The meaning and importance of service for health professionals

A thesis presented in partial fulfillment of the requirements for the degree of Master of Health Science

Susan Mary Raleigh

Auckland University of Technology
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Attestation of Authorship

"I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material which to a substantial extent has been accepted for the qualification of any other degree or diploma of a university or other institution of higher learning, except where due acknowledgement is made in the acknowledgements."

Signed:

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Susan Raleigh
31 January 2006

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Abstract

The primary purpose of this study was to explore and identify the meaning and importance of service for health professionals. Those who participated in this study are all registered nurses who each have between 10 and 40 years of clinical nursing and nurse lecturing experience. The participants each wrote two stories, one about the meaning of service and the other about the importance of service. Definitions of service generally suggest organised labour involving an act of help or assistance. Our intent was to understand what constituted service for each of us in the healthcare – and specifically the nursing practice/education – context.

A secondary purpose of this qualitative research was guided by participatory and critical theory paradigms. Seven participants and I (as the initiating researcher) formed a co-operative inquiry group to undertake the research using a collaborative process. Within this method the leader and the group became co-participants and co-researchers. Nurses and women are identified as marginalised people and by honouring the principles of co-operative inquiry we were empowered through this process. While the initial data was analysed thematically by the lead researcher, the original 19 sub-themes were refined by participants into five themes.

The findings of the participants are consistent with overseas studies on emotional labour and sentimental work. The five themes that emerged as the meaning of service are helping, giving, elements of service, acts of doing, and pride in work. Helping was defined as an attitude and an action, which often results in a spiritual connection. Giving involves stretching yourself, and altruistic behaviour that also incorporated a spiritual component. Five sub-themes merged to form the third theme elements of service; working with people, being a public servant, being a servant, need and duty. The complexity and hidden aspect of service work was expressed in acts of doing where being professional was paramount. The final theme, pride in work, acknowledged childhood conditioning and a sense of contributing to the greater good through our unique work as nurses. This study affirmed that service has much importance to those involved and deepened our understanding of the blend of meanings service expresses.

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Chapter 1 Background and introduction

Come! We shall transform the world by our discoveries.

Louis Pasteur, 1868 (Adler, 2004)

Origins of an interest in 'service'

Initial perceptions

To be of service to others is, I believe, the motivation at the heart of practice for many who work in healthcare. It is certainly true for me. My perception is that the importance of service work has been poorly explored, its value diminished, and its proponents marginalised. Women and nurses are both identified as marginalised groups in society and the work they do in nursing is often obscured from view (Graham, 1983).

As the quote above suggests, we can transform the world with discoveries. This thesis seeks to examine the notion of service, to uncover its changing place in our society, to review how it is perceived in literature, and to discuss its meaning and importance for a group of health professionals. In short, it is designed as a journey of discovery. At the same time I am committed to conduct such research in a manner that deeply respects and empowers the participants and this has guided my choice of method. This study has utilised the infrequently used method of co-operative inquiry where research is done with people rather than on people; participants become co-researchers with the initiating researcher (Heron, 1996). The process of co-operative inquiry and its relationship to this study is discussed in detail in chapter six.

Many nurses have sought to explore and define the functional aspects of their practice and endeavour to articulate intangible aspects of their work (Chinn, 1991; Christensen, 1998). The intangible aspects of nurse's work are often the most interesting, meaningful, revealing, and difficult to investigate. This thesis aims to explore service, an imperceptible and taken for granted aspect of nursing work that has received little attention. Many people are affected by the service nurses provide. By closely

examining service to understand its intricacies, the nursing profession may be in a better position to strategise the attraction and retention issues facing nursing in New Zealand (Nursing Council of New Zealand, 2000). The attraction and retention of nurses is vital for maintaining the health status and health service delivery to New Zealanders. This is an important issue for at least the next five years, and the Nursing Council of New Zealand reports “that the potential pool of women from which nursing and midwifery students are drawn will be at its lowest” until 2010 (Nursing Council of New Zealand, 2000, p. 11).

This chapter begins with personal reflections on my developing interest in the notion of service and how childhood experiences and past work experience in clinical nursing and education have contributed to this interest.

Personal reflections

This research on the meaning and importance of service is of both a professional and personal nature. After 20 years in full-time clinical practice as a nurse my career moved to nursing education and the opportunity to explore service. Nursing is deemed a service profession yet, as a concept, service currently receives little if any attention in nursing. Peter Block (1993) is one proponent of service; he advocates that the deeper meaning of service involves a search to find a cause and commitment to a project outside ourselves. Certainly many nurses may relate to the idea that nursing requires commitment and Block (1993) also suggests that adventure, risk, and sacrifice are part of the creative process entailed in service.

Currently in nursing, it appears that service is an abstract component of the job. Nursing often involves personal sacrifice, but the level of adventure and risk varies according to the context in which we nurse. I doubt nurses would be likely to identify adventure and risk as components of service. Nursing tends to utilise the word service in reference to itself as a service industry or service profession. There

appears to be a gap in the literature about the nature of service provided by nurses.

I believe nurses seek to understand nursing they have tended to focus on understanding the essence of nursing through the lens of nurturing roles. Salmon (1983) agrees with this notion stating “the unique function of nursing which is to nurture, sustain, foster, protect, conserve an individual’s or family’s energies, … the central core or essence remains, the nurturing” (p. 8). The word nursing is linked to the suckling and nourishment of infants and was considered fundamental to life (Weatherston, cited in Christensen, 1998, p. 12). During the 19th century, Nightingale proposed the interpretation of nursing be expanded to include nurture of family and the wider community in two distinct roles (Christensen, 1998). In the West, formalised nursing education began during the 19th century. Nurses in the 1950s and 1960s commonly defined their role by the activities they performed (Christensen, 1998, p. 14). Conceptual models of nursing have also been developed, for example Wiedenbach (cited in Salmon, 1983, p. 51) states that nursing is a helping art.

An evolution in the education and preparation of nurses has impacted on the nursing service in New Zealand. This evolution occurred during the 1960s to the 1980s when nursing was reviewed, and education moved from hospital-based schools of nursing into tertiary institutions. The concept of nursing as a service emerges from the struggles nursing theorists have encountered in defining nursing, as illustrated by this definition, “a chance kindly act and a professional service” (Wiedenbach, cited in Christensen, 1998, p. 14).

Childhood influences

My interest in nursing was sparked at an early age. My mother and aunts were nurses and portrayed strong images of women with special knowledge and skills. I viewed nursing positively as a helping profession and my parents and wider family reinforced these views. I can recall my mother nursing me when I was sick with measles, chicken-pox, and

other childhood aliments. She knew what to do to make me better and I trusted her knowledge and skill; in our home nurses held mana, honour, and esteem.

Being helpful, considerate, and accommodating the needs of the wider family and the community were consistently demonstrated in my nuclear and extended family. My grandparents, aunts, and uncles were involved in voluntary work ranging from their churches to more formal community voluntary groups. Thus a foundation of service values was laid down in my life and these service values were played out and reinforced at a more personal level as well. I often participated in the collection of donations for Red Cross, IHC, and other voluntary community groups.

The expression of service at a personal level is strongly connected with my twin brother. He required special care as a baby and during his young childhood years. At school, as the need arose, he would seek me out and I would take him to the sick bay. Being the eldest of five, I was expected to watch out for my other siblings too. Outside the home I was encouraged to participate in activities that contributed to the welfare of others, such as voluntary work. I grew up believing it was normal to provide service to people in the community and that you often did this in your own time. Nursing held positive images for me and I was easily coaxed into a career in nursing.

Professional influences

As I began my career, nursing was in the early phase of transition from hospital-based schools of nursing education to the education of nurses in the tertiary sector. A review undertaken in 1969 by the Health Department had identified concerns related to the education and preparation of nurses. An example of this concern was the deficient monitoring of student nurses on the three eight-hour shifts worked in 24 hours inside public hospitals. Monitoring of students, in the new tertiary training system was greatly improved, the apprentice-style hours of working were reduced and there was a shift to a more academic focus. This major transformation of nursing education commenced in 1973 and

continued until the final school of nursing attached to a public hospital in New Zealand closed in 1990.

I was aware from media reports and conversations with my mother during the mid- to late 1970s that I had options about how to pursue my nursing career. I decided to follow a similar training to that undertaken by my mother; the hospital-based training. My decision was influenced by the knowledge that I would have a place to live and receive an income. These options were important to a 17-year-old, I wanted independence.

In the early days of my training I often wondered what on earth I was doing; I did not feel intellectually stimulated and hierarchical processes dominated my experience with rules that were archaic by today's standards. I had awareness that women in other careers throughout New Zealand society were experiencing unprecedented change and increasing freedom compared to what I was experiencing in nursing.

It was a jolt to the senses to leave home at 17. Real life was different from my much-protected home environment, where honesty, truth, and kindness prevailed. I was the youngest in my class and the experience of providing nursing care to total strangers in a public hospital considerably hastened my growing up. It was a tough career; we were still permitted to work ten days in a row without a day off when I started work in 1977. The number of days worked in a row was reduced to seven during my first year when new legislation passed into law. We were expected to work weekends and the full range of shifts including night shifts. Military influences echoed from the past in our shoulder lapels which designated our status and the expectation we would follow orders without question. Thinking for yourself and voicing your opinion was not openly encouraged, yet we were expected to think about what we were doing and were frequently challenged in nursing handovers to express our thoughts on nursing processes and rationale.

