & Zderad (1976).

Parse's (1981) theory involves a number of assumptions made about health.

> "Health is an open process of becoming, experienced by man.
> Health is a rhthmically co-constitiuting process of the man-environment interrelationship.
> Health is man's patterns of relating value priorities.
> Health is an intersubjective process of transcending with the possibles.
> Health is unitary man's negentropic unfolding" (p. 73).

Newman (1986) also views health in this perspective, defining it with the view of disease as an integrating factor. Newman (1986) states "If becoming 'ill' is the only way an individual's pattern can manifest itself, then that is health for that person. Health is viewed as the totality of the life process, which is evolving toward expanded consciousness" (p. 58). Paterson & Zderad (1976) view health as a process of growth toward authentic awareness and the making of responible choices. Collectively these perspectives of health reflect an understanding of health which complements the four nurses' understanding of this concept.

The holistic quality of health that these nurses speak of, opens our awareness to the meaning of wholeness in our

connections with others. Connecting with others touches on the experiences of dialoguing, relating and using all one's faculties to understand and be understood. The four nurses told us of moments such as these when they experienced a real connection with their clients.

The stories the nurses share also illustrate the vision of health and illness together. In our more logical moments we make distinctions between health and illness to avoid the paradox of the holistic perception of health. If the lines between such polar opposites as health and illness are blurred, how then should one distinguish when one is healthy? In our dual way of thinking, distinctions are necessary for terms such as: subject and object, mind and body, and health and illness.

What the nurses in this study tell us through their stories are not simply separate notions of health and illness. Their stories suggest that one is meaningless without the other. One cannot know health, without the awareness of illness. These nurses share an acceptance of illness, not as a mere function of helplessness or physical malfunction, but see illness as a catalyst to a deeper understanding of health.

In the view offered by the four nurses, health is a personal quality that the person already has. Health is illuminated in the presence of illness and needs to be recognised simply for its existence, not for its potential.

When health is seen for its potential, a goal to attain, the notion of the existence of health is lost. The limitation of the approach of health promotion is that it places the person in the position of always pursuing, but never attaining health (Benner & Wrubel, 1989). The nurses' stories illustrate their commitment and disposition to view health not as a quest or something to promote, but as a reality.

The stance the nurses in this study take in their view of health is to look beyond control to empowerment. They call attention to the importance of the mind, body, personal meanings, and social context for their client's health. These nurses challenge us to see moments of: trusting and letting go, hopefulness, being in relationship with another, and peace that passes understanding, as health.

When health is framed with qualities such as being time-less, presence, holistic and illustrated with descriptors such as peace, hopefulness, empowerment, and connecting with others, we begin to appreciate the complexity of the meaning ascribed to the term. These nurses embrace this understanding of health as an expression of their understanding of the world as it reflects their ontology. Through their stories they open the doors to broaden our perceptions of health.

CHAPTER 5

FINAL THOUGHTS

In this interpretive study, the understanding of health was explored from the perspective of four registered nurses. This study was initiated to consider the understanding of health that today's nurses hold. Although the traditional nursing view of health was shaped by an understanding of disease, health care is shifting to turn its attention to health. This chapter includes a discussion of the interpreter's personal discovery of health, the implications this study has for nursing practice, and suggestions for further research.

A Personal Discovery of Health

Through the perspective of the four co-researchers one begins to appreciate the complexity of the concept health. In the journey to understand health in this study I began to gain an richer perspective from which to view health.

The exploration of our understanding of health thrusts one into contact with the reality of our existence. Health is a state that is defined in different terms by each person. That perception of health is personal and unique. Asking the question of "what is health?" forces us to inspect what we really mean when we say we are healthy.

As the researcher, asking this question of others, I marvelled at the wealth of expression in the stories and the wisdom of the co-researchers. As I listened to the stories

the image of health that I had constructed over the years began to take on new possibilities. This study encouraged a reappraisal of my personal understanding of health.

For the nurses in this study the following aspects of health are considered in their meaning of health. Specifically, connecting, hopefulness, peace, and empowerment were brought forward to describe health. The presence of health within illness, the time-less quality of health, and the holistic aspect of health also became clear through the interpretive process.