Our rough entrée into life as nursing apprentices was strongly linked to the expectation that we would serve the needs of others. Many found

this a daunting task and escaped this reality by resigning, only 12 of us graduated from the original class of 35. In a paper titled “A view on training of nurses in hospitals” presented to the State Services Commission in November 1969, Salmon (1983, p. 41) reported that 45% of students who enter hospital-based schools of nursing fail to complete the programme. I came from hardy stock with a strong protestant work ethic and never considered the option of giving up on nursing. Gradually I gained knowledge, skill, and enjoyment from my chosen career.

My full-time nursing career following registration has spanned two decades and included work in intensive care, coronary care, cardiothoracic intensive care, respiratory medicine, orthopaedics, haematology and oncology, renal, and urology surgery. I have worked predominantly as a staff nurse with shorter periods as a clinical nurse educator, charge nurse, duty manager, and clinical product specialist. My shift to nursing education occurred six years ago. This research project has evolved from my thinking about what constitutes the essence of nursing and has been shaped by my experiences as a nurse and teacher. It is important to consider what others propose is the essence of nursing. While this is not the place to examine all the constituents of nursing, caring and partnership have been singled out as two particular concepts worthy of comment because I believe they lie at the heart of what constitutes service in nursing.

Service in healthcare

The nature of service

Working with people and offering them help or assistance is, I believe, the nature of service in healthcare. It includes altruism where the needs of another are put before your own, even though you may feel tired, and the person you are helping is disagreeable, angry, or ungrateful. Some people may commit themselves to the service work of nursing because of spiritual beliefs.

For some, service in nursing may conjure up images of a nurse as a gentle, efficient, obedient, kind, handmaiden dressed in white. Yet the

spiritual connection is the nub of the person-to-person interaction that I suggest is service, a multi-dimensional phenomenon. The nature of service is explored from six discrete perspectives in a review of the literature presented in chapter two of this thesis.

Nursing service themes – caring and partnership

When Arendt (cited in Greenleaf, 1991, p. 80) defined work, carework the production of service for people was excluded from the definition. Arendt describes carework as labour which the ancient Greeks viewed as embarrassing and the realm of women, slaves, and beasts of burden (Greenleaf, 1991, p. 80). According to Chinn (1991), caring has been suggested as "fundamental to human experience" (p. xv). Caring is proposed as the essence of nursing (Gaut & Leininger, 1991, p. ix; Styles, 1982, p. 230). Alternative views of caring have been offered by Payne and Ellis-Hill (2001, p. 6) who suggest that women in kinship networks shoulder the burden of the majority of caring in the community. Another view, though, suggests that caring was not evident in an acute hospital setting where Kavanagh (2002) described, "caring by nurses as illusory … carers do not get paid for caring or being caring, but for providing efficient care" (pp. 64-65).

'Partnership' has been proposed as a significant component of nursing (Christensen, 1998, p. 25) and more widely applied by Suchmann, Botelho and Hinton-Walker (1998, p. 266) to health professionals; indeed identified as a necessary component of health professionals' competency. I believe the essence of nursing is about the intangible interaction that occurs between two people, much like the pictorial image of two circles overlapping. Something happens in the overlap that is what I call service.

As a charge nurse, and more recently an educator, I have had the opportunity to stand back from the bedside and view other nurses in action. Fledgling ideas about the notion of service as a concept or essence in nursing have simmered away as I observed patients' response to my nursing and the nursing of my colleagues. Some

colleagues appeared to have an attitude of service obvious in their work, while others lacked this demeanour. Looking back I am aware that my cumulative nursing and teaching experiences have shaped my quest to explore and understand the meaning of service. The opportunity to more formally scrutinise the concept of service will be made possible through this thesis.

Marketing and commercial views of service

Prior to my role in education I completed post-graduate study in marketing, where the notion of service was espoused as a measurable phenomena that marketers could evaluate and shape into a competitive advantage for a business. Marketers frequently seek to identify customer satisfaction via customer feedback. I recall anecdotal evidence about the customer feedback on hotel services, where the cleanliness of a hotel bathroom rated the most significant feature of hotel services. My desire to understand the concept of service and how it related to health was further fuelled during this study. It appeared that while marketers measured service there was less conviction around measuring outcomes relating to the dynamic that occurred between people.

Many similarities do exist between the operation of a hotel and a hospital. Both provide a service to the public, but a public hospital service would contrast starkly to with that provided in a private hospital. I have observed many public hospital patients tolerate unfavourable environmental and aesthetic issues, such as a communal bathroom for six people. This is unlikely to be tolerated by a patient in a private hospital. Perhaps a patient's focus on service in a public hospital is weighted in favour of the interpersonal relationships, because people become the measure of service rather than the meal service or room service. When people are unwell and dependent on health professionals for timely and considerate interventions and care, trust is likely to rank highly in their service experience.

The key element of trust

Trust is a phenomena explored in an annual survey by the New Zealand Reader's Digest magazine ("Who do you trust, New Zealand?" 2005). From February 23 to March 1, 2005 inclusive, 501 New Zealand adults participated in the Trust Survey. The three most trusted professions were identified as fire fighters, ambulance officers, and nurses. It is interesting to note that all three would identify themselves as service professions providing a service to the public. Trust, according to Gasquoine (1996), needs to be developed between nurses and families and will develop following frequent interactions from the "little things" that nurses do (p. 107). Van Eyk and Baum (cited in Ayers, Beyea, Godfrey, Harper, Nelson & Batalden, 2005) comment on trust between a hospital and community project as, "trust is both a prerequisite for collaboration and is further reinforced and confirmed [through] collaboration" (p. 266).

Earlier I described my concept of the service dynamic as the overlapping of two or more circles, service being the shaded area where overlapping circles meet (see chapter 6, figure 5). The shaded area is where two or more people may interact in a number of ways. I believe the interaction may take the form of conversation, expression of feeling through body language, or intangible intellectual, emotional or spiritual connections; touch and listening may occur. The interaction may happen with or without eye contact and with or without verbal consent. Although my concept spans a wide arena, and is loosely conceived, most people will have experienced service from a health professional at some point in their lives; I suggest this service will have involved an element of trust.

Thesis structure

Service is an intangible phenomenon that has influenced my life and choice of career. I am intrigued to understand the meaning and importance of service for health professionals and especially nursing colleagues. In chapter one I have identified the origins of my interest in the topic of service, through personal reflections, childhood, and professional influences. The themes of caring and partnership and their

place in nursing were briefly considered. The marketing and commercial views of service were presented and the significance of trust recognised.

A review of literature is presented in chapter two; a paucity of material on the meaning of service resulted in a review of six related topics. The subject matter considered includes vocation, spiritual care, emotional labour, caring, compassion, and sentimental work.

Chapter three presents and discusses the methodology. Rationale for utilising the method of co-operative inquiry and information about the data collection process are addressed. An explanation of participant selection, provision of information, ethical considerations, and processes of validity and reliability are presented.

The fourth chapter reveals the findings of this study following a thematic analysis and is generously illustrated with the voices of participants. Participants in this study collaborated with the lead researcher and identified five themes that express the meaning and importance of service.

Chapter five discusses the findings and five themes in detail. The five themes that emerged from this co-operative inquiry are ‘helping’, ‘giving’, ‘elements of service’, ‘acts of doing’, and ‘pride in work’. Helping is expressed as an action and attitude. Giving is seen as women’s work, involves altruistic behaviour, a spiritual connection with another, and participants agree that giving stretches us as people and nurses. Elements of service is composed of five sub-themes; working with people, being a public servant, being a servant, need, and duty. Acts of doing comprise two sub-themes, respect and sharing of wairua/spiritual connection. The last theme discussed in chapter five is pride in work and also consists of three sub-themes; motivating factors, problem solving or anticipating, and being proactive.

The process of co-operative inquiry is explained in chapter six. This infrequently utilised research method is deeply respectful and honouring of people. The four components that Heron (1996) reports as

components of co-operative inquiry are politics, epistemological issues, ecological concerns, and the spiritual dimension of life; these four components are explored in relation to this study.

Chapter seven concludes this thesis on the meaning and importance of service for health professionals. The conclusions of the group of participants are presented along with their experience of the co-operative inquiry process. Future research issues are identified. Personal conclusions and closing thoughts bring this thesis to its conclusion.

Chapter 2 Literature review

The Dali Lama says that;

> when you leave this planet, this body, you cannot take one single penny. All money, or whatever valuables you cannot take. The only thing which will follow you is *merit*. [*Merit* in Buddhism is the good karma, resulting from selfless actions that accumulate over our lifetime, or lifetimes]. So, in order to create a good future in this infinite future, you must utilise the present life to its maximum usefulness. That is making merit. The best way to accumulate merit is through serving others. (quoted in Weber, 1986, p. 130)

Introduction

Service work involves an intangible giving and receiving between people. Due to a paucity of literature on the subject in relation to healthcare, this literature review adopts a flexible conception of the notion of service. Following initial scanning of the literature, the author identified topics that had a synergy with service, thus creating a manageable boundary for the review. Four main concepts were eventually singled out. The following three topic areas were identified as stand alone subjects: vocation, spiritual care, and emotional labour. The fourth theme considers a combination of caring, compassion, and sentimental work (Figure 1).

Service as:
1. Vocation
2. Spiritual care
3. Emotional labour
4. Caring, compassion, and sentimental work

Figure 1. Literature perceptions of service

The four topic area headings were utilised as key words in a search across literature spanning the past 40 years. The electronic databases of both the Auckland Public library and the library of the Auckland University of Technology (AUT) were utilised. The searches in AUT

library databases such as Health Sciences: A Sage Full Text Collection, EBSCO Health Databases and ProQuest Nursing Journals were initially restricted to nursing literature but widened as the search progressed. This process was a deliberate attempt to manage the potentially large volume of literature.