As a nurse I shared a similar knowledge and experience base with the co-researchers. Many times in the process of reflecting on the nurses' stories I was carried back to my own nursing experiences. In the process to understand and interpret the meaning of health for others, my experiences with health also supported and carried the meaning of health further.

The understanding of health is not simply just a matter of one's physical condition. The intactness of the body is one way to talk about the "holism" of the human being. The narratives convincingly reinforced the inclusion and consideration of psychological, emotional and spiritual aspects of the person.

Embedded in this aspect of holism is a complex perception of health. This view influences what one sees, what one expects and how one experiences health.

Unfortunately holism has become a slogan for many practitioners in health care and in health education. Rather than being viewed as an interesting perspective on human nature and experience, holism has become a conviction without critical analysis (Kestenbaum, 1982).

A view of health based on the aspect of holism suggests a natural tendency to form a whole that is more than the sum of parts. In a holistic view, the person's activity can be described anatomically, physiologically, neurologically, behaviorally, and phenomenolgically. Localising only one of the functions to describe health would be a kind of reductionism which would limit the possibilities of understanding health as holistic. Rather, the view of health on these multiple ways of being could enhance and broaden the possibilities of how one can experience health.

In my own view of health, the person functions in a complex, integrated manner. For example, an individual's nervous system has anatomical parts that function as a whole. And that whole is a part of the individual, who in turn functions as a whole in a social world. When damage to the nervous system occurs, the individual adapts through the functional parts of the whole person. This includes neural regeneration, the takeover by other parts of the brain, and the ability to learn new ways to carry out formerly automatic functions. In the holistic view health is not lost. The damaged brain is part of a person, but the person

still has a sum that is greater than the parts. The person is still involved in a social world, has concerns and beliefs, and has unique possibilities.

This view of an individual's wholeness is considered in Martin Buber's philosophical work somewhat differently. In Between Man and Man, Buber (1955) suggests wholeness does not exist apart from the real relationship to others.

> "Only the man who has become a Single One, a self, a real person, is able to have a complete relation of his life to the other self, a relation which is not beneath but above the problematic of the relations between man and man, and which comprises, withstands, and overcomes all this problematic situation. A great relation exists only between real persons" (p. 116).

The person can be complete and whole despite identified deficits with the body or with the problems existing in relationships with others. It is in this social aspect of being in complete relation to others that Buber (1955) sees the Self realised and whole.

Another key to my understanding of health centred around the development of empowerment and time-less quality of health revealed through the nurses' stories. Health, for some exists with the illusion of control, active resistance against disease, and the goal to direct one's destiny. Those strategies to manage one's helplessness and mortality by controlling one's environment and eradicating disease are reflected in commonly held perspectives on health. The views of health as a disease-free-state, adaptation, or as high-level-wellness, described in Chapter Two, reflect a

struggle for survival. Benner and Wrubel (1989) capture this respect for the struggle to adapt and the quest to control one's health.

> "It is the view of the self as a competitor struggling to survive in spite of a hostile environment. In this technical world of control, one may gain control of one aspect of one's life and win victories, but the victories are always on the background of danger, the threat of loss of control. The 'Challenger' disaster was so disquieting not just because of the tragic loss of the brave astronauts. It reminded everyone of the limits of control--of the faultiness of 'O' rings. In our most controlled efforts, we confront the limits of control" (p. 162).

Benner and Wrubel (1989) suggest we are simply confronting the limits of control when we seek to control our health.

Although autonomy, control and independence are held as ideals in our time and culture, I began to sense the futility of the struggle to attain these positions. The presence of peace exists in the act of letting go of our control. As individuals in a social context we cannot exist truly independently of each other. The person is fully realised and whole only in relation to others (Buber, 1960). In this perspective health is not an unattainable ideal but a reality already in our grasp.

As I recall that night caring for a dying man, Mr. Grayson's example stands to remind me of the conflicting strains of human helplessness and the health within us. In that scene I began to understand how health can be experienced even when the body fails us. Health is only limited in its possibility when one cannot see beyond one's

pain and suffering.