The literature review begins with a selection of service definitions that are provided to ground our understanding of the notion of service. The definitions are followed by the review of the literature. The four topic areas are titled and separated into distinct sections, each beginning with a definition of the term(s), followed by a discussion of the literature and then a concluding summary. The latter part of this chapter includes a summary of the main findings of the literature. An assortment of definitions on service is now presented.

The Collins Concise English Dictionary (1992) provides 25 definitions of service; of those, only four are advanced here. These four definitions were selected because they relate most specifically to people. Firstly, service is “an act of help or assistance”; secondly, “an organised system of labour and material aids used to supply the needs of the public”; thirdly, “the act or manner of serving guests, customers”; and finally, “employment in or performance of work for another” (Collins, 1992, p. 1228). Authors who specialise in the subject of marketing, for example Kotler, Chandler, Brown, and Adams (1994, p. 789), define service as “any activity or benefit that one party can offer to another that is essentially intangible and does not result in the ownership of anything”. Heskett, Sasser, and Hart (1990) offer a similar exposition where the service concept is defined “not in terms of products and services but in terms of results produced for customers” (p. 20). These service definitions link people who give through their work actions with people who receive help or assistance. The giving of self through your work is not a component of every job, and a job which asks this of people may be viewed by some in society as a vocation; the notion of service as vocation is now explored.

Service as vocation

Four relevant articles on vocation were identified (Downe, 1990; Siccard, 1995; Warr, 1996; White, 2002). Vocation is defined as "a specialised profession or trade; a special urge or predisposition to a particular calling or career especially a religious one" (Collins, 1992, p. 1511). Two prominent world figures that epitomise vocation as a calling of a religious nature are Mother Teresa and the Dalai Lama. Some might argue that the Dalai Lama does not strictly fit the definition as he was selected for spiritual training following recognition by others as the 14th Dalai Lama at the age of two (Vreeland, 2001). However, the Dalai Lama has and does continue to freely give service to people all over the world. Mother Teresa, born Agnes Gonxha Bojaxhiu, reportedly told her mother on more than one occasion that she had received a call to serve God and felt deep joy at the prospect (Rai & Chawla, 1996). White points out that the concept of vocation, where being responsible and serving others rendered us useful and was linked to our station in life, can be traced back to Luther's philosophies (White, 2002). Expanding on this definition, White suggests people in vocational work often not only experienced difficulties in their own lives, but in the serving of others, took on *their* hardships too. Vocations actually involved knowledge, skill, and often the individualised care of another.

Historically the vocational model was applied to nursing and articulated through motherhood, femininity, and altruism. White advocates that nursing is a vocational job thereby involving a greater focus than simply getting the job done. Although White supports the view that nursing is a vocation, she goes on to suggest that femininity was hidden in the home and resulted in nursing being made invisible, that is, as the "professionalisation of the domestic" (p. 286).

The values and ideals of caring for others and meeting the needs of patients often match the stated values and ideals of the nursing vocation itself; as a result, White proposes that the person engages with the vocation. Over the past century, the notion of vocation has gone out of vogue in western societies and White offers three reasons for this

phenomena. Firstly, the scientific paradigm has shifted the previously accepted and encouraged view of vocation. Secondly, civil liberties have exploded and free choice has resulted in movement away from vocational careers. Finally, following the industrial revolution we now live in a productive era where people pursue their own goals, often at the expense of others. In the western world at the beginning of the 20th century, the population comprised greater numbers of women than men. Nursing was promoted as an alternative to marriage; it was considered a moral occupation which contributed positively to society and a respectable vocation for women (White, 2002). Unfortunately today, the wider community is still not widely enlightened about the nature of vocational work such as nursing, and White suggests nursing work is undervalued and poorly remunerated as a result.

Two authors who suggest that the links between nursing and vocation are degrading were located. Downe (1990) accepts that nurses provide care, which is an essential part of humanity and not a weakness, yet says describing nursing as a vocation is demeaning. Warr (1996) suggests nursing is an emerging profession, one which needs to focus on higher education models rather than maintain the links to training or vocational preparation as these make nursing socially inferior.

This was not the finding of a small Latin American study reported by Siccard (1995) and comprising 40 participants. When asked ‘why am I a nurse?’ 90% of the participants identified that they were nursing because it is a vocation. These respondents also believed that a vocational leaning results in patients receiving top quality care. Thirty-five percent agreed that it is natural to serve others, while another group suggested nursing is a calling from God.

Summary on service as vocation

Prior to the industrial revolution religion played a much bigger role in people’s lives. Religion was a major contributor towards shaping thinking about the purpose of work; the vocational rationale for work was supported and nurtured (Rai & Chawla, 1996; Siccard, 1995; White,

2002). The notion of nursing as a vocation persists and is reported in Latin American countries today (Siccard, 1995).

Nursing has been identified as a calling, a noble vocation, offered as an alternative to marriage, and identified as suitable employment for young women (White, 2002). Unfortunately the work women do as nurses has not been articulated as widely as it could be and White suggests society is not acquainted with its demanding nature or complexity. Consequently, nursing has struggled to be valued and receive adequate payment for services rendered.

Warr (1996) advocates that nursing pursue higher education and aim to fully emerge as a profession. According to Warr, cutting the links with apprentice type training and moving away from the notion of nursing as a vocation may elevate the standing nursing has in society. Nursing links to the notion of vocation are also connected to the concept of service as spiritual care and this concept is now considered.

Service as spiritual care

The search for literature on spiritual care resulted in a limited response. Caron (1995) offers a Christian definition of spiritual care, “the second essential attitude of Jesus’ covenantal ethics” (p. 52). A second definition comes from Henri Nouwen (cited in Warren, 2002, p. 269) “In order to be of service to others we have to die to them; that is, we have to give up measuring our meaning and value with the yardstick of others … thus we become free to be compassionate”. Spiritual care is considered a transcendent theme that is influenced by culture and history. Previously part of nursing heritage, as nursing has evolved the spiritual care of patients has become less important. Lane (1987) has explored the spiritual care of patients and is hopeful that nurses will, over time, have an increased desire to attend to this aspect of patient care.

The spiritual care of other people involves participating in spiritual activities that extend us as people. Lane suggests this includes reflecting

on the past, searching out the meaning of life, and achieving some inner wisdom from this process. The inner journey related to spiritual development has us learning to live in the present stretching ourselves and risking loss. The personal struggle clarifies our limitations and will often inspire us to achieve more (Lane, 1987). The personal journey of Viktor Frankl is used by Lane to effectively illustrate this point.

During the Second World War Frankl (1964) searched for meaning while detained in a concentration camp. Frankl suggested it was possible to experience a deepening spiritual life despite interment, and noted that this came more easily to sensitive people.

The role of the nurse in the care of the human spirit involves being totally present, allowing the other person to struggle, and opening up to the other person without fear. Lane suggests that most nurses prefer to avoid pain and cannot work in this way. Being able to lay fear and ego aside requires inner spiritual resources and is not a natural response. Lane believes that nurses who are ‘called’ can stand in a spirit of compassion with people and view their world through different lens; their world has possibly been shaped by past religious experiences.

Summary on service as spiritual care

Spiritual care has been influenced by culture and history. According to Lane spiritual care was once the domain of nurses but this has diminished over time. The refinement of our spirit may begin as result of hardship where we are inspired to search for meaning (Frankl, 1964; Lane, 1987). Initially we are likely to reflect on our past; achieving some degree of inner wisdom we then learn to live in the present. This is followed by a willingness to go beyond ourselves, risk loss, and endure hardship as we connect with other people (Lane). It is uncommon to find people naturally imbued with inner spiritual resources and willing to lay aside their ego (Lane). The people who engage in the spiritual care of others have usually experienced some type of hardship, searched for meaning, and learned to trade in the messy landscape of feelings; Frankl suggests this comes more easily to sensitive people. Emotional

labour is one name given to this type of work, and emotional labour is now discussed.

Service as emotional labour

James (1989) defines emotional labour as “labour involved in dealing with other people’s feelings” and it is undertaken in both the private and public domain (p. 15). The care of others in a domestic setting is predominantly carried out by women and considered unskilled labour. In a phenomenological descriptive study on emotional labour in nursing, three participants identified that managing emotions was beneficial to both home and work life (Staden, 1998). Managing emotions is an integral part of how families function, but it is poorly explored in the literature. Emotional labour tends to receive a low level of public consciousness and is hidden from scrutiny, not considered scientific, is poorly recorded, under-explored, ignored, and poorly defined (Staden, 1998; James, 1992). According to James (1992) women may find themselves stigmatised as emotional and subordinated in society because of the emotional labours they perform. The emotional labour that occurs in health services involves health professionals with knowledge and skills, doing for patients in the public arena. According to James, the most visible aspect of the work is physical, with the emotional aspect long ignored. Nurses retain considerable autonomy in their work and are able to move beyond the rules, using their discretion to add something extra to the patient-carer relationship (Bolton, 2000). This is what Titmuss (1970) described as a gift relationship; it carries no implicit or explicit demand for a return gift.

According to Hochschild (1983, p. 7) emotional labour “requires one to induce or suppress feelings in order to sustain the outward countenance that produces the proper state of mind in others – the sense of being cared for in a convivial and safe place”. Seeking to explore the idea of emotions as a messenger, Hochschild tracked flight attendants performing a day’s work in his quest to unravel this phenomenon. Hochschild was able to identify the characteristics of emotional labour undertaken by air hostesses and separated them into three distinct

groupings. Face-to-face contact with the public was revealed as the first characteristic of emotional labour. Secondly, the air hostess would produce an emotional state, such as gratitude, in the other person. Lastly, the behavioural activities of the air hostess were controlled and influenced by the employer's training scheme and close ongoing supervision.

Emotional labour involves a host of learned skills. These skills include; listening to someone, being with someone, using intuition and instinct, juggling time, anticipating, trouble shooting, and demonstrating warmth through personal attention (James, 1989). It can be physically and emotionally exhausting; the worker does not provide a formulaic response, and society does not recognise the challenges this creates (James, 1989; Staden, 1998).

It is reported that men tend to work as the emotional managers, setting the parameters of the work with the real emotional work completed by semi-professional females (Hearn, cited in James, 1989, p. 32). Men's work is valued and viewed as rational; on the other hand women's work is marginalised and subordinated. In the age of management accountability, it is startling to realise that the impact and consequences of emotional labour are rarely accounted for. Levinson (cited in James, 1989) suggests that aggressive emotion is sanctioned if it contributes to competition. Men tend to be under-represented in jobs that require significant emotional labour (James, 1989, p. 36). Until men are better represented in careers such as nursing, one wonders how much recognition emotional labour will receive and how much financial reward women can achieve.

Summary on service as emotional labour

Emotional labour deals with people's feelings and is considered beneficial as well as being considered a commodity (Hochschild, 1983; James, 1989). Occurring in both the public and private sides of life, emotional labour receives scant attention in comparison to physical labour (James, 1989; Staden, 1998). The public is reported to have a

low level of awareness of emotional labour, as it is under-explored and hidden from scrutiny.

One of the key characteristics of emotional labour is face-to-face contact; another – identified in the study of flight attendants – acknowledged that the employer maintained significant emotional control over the employee via training and supervision (Hochschild, 1983). Despite this, James (1989) maintains that managers rarely, if ever, take emotional labour into account.

There is no set formula for the delivery of emotional labour and it takes much energy from the person providing this type of work (James, 1989; Staden, 1998). Elements of emotional labour can be learnt and include listening, being with, anticipating, troubleshooting, and provision of personal care.

Men are seldom involved directly in emotional labour, they tend to plan and supervise its delivery. James reports that women carry out the bulk of emotional work. There is an association between emotional labour and caring, compassion, and sentimental work, this affiliation is now considered.

Service as caring, compassion, and sentimental work

The strategies for maintaining composure developed by nurses caring for dying patients was identified as sentimental work (Strauss, Fagerhaugh, Suczek, & Weiner, 1982). One definition of sentiment is “a mental attitude determined by feeling” (Collins, 1992, p. 1224). Strauss et al (1982) classified seven types of sentimental work during their large qualitative grounded theory study that considered the impact of medical technology in hospitals. It is acknowledged that there may be more than seven types of sentimental work (Strauss et al, 1982).

The first type of sentimental work involves an interaction between people. The hallmarks include being courteous, listening without interrupting, and interacting with the patient in a pleasant manner. Strauss et al (1982) related several stories about neglectful and insulting experiences where this interactional work did not occur. The second type of sentimental work is trust. The building of trust varies from situation to situation and person to person. It may involve lengthy discussions and possibly demonstrations; in an emergency situation this type of work may be neglected (Strauss et al). Creating composure through the holding of a hand or offering reassuring words of comfort comprise the third type of sentimental work. According to Strauss et al the flow-on effects of composure work can be significant, especially when procedures or treatments are repeated.

The fourth type of sentimental work is called biographic (Straus et al). Used predominantly to obtain a patient's history for diagnostic purposes, it can enhance the therapeutic relationship when healthcare professionals disclose some of their own biography. A second positive outcome that results from biographic work is the motivating force it creates to assist patients through tough times. The lack of biographic work is reported to reduce both patient and general ward morale (Strauss et al). Physiological work is connected strongly to the identity of the patient and identified by Strauss et al as the fifth type of sentimental work. Strauss et al note approvingly that there is a trend in nursing to "work with a patient" to prepare the patient for the next phase of their health journey. The sixth type of sentimental work is awareness of context and is aimed at helping patients maintain composure and will, on occasion, involve the withholding of information regarding an unfavourable diagnosis (Strauss et al). The final type of sentimental work is called picking up the pieces and is likely to involve a healthcare professional making an apology to a patient. The apology usually relates to inconsiderate behaviour by another healthcare professional (Strauss et al).

Interestingly, Strauss et al (1982) report that sentimental work is not made explicit, and is not usually documented in the notes of hospital patients. Neither is anyone held accountable for this type of work. Despite acknowledgement that this type of work is complex, it tends to be embedded in other work performed by doctors and nurses. Strauss et al caution healthcare workers not to neglect sentimental work because lack of it is likely to incur patient complaints related to depersonalisation. Connecting with patients will often result when the healthcare workers, often the nurses, provide physical and emotional care to a patient. The concept of caring in nursing practice has resulted in the production of multiple theses. Some of these views are now considered.

Caring is defined as "showing care and compassion; of or relating to professional social or medical care" (Collins, 1992, p. 201). According to Chinn (1991) "caring is fundamental to human experience" and although it has remained largely unexamined by academia, Chinn suggests nurses need to embrace caring as an aspect of their practice (p. xv). Vezeau and Schroeder (1991) selected seven authors and examined their views on caring. The view of each author is briefly presented.[1] Mayeroff (p. 2) proposes that caring brings self-actualisation for the one being cared for and is grounding for the one who provides caring. Caring is described by Gadow (p. 3) "as an end in itself and the highest form of commitment to patients". Noddings states that caring may or may not involve action or verbal communication and is a way of being. Watson identifies nurses as the leaders in caring where,

> caring involves the will to care, the intent to care, and caring actions. These actions can be positive regard, support, communication, or physical interventions of the nurse. Caring is commitment to an end, the protection, enhancement, and preservation of the dignity of the other. (p. 3-4)

Rather than action, Buber like Noddings states that caring is a way of being. Jonas is a philosopher who believes caring "arises out of the

[1] All of the authors in this section are cited in Vezeau & Schroeder, 1991 [V & S]).

freedom to relate" (p. 4). The final view of caring was obtained from Audubon, who suggests that it involves the preservation of the natural state of things.

Vezeau and Schroeder (1991) summarise the seven propositions on caring as a means to an end and propose that caring can be seen as an instrument in this situation. Alternatively the caring relationship may have greater value when the caring is not related to a specific outcome (Vezeau & Schroeder). Caring is reported to be beneficial for both the carer and the person receiving care; it may promote healing, and facilitate life being experienced fully. Vezeau and Schroeder suggest that caring can be understood in a variety of forms and that one definitive model does not exist.

Pellegrino (cited in Bishop & Scudder, 1991, p. 24), "describes four types of caring – all of which are integrally related in healthcare; (1) compassion for others, (2) doing for others what they can't do for themselves, (3) using professional understanding and skill for the patient's good, and (4) taking care in the sense of being diligent and skilful in actual practice". These findings are similar to those presented by Staden (1998) in a phenomenological study that explored caring and the emotional labour components of nursing. The six themes identified by Staden that emerged are briefly listed here; public and private spheres, giving of yourself, coping, appearing caring, value and visibility, and nurses are human too.

Graham (1983) believes that caring can affect how we define ourselves and our social relationships, and that caring impacts on social policy. Caring is depicted as a labour of love that usually occurs in the privacy of our homes (Graham, 1983; Staden, 1998). Feelings expressed in conversation convey caring to friends, children, lovers, and parents (Hochschild, 1983; Graham, 1983). Although caring is recognised as a universal need, Graham suggests that care is only facilitated in certain social relations and is usually undertaken by women, in contrast men tend to have relationships based on competition.

Most jobs accept social distance as the norm, but jobs such as nursing, teaching, and social work are the exception. According to Graham (1983), many psychologists suggest women achieve femininity and a sense of fulfilment through caring. Graham states that psychologists "misrepresent and trivialise the nature of women's role" (p. 20). Graham agrees with Greenleaf (1991) that civilisation has not recognised the contribution of caring. Caring is dismissed and, at most, considered an incidental contribution to the maintenance of patriarchy and capitalism. The stressful nature of caring is obscured according to Graham. The conclusion reached by Graham is that there are disadvantages in separating labour and caring, with caring seen as a sacrificial female act rather than self-actualisation and fulfilment.

Caring is unique in that it remains a form of labour with limited scope for mechanisation, while profit making is usually dependent on mechanisation (Graham, 1983). Baker Miller (cited in Graham, 1983, p. 21) suggests that women acquire the predisposition to care to survive in a male-dominated society. Graham does not agree with Baker Miller and postulates that economic and social relations at work and at home affect the caring role. By supporting the assumption that women enjoy this role, the ideology that supports women's subordination is perpetuated (Sayers, cited in Graham, 1983, p. 22).

Social scientists suggest that for an economy to function, families must provide significant privatised care, labelled as unspecific labour (Graham). Caring, or the lack of it, becomes visible only when it is not undertaken as expected (Meylan, 2005; Johns, 2005). According to Graham women in caring roles outside the home often confront the very demands that oppress them within the home; unending helping, nurturing, supporting, and educating. Women experience contradictory tensions in relation to caring; they often provide care but may not receive care from others (Graham).