Sometimes, as in the case of Tolstoy's (1960) Ivan Illych, the ill person believes the illness can be ignored, and is surprised and confounded when the illness persists, devouring his attention. All Illych's time and effort are spent over the illness. When our body fails all our other concerns begin to pale. Our reality seems unreliable and unpredictable. In Tolstoy's story, Ivan Illych refers to his pain as <u>It</u>. Anywhere and everywhere he turns, always It appears. He is left "...alone with It: face to face with It. And nothing could be done with It except to look at it and shudder" (Tolstoy, 1960, p. 134).

Schrag (1982) offers a phenomenological description of the experience for the person in pain.

> "In experiencing particularly intense pain we speak of every moment's seeming like an eternity. The 'now' of pain appears to be endless. It is precisely the living through pain that becomes the uppermost concern. Indeed, we wonder how we will live through it; we wonder when it will stop; we may even despair in the face of the possibility of its never stopping. In all this we see illustrated a peculiar fabric of temporality, a time span of concern, comprehended not as a succession of discrete, homogeneous, instantaneous nows but as a stagnation present with breadth and thickness that moves ever so slowly toward a hoped-for liberating future" (p. 122).

Although the moments of pain are subject to variations in intensity, the temporal nature of pain persists for Tolstoy (1960) and Schrag (1982). However, health itself is not bound by time and can exist in the midst of pain and suffering. Health does not follow the regular and ordered

sequence of seconds and minutes that are marked off by a clock, nor does it necessarily have a beginning or an end. If one concludes that health is present within illness, is the capacity to be in the present, and is letting go of the control we often seek, then health is time-less.

On this journey to understand health better, I see health is much more than a condition to be sought after, it is a reality that is full of promise and possibility.

Implications for Nursing Practice

The implications of this study for nursing is explored. The understanding that Lucy, Jill, Lauren, and Christine offer to us through their stories suggest health is complex and dynamic. The actions and responses to client's health needs and their own health experiences also tell us something of who they are and how they stand in the world. Although each of the nurses' stories are unique, and offer individual insights into the meaning of health, how can nursing be best served? What are the results of these four nurses' stories for nursing?

The world of nursing practice can make major contributions to nursing and nursing education. All too often, too little attention is given to those in nursing practice to consider practising nurses as a source for theory (Bevis & Watson, 1990). However, the findings in this study show the abilities of these experienced, expert nurses to reflect on a complex concept such as health.

Indeed, in a practise field such as nursing, theory and practise must shape the other (Bevis & Watson, 1990). Benner and Wrubel (1989) offer the goal that:

> "A theory [of nursing] is needed that describes, interprets, and explains not an imagined ideal of nursing, but actual expert nursing as it is practised day to day. This type of theory could be used to develop curricula in which practice informs nursing education in a way that nursing education has always influenced practice" (p. 5).

In educational terms, these nurses throw open a challenge to inquire into what each of us mean when we use words like health. The question for nursing educators is to ask what makes it possible for us to think about health in the ways that we do? How does one come to a holistic knowledge of health?, for example. What supports our situated, personal knowledge of health? Do we understand this situated knowledge of health entirely through personal experiences with the phenomenon, through literary criticism, through the stories of others, or through theoretical assumptions?

The study also has implications on how nursing chooses to acquire new knowledge. Only recently has nursing research and nursing education recognised the value of qualitative research and the creativity of this research approach to expand the study of nursing (Bevis & Watson, 1990). The four nurses, who participated as co-researchers in this study, can make a unique contribution to the study of nursing in our understanding of health. Research of this

nature can help deepen our understanding of the epistemology, ethics, and other meanings held in nursing. The real world of practice can then inform the reflective world of theory (Bevis & Watson, 1990).

The fact that nursing science has only recently moved to accept qualitative research reflects the history of nursing in health care. Nursing has primarily addressed the biological sciences and technical approaches to health and healing in attempting to achieve colleagueship and recognition with others in the health care system (Bevis & Watson, 1990). It has been a major shift in the field of nursing to emphasise the unique place nursing has as a human science. Watson, in her book Nursing: Human Science and Human Care (1988), offers leadership to the perspective of nursing as a human science. The following ideas summarise her views.

> "There is anomaly between the organismic concept of person in medicine and traditional psychology and the concept of person as a whole referred to in nursing. There is a strain between the study of person as whole (and human responses) and the process of nursing care and the traditional reductionistic assumptions of natural science, basic sciences and biomedical sciences.
> Nursing is a relatively young discipline, dating back to the mid-to-late-19th century; hence, it is susceptible to the temptation to follow the rule of the older natural sciences, without raising important philosophical, epistemological, ethical, and scientific questions relevant to the study of nursing and nursing phenomena" (p. 15).