Compassion is the third and final theme in this section. Compassion is defined in the Collins Dictionary (1992, p. 269) as "a feeling of distress

and pity for the suffering or misfortune of another". McNeill, Morrison, and Nouwen (1982) define compassion from the Latin words pati and cum – to suffer. In a narrative study on compassion in organisations, Frost, Dutton, Worline, and Wilson (2000) define compassion as empathetic concern for the welfare of others. Frost et al (2000) link compassion with people sharing pain, fear, anguish, and vulnerability. McNeill et al offer an opposing view, that most people avoid being compassionate and consider suffering in this way to be abnormal. Frost et al report that participants in their study did not adhere to normal organisation rules when they engaged in a dialogue about compassion. One of the normal rules that was cast aside was that of putting on a front to keep life problems at home and separate from the workplace (Frost et al, 2000).

According to Frost et al people bring their pain to their work. Actions of kindness and affection allow people (staff members as well as patients) to connect with each other and promote healing in these workplace communities in broad, reciprocal relationships; this compassion represents humanity in the workplace. Acts of compassion may be planned or spontaneous, solo or collective, and usually target the moment that might make a difference for someone; "compassionate action involves moving from not knowing and using attunement to guide action" (Frost et al, 2000, p. 32). Advanced nursing practitioners are reported by Frost et al to have developed emotional attunement that enables them to read a patient and grasp the emotional tone of the situation.

Frost et al have identified nine characteristics of compassion; (1) being present, (2) patience, (3) sensitivity, (4) giving of self (5) strengthened relationship, (6) increased trust, (7) co-operation, (8) mutual support, and (9) collaboration. Workplaces that were identified as being compassionate were able to attract and retain staff, despite work exhaustion or emotional overload limiting or inhibiting expressions of compassion (Frost et al). According to Roach (1991) the world is crying

out for meaning, love, tenderness, and compassion and Nouwen (cited in Roach, 1991, p. 13) suggests we:

> go where it hurts, to enter into the places of pain, to share brokenness, fear, confusion, and anguish. Compassion challenges us to cry out with those in misery, to mourn with those who suffer loneliness, to weep with those in tears.
>
> Compassion requires us to be weak with the weak, vulnerable with the vulnerable and powerless with the powerless. Compassion means full immersion in the condition of being human.

Summary on service as sentimental work, caring, and compassion

The seven types of sentimental work identified by Strauss et al (1982) are headed by 'interaction between people' – which was listed first of the seven types – and is where being courteous, listening without interrupting and being pleasant are important. 'Building trust' was the second type of sentimental work. The third type is called 'creating composure' where the health professional offers verbal reassurance and physical reassurance through touch, such as holding a patient's hand. Motivating the patient through tough times and enhancing the therapeutic relationship is claimed to be achieved through 'biographic work'. This fourth type of sentimental work involves disclosure of personal information or sharing the health professional's biography with the patient. 'Physiological work' is the fifth type of sentimental work. The sixth type is called 'awareness of context', and means working with the patient to maintain the patient's composure in the context of the patient's situation. The seventh and last type of sentimental work is called 'picking up the pieces', and involves one health professional making an apology to a patient regarding the attitude or behaviour of another health professional.

When sentimental work is not attended to, patients report that their care lacks a personal touch and feels depersonalised. Strauss et al have highlighted that sentimental work is important, but note that it is rarely specifically assigned to any particular health professional, made explicit, and not usually documented in the patient's records.

Vezeau and Schroeder (1991) considered the views of seven theorists on the notion of caring. Mayeroff (p. 2) linked caring with self-actualisation. Gadow (p. 3) suggested caring is the highest form of commitment to a patient. Noddings and Buber (p. 3) agreed that caring is a way of being. Watson (pp. 3-4) promotes the idea that caring is protective, enhancing, and preserves dignity. Jonas (p. 4) says caring creates freedom to relate. Finally, Audubon (p. 4) believes caring preserves things in their natural state. No one model of caring was elevated above others by Vezeau and Schroeder but they suggest that caring is beneficial to both the carer as well as the person being cared for.

Four types of caring were proposed by Pellegrino (cited in Bishop and Scudder, 1991, p. 24): firstly, compassion for others; secondly, doing for others; this was followed by applying professional skill for the good of others; and lastly, ensuring you were mindful in your provision of skilled care.

In a study undertaken by Staden (1998) six themes on caring emerged; firstly it was considered beneficial to learn how manage your emotions and these benefits affected both the private and public spheres of life. The next theme involved nurses being ‘real’ with patients and role modelling alternative methods for emotional management to patients in their care. The third theme identifies women as emotional sponges who cope with the highs and lows of providing care. Being able to control your facial expression and body language was the fourth component of caring. The fifth theme that emerged in the study suggested that caring is not valued and receives poor visibility. Lastly, the relatives of patients suggested that nurses are superhuman when they deal with, and care for, demanding and difficult patients. Nurses believed they were simply human but required appropriate remuneration and greater acknowledgement for the caring they provide.

Graham (1983) believes that caring is usually expressed by women, hidden predominantly in the home, and involves an expression of

feelings that creates stress. Caring cannot be mechanised and does not follow a set formula. The caring roles women perform are often trivialised and Graham (1983) suggests that women's subordination is perpetuated by the assumption that they enjoy the caring role.

Compassion in the workplace was considered unusual but recognised as enabling connection between people (Frost et al, 2000). This connection was considered a hallmark of advanced nursing practice. According to Frost et al, compassion comprises the following nine characteristics: being present, patience, sensitivity, giving of self, strengthened relationships, increased trust, co-operation, mutual support, and collaboration. Compassionate action was limited in times of workplace exhaustion and emotional overload.

Summary

Vocation is identified as a special urge or predisposition, a religious calling, and has traditionally been used by men to persuade women into professions such as nursing. Appropriate financial remuneration for service jobs such as nursing has not been forthcoming and as the scientific paradigm has gained prominence, and as civil liberties and individual rights have gained prominence over the 20th century, the notion of vocation has gone out of favour. These issues have impacted on the attraction and retention of people into service professions such as nursing. Interestingly, the links between vocation and nursing appear to have remained dominant in Latin American countries where the Roman Catholic Church continues to play a significant role in people's lives.

Spiritual care as service has a very low profile in the west. A journey of self-reflection, ego reduction, and a willingness to work with others usually involves pain and fewer people are prepared to travel this path. The spiritual care of another does have links with vocation, emotional labour, and sentimental work. All these concepts involve some degree of face-to-face contact, where listening skills, being with, problem solving, and personal care are utilised. These concepts demand a degree of emotional self-management/emotional intelligence and are usually also

physically demanding. Unfortunately the complexity and challenges of these aspects of work have been poorly explored, not made explicit, and not bought into the public consciousness. As a result, the spiritual care of another, emotional labour, and sentimental work remain predominantly the realm of women and a myth exists that women are fulfilled in these roles.

Caring and compassion underpin our society, yet their importance and value to society is hidden; ironically, they tend to become visible only when they are absent. Caring and compassion cannot be prescribed or mechanised they require time and energy. Some aspects of service work are learnt; for example, it is possible to improve your listening skills and therapeutic communication skills through repetition and practice. Use of intuition and patience, building trust, and sharing something of your own biography are essential to skilful service work with others in this field.

Multiple perceptions of service exist, and this literature review has presented a selection of the views of academics and theorists. Exploring the complexity and demanding nature of service may highlight contributions that are made to society, promote and re-brand nursing as a fulfilling career, uncover hidden meaning, and enhance and expand the dialogue on service. It is important to hear the voices and experience of health practitioners for their perception on the meaning and importance of service.

Chapter 3 Methodology

A lack of clarity surrounds the meaning of service, why it matters, and to whom it matters. I have a deep conviction that service matters to people who provide it and to people who receive it. Yet the notion of what service is and its meaning rarely receives attention in healthcare circles. It does not appear to be fashionable to be attracted to a career where you provide service to others. A case in point is the increasing difficulty schools of nursing have encountered in attracting potential candidates to a career in nursing (Nursing Council of New Zealand, 2000).

As a nurse and educator I have observed and participated in many service encounters. I noticed how my colleagues interacted with patients and students and how the patients and students responded. I have tried to 'cherry pick' the best ideas and integrate these ideas into my own practice; many of these ideas were related to the delivery of service. For example, the simple courtesy of introducing yourself to a patient and explaining how long you'd be on duty and how to call for assistance if you were not around appears to have a very positive affect on the ensuing relationship. I have not found it demeaning to serve, to help, to meet another person's needs, to educate, to facilitate, or to assist with day-to-day activities of living in the course of my profession.

With a deep conviction that service matters, I am interested in knowing whether it matters to other health professionals, especially nurses. I believe it is important to explore this challenging issue and, importantly, to utilise a process that empowers people. Women and nurses can often find themselves marginalised, so group processes were specifically utilised to empower and maximise success with this venture. Instead of the lead researcher potentially holding all the power, everyone who attended the group sessions was encouraged to have power, by contributing ideas and being actively engaged with analysis and decision making. Everyone in the group agreed to be involved both as a participant and as a co-researcher. The participants acknowledged that

a group of people would often challenge, debate, and develop an idea past the point that an individual can achieve. This whole approach then sought to use a research methodology that philosophically honours the participant, contributes to participatory involvement, and in so doing increases the epistemological validity of the data generated (Reason, 1988).

Methodology

A qualitative rather than a quantitative paradigm was required to address the research question in this study. Subjective information was sought from participants avoiding the use of variables and quantitative measures. The qualitative research approach has evolved from poststructuralist schools where the number of participants is small and the purpose of the study is to understand them rather than measure them. A qualitative methodology was selected in preference to a quantitative methodology because the notion under study is of a subjective nature and involves the lived experience of the participants. The research involved “collaboration, participation and valuing naturalistic experiences rather than setting up controlled experiments in which the researcher is distanced from the subject” (Cotter & Smith, 1998, p. 217). The participants and researcher expected to work together to uncover meaning during the research process.