Health care, itself, is undergoing changes which involves the delivery of nursing care. As the health care

system is confronted with rising deficits, and a client population with problems such as aging, chronicity, and AIDS, changes are necessary. The future trends will move more nurses from hospital based services to community based services. Parse (1992) suggests that in the 21st century nursing will exist as an autonomous discipline where nurses will primarily practise in community centres, schools, and corporate work places. Many factors have merged to expand the education sphere for nurses, creating potentials in the contextual aspect of nursing. It is possible for nursing to acknowledge its research and practice potential by involving the experiences of nurses who are part of these changes.

Although there is opportunity to involve the findings of this research in the changing arenas of nursing research and nursing education, the implications of applying the findings of this study must be considered. There are no reported qualitative studies of nurses' perspectives of health, and this creates difficulties in the comparison of similar research. As an interpretive study the following implications, however, are suggested for nursing practice:

a) To fully understand the concept of health, we need more than a definition of the term, we need to understand the experience of health in the lives of our patients.

b) The notion of health expounded here, while much broader than the notion of a mere absence of disease, adaptation, or

a norm, suggests a careful review of the goals in nursing around health promotion is necessary.

c) To understand a person's health, nurses are encouraged to look beyond current jargon used with health (ie; holism) and investigate the meaning of health from the perspective of patients and their own experiences.

When the study involves the researcher and the four co-researchers who are given the opportunity to speak in their own way, as in this study, individual characteristics of the nurses add to the subtleties and complexities of the views on health. An appreciation for the intensity of the nurse's experience with the client's health challenge is the starting place. Linking our awareness of the humanness of both the nurse and the client should guide our understanding of the complexities and dynamics of the stories the nurses shared. Nurses can and should share meaningful information about their experiences to add to the study of nursing.

Suggestions for Further Research

This study illuminates four individual nurse's insights and understanding about health as it is experienced in this time and in our culture. The research in this area is timely and necessary given the current changes in the direction of British Columbia's health care system. Following the royal commission report in 1991, it was made obvious that nursing's views made in over 100 submissions from nurses and nursing groups had been heard by the

commissioners (Bruce, 1993). In bringing about new directions for health care based on the royal commission, the Ministry of Health has not only adopted a broader view of health, but in 1993 it has started to specify the actions it intends to take to make this vision a reality.

With the Ministry of Health's plan to empower communities and regional areas in British Columbia to make decisions over health care, the impact will be immense. There is no question it may also see some fairly significant regional differences in the nature and understanding of health and health care services. Thoughtful consideration of the differences and variations in what constitutes health for others must be maintained throughout the process of health reform. Nurses can play a large role in helping to define this vision of health and contribute to the kind of health care provided. If the nursing profession is to be involved in future directions for health care, research into the nurse's perspective on health continues to be important.

A whole host of questions in connection with nursing research and education provides suggestions for future research that is implied by this study. What are other useful ways of inquiring into the nature of the phenomena, health? How <u>do</u> expert practising nurses with a vast number of experiences form their interpretations? How do nurses learn to pursue their meanings, enhance their perceptions and check out intuition's quiet voice? When looking at

health, how do nurses distinguish the important from the trivial, and learn to appreciate what are subtle, important qualities and characteristics of health?

In addition to questions about the practising nurse, related areas for inquiry could involve the nature of teaching and learning about the concept health. As nurse educators, in taking the opportunity to examine meanings of situations with students, that is examining what they see and educating their perception, how does one view experiences more clearly? The creative, thoughtful approaches necessary to develop our understanding of the subject matter of health and illness needs to be explored further. As the student makes meanings and judgments based on experiences in the process of learning, how does one address the issue about what kinds of learning are valued in the curriculum? This raises the question of how one should devise appropriate learning activities which could inform the student nurse about the meaning of health.

Exploring further questions about the meaning of health developed in this study could lead to a broader understanding of the concept, not only for the student, but for nurses in general. Research of this nature is important to consider with the impact that nurses can have in the experience of health for others.

A Final Word

In summary, the understanding of health for the four co-researchers was explored to discuss how this study has informed the interpreter's understanding of health. Health is considered and developed through the themes of connecting with others, hope, peace and empowerment. Furthermore, the aspects of the presence of health within illness and the timeless and the holistic qualities of health are presented to contribute to a perspective on health. Significant to the exploration of health and the discussion of this study's interpretation, the following issues emerged. Although the interpretation developed from this study is limited to the four nurses in this study, it does provide insights which has value for others in the helping professions.

I discovered that the nurses I interviewed shared a common understanding of health to express a spiritual depth to health. This is a different focus than that seen in traditional medicine in the goal of curing disease or eliminating problems. As we can see from the descriptions of what health is like for these nurses, health moves beyond the common notions to explore new horizons. With the view that health transcends the possibilities and exists as a reality within each person, health is indeed a resource. The World Health Organisation's (1984) more recent definition of health supports the view of health as a resource for individuals.

Current nursing literature addresses the notion of understanding health spiritually and as a resource. In addition to numerous articles addressing guidelines for spiritual assessment in nursing (Peterson & Nelson, 1987; Stoll, 1979), there has even been research examining the extent to which nurses assess their client's spiritual needs (Kaczorowski, 1989). Reed (1987) and Kaczorowski (1989) develop the notion of spiritual well-being in the midst of terminal illness. The study of the relationship between spirituality, contentment and stress during recovery from alcoholism by Corrington (1989) reflects an interest in the spiritual aspect of recovery.

Although this study describes a way to understand health from the perspective of the practising nurse, the challenge is to continue in a search for understanding such terms as health. As I worked through the interpretation of this study, I wondered about the need for understanding health, not as a problem to be solved, but as an invitation to consider the boundaries and limits of one's own understanding. For nurses in practice, this is part of our shared future.

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APPENDIX A

LETTER OF INFORMED CONSENT

You are invited to participate in a study which seeks to explain and understand the nurse's understanding of "health." This study is part of a nurse's degree requirements for a Master's Thesis in Curriculum Studies at the University of Victoria. What you experience in your practice when dealing with health will form the basis for building an understanding of health, and hopefully can be used to link nursing practice with curriculum changes in nursing education.

If you decide to participate, the researcher will contact you to set a convenient time for an interview. The interview will take about 60 to 90 minutes. You will be asked about your experiences with nursing, and about the kinds of things that have stayed with you in experiences with health. You will also be provided with a journal notebook and asked to describe incidents and experiences from your practice.

The researcher would also like to speak with you a second time, at a time that is convenient to you. The reason for the second interview is to double check that the researcher has understood your point-of-view, and to request your responses to the findings. The information you share in your stories and descriptions of your experiences will be used to better understand this key concept in nursing.

All information that is obtained in connection with this study will remain confidential in order to protect the employment status for all participants. Code names will be used on all information. Interviews will be tape recorded and the tape recorder will be turned off whenever you request. The tapes will be erased after the researcher has written out the information.

If you have any questions, please contact the researcher:

Renate Hormes Phone: 474-5076

You are making a decision whether or not to participate. Your signature indicates that you have read the information provided above and have decided to participate. You are free to discontinue participation at any time without prejudice.

_____

Signature of Participant Date

APPENDIX B

LETTER OF INTRODUCTION

Dear _____;

Why study health?

Why is the nurse's understanding of health an important aspect for research? The answers to these questions are threefold:

First, most nurses do not have a "set" definition or meaning attached to their understanding of the term health. The definitions offered by various nursing theorists have little impact on what nurses think about the term. This apparent division between practise and theory needs to be understood in greater depth.

A second reason to consider this research on health important to the practise of nurses can be understood by the impact of one's beliefs on one's practice. What a nurse believes and understands about health will influence the nurse's responses when caring for others with health needs.

Lastly, in response to recognising how nurses' views are unique and often shaped by their experiences, your stories about clinical situations are important. Nursing science has much to gain from nurses who describe and share observations on a central concept to nursing, health.

You are invited to reflect on and participate in a search for meanings about your understanding of health. You will be asked to reflect on and share experiences from your practise. Whether written or discussed, these experiences will be used as part of the material for a study on the meaning of health. The full extent of your participation in this interpretive research is outlined in the LETTER OF INFORMED CONSENT. Please read this prior to making a decision to participate.