The initiating researcher required the research approach to complement critical social theory and is asking whose interests were being served. The research must also be emancipatory and participative in character. “The simplest description of co-operative inquiry is that it is a way of doing research in which all those involved contribute both to the creative thinking that goes into the enterprise … and making sense of what is found out … a form of education, personal development and social action” (Reason, 1988, p. 1). According to Heron (1996) co-operative inquiry is “a vision of persons in reciprocal relation using the full range of their sensibilities to inquire together into any aspect of the human condition with which the transparent body-mind can engage” (p. 1). Thus the co-operative paradigm follows post-positivist thinking, where the

worldview was reductionist; in co-operative inquiry people participate in the research rather than have the research done on them (Reason, 1988).

The research paradigm needs to match the topic under inquiry. The co-operative inquiry methodology is suited to the question under consideration (that is, to determine the meaning and importance of service for health professionals) as well as my own philosophical values. These values include the notion that people are unique, that group work can be healing and empowering, and that we honour each other by listening to each other's experiences and stories.

The challenges to this approach include the time and energy commitment required from participants. It may be difficult to capture interest in a venture that requires such a commitment. However, knowing this in advance helped when scoping the agreed group process. For example, we agreed to have monthly meetings on campus, in a central location, and to meet at the end of our working day for no longer than two hours. Co-operative inquiry allows two or more people to experience and reflect on a research topic; a description of the origin, intent, and general manner and structure of co-operative inquiry is now presented.

Co-operative inquiry

Experiential learning and action research developed from the work of Kurt Lewin during the 1950s and has some affinity but also difference with co-operative inquiry. Heron (1996) suggests that in co-operative inquiry both the researcher and participants engage in a reciprocal relationship where they take on the double role of being both a participant and co-researcher. Heron presented the model of co-operative inquiry in 1968-69 as the result of reflection on mutual gazing that occurred during interpersonal encounters. During the 1970s Heron applied rudimentary forms of co-operative inquiry during workshops that explored a large number of topics, and reports that three phenomena emerged. Firstly, that an interdependence exists between observing

phenomena and exploring alternative behaviour. Secondly, in the field of transpersonal psychology it was possible to counter authoritarianism and arbitrary intuitionism by applying peer experiential research. Lastly, social oppression and disempowerment could be opposed with co-operative inquiry to form a self-generating culture (Heron, 1996).

John Heron, Peter Reason, and John Rowan established the New Paradigm Research Group in London in 1978. During the early 1980s Peter Reason and John Heron collaborated on the methodology of co-operative inquiry and worked on research projects with counselling colleagues and later with a group of general practitioners. The academic centre for co-operative inquiry in the UK is located in the School of Management at the University of Bath, within a Post Graduate Research Group that includes Peter Reason (Heron, 1996).

Meanwhile, in other parts of the world, co-operative inquiry has developed its own distinct style. Finnish academics Marja-Liisa Swantz and Arja Vainio-Mattila have worked in Africa for many years with an emphasis on establishing a dialogue between grass roots peoples and researchers. They call their form of co-operative inquiry ‘participatory research’ (Reason, 1988). In the USA, collaborative inquiry and action science emerged from critical theory, humanistic psychology, and organisational development and its proponents include Bill Torbert and Bob Krim (Reason, 1988).

The intent of co-operative inquiry is to undertake research with people where any feature of being human is explored by considering the group experience. Heron (1996) suggests that most qualitative research is explained as an interpretative science within a constructivist paradigm. However, co-operative inquiry rests in what Heron describes as a fifth paradigm, called participative reality, which has two wings – the epistemic and the political. The epistemic wing is interested in truth and values. The political wing is concerned with human flourishing where participative decision-making affects all aspects of life and the ecosystem (Heron, 1996). Both the epistemic and political wings may

result in personal transformation, liberate disadvantaged groups, develop theory, bring about change and development within institutions, and culminate in the exploration of the human experience.

The general manner or structure in which co-operative inquiry is undertaken includes the following processes. Firstly, reflection on the subject under consideration followed by planning and decision making about the way ahead. Secondly, the agreed action occurs and data about the action is recorded. The group involved is likely to meet and discuss progress and consider the data and come to some new awareness on the topic of the inquiry. At this point the focus of the topic may be reviewed and the way ahead discussed and decided. It is common to cycle through these four processes between five and eight times before the concluding threads are pulled together and final decisions about the reporting process are agreed. It is common for the report writing to be collaborative in nature.

Research method

The collection of data for this study occurred during focus group interviews. This is a common method used in the social sciences (Sarantakos, 1993). The process of co-operative inquiry allows contribution from all involved and the distinction between participants and researcher disappears as all become co-researchers and participants (Reason, 1988, p. 1).

Story telling was utilised as the method to explore the meaning and importance of service by seven tertiary educators. Tate (1998) suggests that marginalised groups can use story telling as a powerful method for revealing the history of a group. Qualitative research is characterised by a small sample that share their experience. The aim of the research is to understand the participants' experiences.

The potential participants met together in process meeting one, to gather first-hand information about the project and the purpose of the research. The participants met for a second process meeting and committed to the

study by signing consent forms and agreeing to follow a timetable to facilitate the process. Two focus group interview meetings followed, where the seven individuals and lead researcher shared their stories on the meaning and importance of service. These sessions were not process meetings. The focus group gathered for a third process meeting to review the themes that had emerged from the initial focus groups interview sessions. The themes revealed the meaning and importance of service; these themes were reviewed, discussed, and agreed by the group.

In the first process meeting, the focus group spent time discussing and coming to an agreement on group process prior to addressing the issues under consideration. The participants received an information sheet (Appendix B & D) about the method, and a consent form (Appendix C). I made it explicit to the group that the purpose of this endeavour was primarily for the intention of completing my Master's thesis. The group collaboratively agreed that we would continue to meet following completion of the thesis to pursue our desire to publish data that emerges from this study.

The focus group discussions were audio taped and later transcribed. Each participant received a copy of the transcripts following each meeting and a table of the emerging themes via e-mail prior to the third (final) meeting where the emerging themes were discussed.

Data collection

The data collection occurred via audio taping of the focus group interview sessions, and these recordings were typed as transcripts. As the person who initiated this research, I also recorded my own impressions, feelings, and thoughts of this journey in an electronic journal. The data analysis was undertaken by the initiating researcher only and followed the story telling focus group sessions; the data analysis aimed to make sense of the data collected. Each participant had shared their thoughts through two stories, one on the *meaning* of service and a second on the *importance* of service. The stories were

from both a personal and professional stance. The story telling stimulated other group members to contribute new ideas and insights on matters presented. This occurred after participants had shared their stories.

The process of data analysis occurred following the four-step process that is described by Lamnek (cited in Sarantakos, 1993, pp. 305-306); step one, transcription of the audio tape recordings into typed script. Step two, analysis of the transcripts for key themes. Step three, generalisation occurred where the differences and similarities from each participant's story was identified. Step four; a process of control occurred when the participants examined the transcripts and where the material was organised into agreed themes.

Participant selection

The prospective participants identified themselves to the researcher by responding to an e-mail distributed across the Faculty of Health, Auckland University of Technology (AUT) (Appendix A). Initially 14 prospective participants from various schools such as Occupational Therapy, Physiotherapy, Nursing and Sport and Recreation within the faculty made contact and attended the preliminary discussion meeting. They were all health professionals involved in health education and they were selected according to the following criteria, each must:

- work as a health professional in the Faculty of Health, AUT; and
- have an interest in exploring the meaning and importance of service.

E-mail and telephone contact was made with the prospective participants and discussion regarding selection criteria occurred at this time. In the end it was only nurse educators that committed to participation in the project.

Ethical considerations

To facilitate decision making regarding involvement in the research project, the interest, intent, and potential outcomes of the project were discussed openly with the potential participants. The prospective participants were invited to meet together to obtain written material (Appendix B & D) and to hear from the researcher about how we could facilitate this research project through sharing stories about service. The process granted them free choice and was not coercive in any way. The prospective participants were provided with a consent form (Appendix C) that was to act as a contract of understanding about the nature of the research.

Comprehensive explanations about following a check-in , discussion and check-out meeting process, regularity of meetings, taping the discussions, the transcription of material and when participants could expect to receive material to read following each meeting and how they could respond to the material were provided to the prospective participants from the start of the project. Co-operative inquiry is unique in acknowledging the dual roles of the initiating researcher and participants as both researchers and participants in the study.

Participant information

Material about the project was shared in two stages. The initial e-mail invited people to respond if they shared an interest in “being of service” and “seeking to foster empowerment” (Appendix A). Those expressing interest then attended a discussion meeting where information about the project and consent forms were presented (Appendices B, C & D).

Validity and reliability

It is important to test and confirm findings in qualitative research. Processes that contribute to validity and reliability have been identified by Miles and Huberman (1994) and include: checking representativeness; triangulation; checking for researcher effects and gaining feedback from participants.

Representativeness

The data collected in this study was obtained from seven participants and the lead researcher who met in focus group meetings on three separate occasions. The seven participants emerged from a total initial group of 14 who identified an interest and attended two background meetings. All seven participants were known to the lead researcher and from the same academic community. Their suitability to participate was confirmed initially by telephone follow-up to the e-mail. At the second background meeting the prospective participants confirmed their willingness to proceed by providing their consent (Appendix C).

Triangulation is defined by Polit and Hungler (1997) as “the use of multiple methods or perspectives to collect and interpret data about some phenomenon, in order to converge on an accurate representation of reality” (p. 470). There are drawbacks in using only one method, so to increase the research validity three approaches were utilised; focus group meetings, feedback from participants, and confirming consistency with the literature.