Thank you,

Renate Hormes

APPENDIX C

OUTLINE OF DATA ANALYSIS PROCESS

1. Following each interview the tapes will be transcribed verbatim.

2. Each transcript will be reviewed for statements or phrases that directly relate to aspects of health and health care.

3. The stories will be reviewed for the presence of material and/or reflections on health.

4. Through reflection, themes will be generated which encompass meaning and indicate the participant's understanding of health.

5. Themes will be made explicit and validated by referring back to original transcripts. Themes will be critically reexamined for how completely they account for and do not exceed the data.

6. Participants will be invited to review, and examine the interpretations presented.

7. Themes will be reexamined and revised to include the participants point-of-view.

8. The written account will indicate the following:
   -the specific purpose of the study,
   -how the participants came to be involved in the study,
   -how the data were collected and transcribed,
   -the review of the data with the participants,
   -how the data were used for analysis,
   -how the themes drawn from the stories were placed in the context of the meaning of health,
   -a review of the implications of the research, including future research.

APPENDIX D

STATEMENTS ILLUSTRATING HEALTH IS PRESENT WITH ILLNESS

Christine	--That [connection] lessened the trauma of the pain and he was able to be at peace even though I knew the medication wasn't taking all the pain away.
	--There are healthy people who happen to be paralysed and in a wheelchair. I like to think it's there if they are happy and well adjusted in their life with the presence of independence and autonomy.
Lauren	--People are very complex, and there are so many things that we can do to make them have the best death possible, the healthiest death.
Lucy	--I felt Wilma's health at the time would have been just to feel comfort and at peace. I knew she needed some hope and to be at peace with herself and with what was going on.
Jill	--Terry wasn't upset about his situation at all, he was happy. From the outset he had never looked back. It was as if he said "this is the way it is and let's get on with life."

APPENDIX E

STATEMENTS ILLUSTRATING HELATH AS TIME-LESS

Christine	--When I think of health, I find it difficult to really give that a definition. It's really more something I sense as much as I understand intellectually.
	--Now I can be more accepting that I am not my weight, my weight just happens to be and it still needs to be worked on, but the me inside the body is a lot healthier than I was a few years ago.
Lauren	--Douglas was very short of breath and hallucinating...it was obvious he was going to die within the hour. I sat down on his bed and I started stroking his forehead and saying "it's OK, just let it go."
Lucy	--I think it [health] varies at different points in your life depending on your situation.
	--The better you feel about life the more you are able to cope with things that come your way.
Jill	--This frail, little lady raised herself out of bed with all the strength she could muster to give me this wonderful hug. I think, in her way of knowing, we both needed this hug.

APPENDIX F

STATEMENTS ILLUSTRATING HEALTH AS HOLISTIC

Christine	--Now that [weight] doesn't stop me from doing things in life...and that's what I consider being more healthy and whole, because now I'm not inhibited by what others believe.
	--Healthiness is again my relationship with my God. It seems so intertwined that everything works better when I'm more in balance, that's when I'm healthy again.
Lauren	--I was able to get across to others that I'm there to help them 100% and that I'm not there for my own reasons was really important it was important to me to be able to connect with a person.
	--Greg taught me about the system and how it had failed him. Just how important elements other than the physical element can be, and how important it is to recognise and deal with them.
Lucy	--I think that basically people know what they need and what they want in life. Their understanding of health may be totally different from ours. In some ways people reach what they think health should be for them.
Jill	--I remember I was giving her as much medication as I could but there was nothing else that I could possibly do to make her breathing more comfortable. So I asked her if she would like a hug.
	--It's not just the medical side of things, but it's looking after the spiritual side, the emotional needs, and including talking and touch which is so important.

VITA

Surname: Hormes Given Names: Renate Elizabeth

Place of Birth: Pemberton, B.C.

Date of Birth: May 28, 1962

Educational Institutions Attended:

University of Victoria	1987 to 1989
British Columbia Institute of Technology	1986 to 1987
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Title of Thesis: The Meaning of Health in the Nurse's Practice.

Author: [redacted]

RENATE E. HORMES

SEPTEMBER 28, 1993