Participatory storytelling group meetings

The three participatory storytelling group meetings provided the primary source of data in this research project. Two questions were answered in the form of two stories written and shared by each participant. The opportunity to validate the transcripts occurred each time we met. Data was organised into 19 categories by the initiating researcher and discussed, reordered and reduced to five themes that were validated by participants/co-researchers and the initiating researcher.

Feedback from participants

The participants were invited to analyse the data that was presented at each focus group meeting. This involved revision of the typed transcripts, which contained the stories, and the thematic analyses of these stories. The transcripts were sent via e-mail to the participants prior to the next meeting where they would be discussed. No major changes ever resulted. Agreement was easily reached on the major

themes to emerge from this study. Lincoln and Guba (cited in Polit & Hungler, 1997, p. 306) identify this process as a significant method of establishing qualitative data credibility.

Consistency with literature

The themes that have emerged from this project appear to be consistent with the literature that comes from a variety of sources. Comparisons of the research findings with other sources enable discrepant findings to be noted and perhaps re-examined in order to find possible explanations. The general expectation, and thus confirmation of validity, is that local findings are likely to match findings from the wider academic community.

Researcher effects

The author acknowledges researcher bias throughout the study. The interest the researcher has in the subject was explained to participants in the initial e-mail and subsequent discussions on the purpose of the research project. The researcher acknowledges that all participants were female and speculates on selection bias, although all participants were self-selecting for this study. All the participants were known to the researcher prior to the study commencing; whether this familiarity has influenced participation or not is difficult to assess but important to acknowledge.

Summary

This qualitative methodology has sought to explore the meaning and importance of service for a group of health professionals who work as tertiary educators. It has been grounded in a critical paradigm and has utilised a participative/cooperative inquiry method. The meaning and interpretations have emerged as participants gave voice to their experiences, and this is the acknowledged interpretative approach. The data collection occurred through storytelling during the focus group meetings. The participants joined this co-operative inquiry because of their interest in the subject under study and because they met the stated criteria. Comprehensive information was provided throughout the research process. The process of analysis involved participants in

decision making regarding the final themes, and is congruent with the methodology of co-operative inquiry. Validity and reliability issues were acknowledged and discussed through consideration of: participant representativeness; triangulation; and researcher effects.

Chapter 4 Findings

Data collection and analysis

Five categories form the basis of this chapter; these categories emerged following a collaborative discussion with participants and the initiating researcher. Each participant agreed and wrote two stories to share with the group. In the first story the meaning of service was considered and in the second story the importance of service related to our practice as nurses and educators was examined. The stories were spoken aloud to the group, audio-taped and later transcribed.

The seven participants asked that I undertake the initial data analysis and then present the findings to them for their consideration and input. I was very comfortable agreeing to take this role. Nineteen themes emerged following the initial data analysis and were presented to the participants. The 19 categories were discussed with participants and we agreed to reduce them to five themes overall, these are presented below in Figure 2.

Meaning and importance of service:

1. Helping
2. Giving
3. Elements of service
4. Act of doing
5. Pride in work

Figure 2. Meaning and importance of service

Helping

One of the major themes to emerge for the participants in this study of service was ‘helping’. Comprised of two significant components, ‘helping’ was firstly described as an action and secondly identified as an attitude. The actions were likened to being a crutch in times of physical, emotional, and spiritual need. Providing professional assistance for

another was seen as a ‘helping’ action, or manaakitanga, and was expressed to another as encouragement. The ‘helping’ could include presentation of options that may result in another person’s thinking or behaviour changing. Often these changes were considered to be for the better.

The second element of helping was perceived as an attitude that had been instilled in us as nurses. The attitude included the strong helping the weak, or kotahitanga – where we are one with another for the betterment of self and the other person. Participants agreed that the attitude of ‘helping’ could be expressed as wairuatanga, a spiritual connection you can have with another person. We all appeared to accept that we knew what we meant by having a spiritual connection with another person, and we did not explore this concept in any further discussion. On reflection, this assumption that we were on the same wavelength about spiritual connection perhaps was unwise. We have missed an opportunity to explore particular meanings spiritual connection had for us as a component of service work in nursing and education. It would have been very appropriate, given the nature of our study, to have spent some time discussing the meaning and importance of spiritual connection in the context of ‘helping’. The following comments capture some of the essence of ‘helping’.

> *… I would be watching for the people that needed just that little bit extra kind of carrying and the crutch … to help them through the day …*
>
> *… being professionally helpful without being a doormat…*
>
> *… helping others whenever required and this was something that was instilled in us as nurses…*
>
> *… giving and wanting to be helpful…*
>
> *… the strong help the weak, we serve each other…*
>
> *…I came nursing to help other people…*
>
> *… present different options, different ways of responding and behaving, and it offers people a choice…*
>
> *… overall service is one person helping another…*

Giving

The second major theme that transpired from the co-operative inquiry group discussion was 'giving'. Participants agreed that 'giving' was expressed in altruistic behaviour where the concern for the welfare of others would come before our own. 'Giving' like 'helping' also had a spiritual component, or wairuatanga, which sometimes evolved rapidly and at other times occurred over time – either way it required energy and kindness. 'Giving' was also experienced as a stretching of self which, as a by-product, taught us about our own limitations.

> *… at times unquestioning and putting other people's needs before your own…*
>
> *… the word spiritual came to me and I think I had a similar sort of sense that [this] is what service was about…*
>
> *… you give of yourself and your time and your kindness and your ability to listen …we sometimes give and give and give until we almost have got nothing left to give but in that we learn about how far we can go and how far we can't go but it is part of us providing service to other people…*
>
> *… so what you were doing there is recognising her distress and responding to it in a really appropriate way because she was asking for one thing but you knew that it wasn't the best decision for her to be making in view of how sick she was. That is a lovely example of giving to that patient….*

'Giving' needs to be positive for the recipient, but it was identified as fluffy, soft, and difficult to articulate. The inquiry group acknowledged that service work is not so freely 'given' today, and that a culture of 'user pays' has affected service industries, including health. According to Coney (1997) social reform in New Zealand began with a Labour Government in 1984, where the blueprint for changes in health had their origins in a document titled *Economic Management,* which was prepared by Treasury and supplied to the incoming Labour Government in 1984. The document made the following suggestions; firstly, lack of competition did not provide an incentive for keeping costs down; secondly, user charges were needed as an incentive to get individuals to safeguard their own health; lastly, there was a greater need for targeted spending in managing health. In 1988 Alan Gibbs, a prominent

businessman and active member of the Business Roundtable, published a report that echoed work done by the Health Benefits Review and Treasury. It recommended a split between the health purchaser and provider. Alan Gibbs had gone on record saying this was to be a stepping-stone to the privatisation of health in New Zealand. Gibbs promoted tax cuts as the means by which people would buy their own healthcare.

Following the 1990 elections, the National Party was elected to government and Simon Upton became Minister of Health. Coney (1997) reports Upton had worked covertly on the Green and White papers (jointly promoted by Upton and the New Zealand Roundtable Economic Think Tank, documents that advocated a user pays philosophy as an alternative option for health reform) which he released on budget night in 1991. By 1993 the government had replaced elected Area Health Boards with government-appointed boards, which were known as Crown Health Enterprises (CHEs). Businessmen who spent much time on diagnostic related groupings (DRGs) dominated the boards. DRGs involved defining procedures, identifying the unit cost of a procedure, and calculating the number performed in a financial year. In New Zealand the notion of a user pays economy emerged into mainstream economic discussion in the early 1990s. Attempts have been made by successive governments to curb health spending and rationalise services. The most radical user pays policies suggested in the Green and White papers were not implemented in public hospitals in New Zealand. Modified versions were evaluated, such as outpatients paying for their consultations; however these proved more problematic than beneficial and have since been abandoned. The user pays philosophy has been widely promoted across many other aspects of our life. Today it is highly visible in the media and television broadcasting industry, as well as in telecommunications networks.

‘Giving’ of self has been strongly associated with women’s work. However, participants acknowledged that over the past 100 years the role of women has changed; women often work and are not available to offer their time and energy to voluntary organisations as they did 20 years ago. The police screening of potential volunteers was perceived by one participant as a barrier to service work in the community.

> *… I think that there is a great deal that people can gain from giving of themselves and from doing service but because it has never really been out there and it is not talked about and it’s not discussed, it’s kind of soft, fluffy, difficult stuff and it doesn’t get any air time and people don’t realise that it’s got value….*
>
> *… what’s happened in today’s society is that the pleasure people got from volunteering has now become so legalised and organised and the free will to give and to serve has gone…*
>
> *… now people pay to have a St John alarm on their arm … or they have someone calling them to have a chat on the phone and they advertise this as a service, but you pay for it…*
>
> *… I think I have contributed in a big way to the community by giving something back like teaching, being a role model, being generous so I think that is a big contribution and it fits in with that Buddhist belief about a tangible contribution and that is part of the life cycle…*

It was suggested that a significant aspect of ‘giving’ was the way we function and role model ‘giving’ back to the community. Participants talked about the challenge of ‘giving’ without parameters and the need to set limits to avoid the ratchet effect where people go on expecting more and more from you (Sheikh, 2001). A positive effect of ‘giving’ which links back to ‘helping’ was identified as opening doors for dialogue and exploration of options with people. This illustrates the facilitative nature of ‘giving’.

Elements of service

The third component of service was called ‘elements of service’ and resulted from the merging of the following five sub-themes, which are presented below in Figure 3.

Elements of service:

1. Working with people
2. Being a public servant
3. Being a servant
4. Need
5. Duty

Figure 3. The elements of service

The five sub-themes that comprise ‘elements of service’ are; working with people, being a public servant, being a servant, need, and duty. The participants agreed these five sub-themes had some overlap but it was agreed that they be merged into the standalone theme called ‘elements of service’. Both positive and negative connotations of service were revealed in the sub-theme working with people. Working with people was identified, as carrying out orders and doing the things you are required to do. Sometimes the nature of working with people involved use of directives, which would be informative and invoke honesty. Skilful use of self in a co-operative venture with a patient, or another person, was called working with people and involved collaboration and/or facilitation. Many times working with people was described as carrying out orders.

The role of being a public servant or a servant was strongly linked to service. The group agreed that being a public servant meant we were paid for by the state and our role was to provide a service for the state or a state enterprise. The public relies on people in service – such as the police, nurses, and the armed services – being available to meet a need when it arises. The role of nurses evolved from women’s work, where historically women cared for children, older people, and partners (White, 2002). Women tended to be in a role of servitude to the men in their lives and that involved varying amount self-sacrifice, following instructions, and being compliant. There is a commonly held view that nursing is a low-grade and not highly regarded career. The participants felt that they had become subservient as nurses and that this had been detrimental for the nursing profession;

> *… it was how you worked as part of that service, that human element and working cooperatively and requiring quite a lot of skills to achieve a particular task. And those skills that I came up with working with people were negotiation, collaboration, being directive, and also some elements of facilitation….*
>
> *… if you were a public servant you provide a service…we did as we were told*
>
> *… There is going to be some kind of reliance on others, not necessarily totally …they are away from their environment…*
>
> *… service had a sort of noble ring to it as a word, it sort of rings of self-sacrifice and servant hood and honour…*
>
> *… a servant serving, women, little better than a servant, societal expectations of women serving…*

A large sub-theme of elements of service was identified as need and was strongly connected to the sub-theme of 'working with people'. Some participants acknowledged that they needed the reward service offered them and that they believed they could make a difference to people. Other participants viewed service as the method by which you put others' needs before your own; you made yourself available to meet their needs, both spiritually and emotionally. The need each person has is acknowledged as unique and not delivered to a set formula. A wordless interaction may occur and from this a need is perceived and met;

> *… being there and being with … being with the person so that you are available to meet their needs … you are with the person emotionally as well as physically and even spiritually…*

In our professional work as nurses and educators we admit that the meeting of needs is discussed infrequently and seldom acknowledged, it is hidden work that mostly women have done and continue to do in their service roles as nurses. The lack of discussion about meeting patients' needs was identified as an historical roadblock that contributes to poor financial remuneration and undervalued service workers (White, 2002). On occasion negative collegial judgement was experienced and this resulted in patient care being undertaken in a covert manner. The notion of duty was also expressed as being an 'element of service' and involves

reporting for work at the required time, and doing what is required, regardless of time or costs;

> *… at times unquestioning and putting other people's needs before your own…*
>
> *… I need the rewards of service … I believe that the rewards for me are not something tangible but they are really important to me and it is almost like a privilege to be in a position where you can provide a service…*
>
> *I look at service and I think it has got two faces and I think one side of the coin is self-appraisement, putting others before yourself and putting the needs of others foremost … on the other side is the satisfaction of doing the job well…*
>
> *I was more covert about how I looked after the patients in my care so that I could do what I needed to do for them…*

Act of doing

The 'act of doing' is constructed from two main sub-themes; the first of these is wairuatanga/sharing of wairua/connection with another person, the second is respect. The sharing of wairua is described as kotahitanga – to be one with another for the betterment of self and the other person. This theme overlaps with the earlier themes of 'helping' and 'giving' where the notion of being with another for betterment of self and other was expressed. This connection with another person has a spiritual element to it, is unconditional, and comes from within ourselves;

> *… service is the acts that I do…*
>
> *… when I am called to act I do, but the calling to do so does not come from the outside, being told to do something is not a service, that's just being told to do something, it comes from within when a need is seen and an act is performed to reduce that need and for me that is service…*
>
> *… wairuatanga is the connection that you have with another person…*
>
> *… spiritual connection between a nurse and a patient…*

The participants agreed that nursing and teaching 'actions' are performed to reduce the need another person may have. These 'actions' can be physical or emotional but performed with gentle consideration, e.g. washing a patient. The 'actions' offer support, in a timely, efficient, patient, and kindly manner. There is no set formula to these interactions

– they are unique to the person and the circumstances. The nurse often reflects on the ‘actions’ later and new learning derived from the situation is integrated seamlessly into future interactions with the same client as well as with others. Patients often express gratitude for these ‘actions’, while participants reported the feeling of satisfaction from a job well done. Sometimes it was necessary to keep the doing hidden to avoid judgment from nursing colleagues, this type of covert behaviour may well be indicative of workplace bullying. Horn (cited in Needham, 2003, p. 23) defines a workplace bully as “someone who knowingly abuses the rights of others to gain control of the situation and the individuals involved”;

> *… there are power issues in service … woman are not heard, woman’s work hasn’t … been valued, it hasn’t been paid, it hasn’t been respected, it hasn’t been discussed, it hasn’t been out there in the world, it has been a hidden kind of occupation and service has been part of that hidden stuff that women do and I know some men do it too…*
>
> *… I remember coming across people talking in the treatment room about what I was doing, so I learnt to be … more hidden in my practice…*

Respect is the second facet of the theme ‘acts of doing’. It involves respectful communication and ‘action’ with another person. The ‘actions’ are performed in a genuine and professional manner. The participants agreed that nursing is a service occupation that has had a rocky road to respectability and there was speculation that this may be related to the hidden nature of the work and lack of public consciousness about the work a nurse performs;

> *… people would measure our actions as a service. It can be high quality professional with genuineness from the heart … and I think it involves being respectful of the person…*
>
> *… respect for the other is an important outcome of good service…*
>
> *… it has been a hidden kind of occupation and service has been part of that hidden stuff that women do…*

Pride in work

'Pride in work' is the fifth and final theme that became apparent and is a combination of three sub-themes; motivating factors, problem solving or anticipating, and being proactive. The factors that motivated participants to offer and provide service tended to be altruistic in nature. These altruistic threads link back to the theme of 'giving', which was expressed earlier. A few participants talked about nursing as a calling, where they were drawn towards the notion of being a nurse and making a difference because serving others was revered. Making a tangible contribution, making a difference, addressing others' concerns, and doing a job well were identified as motivators. The childhood conditioning of serving others – especially those older than us was acknowledged as shaping beliefs related to service. The participants agreed that older female role models also affected childhood conditioning. The cycle of life – taking and giving back – was also identified as a motivator;

> *… I believe that nurses were once called … into the profession, in other words something happened to make them believe that nursing was what they wanted to do with their lives … and I am old enough to know that this is no longer the case, sadly….*
>
> *… you believe you will be giving a service to others … believing you are going to make a difference, that you are going to meet needs that you are going to address concerns…*
>
> *… It was part of my upbringing … I was taught how to serve other people … without being asked … probably the strongest role model[s] for me [were] my mother and my grandparents…*
>
> *… I think I have contributed in a big way to the community by giving something back like teaching, being a role model so I think that is a good contribution and it fits into this belief about a tangible contribution and that is part of a life cycle, the people that we see here are in the cycle of needing something … I think they are in that cycle of wanting to have … so I am often saying to them you have to give something back…*
>
> *… I need the rewards of service so mine is quite personal really … being part of a community which equals giving something back … so my approach is not to take but to give back…*

Problem solving was suggested as a motivator to providing service to others and is the second sub-theme in the overall theme of 'pride in work'. This is where we would recognise a need existed and that each

situation was unique and would require a tailor-made solution. Problem solving involved the consideration of consequences, with the aim to be a step ahead of the game, yet encourage the patient or student to independence. This aspect of service was acknowledged as expert practice – developed by some but not all practitioners; one participant felt strongly that problem solving is currently constrained by time limitations;

> *… the staff that provide the meals might see their role as only delivering the correct meal to the correct bed space but the nurse who is providing the service with the client is the one who needs to make sure the person is comfortable, make sure they are positioned well, that the food is where they can get it, that it is cut up as it needs to be and then to go back later and see the patient … have their nutritional needs been met?…*
>
> *… I hear what you are saying but I think that the whole context of providing service has changed and certainly in the clinical area the time to be with a patient, to get to know them, to serve them well, is not always available and not looked upon highly [or] necessarily as being something that we do. Just by being there and being with…*

The third and final sub-theme in 'pride in work' is 'anticipating and being proactive'. This sub-theme involves a wordless interpretation of events which are not expressed, talked about, explored, or acknowledged. Historically, service work – especially being proactive and anticipating – has been seen as women's work. This work has been called hidden work, which participants suggest has failed to gain an appropriate public profile and recognition for its complexity;

> *… they weren't able to speak the same language, [yet] the nurse was able to meet [the] need and she did it just beautifully….*
>
> *… it is a difficult concept for organisations … to explore and even to acknowledge … it has really been hidden and a lot of the work of woman over the centuries has been hidden…*
>
> *… it is often associated with lower remuneration and no social conscience [exists] over that because they are providing a service … they are people who enjoy doing something so we don't need to reward them because they actually enjoy it. They are getting enough self-satisfaction from doing it so we actually don't need to acknowledge or reward or care for … in many cases it is an excuse to not look after those who provide service…*

Summary

All of the group members compiled two separate stories; one examined the meaning of service and a second explored the importance of service. These stories were shared verbally at two consecutive focus group meetings. We all expressed anxiety about sharing our stories, and making public what we each thought. Collectively we were respectful, encouraging, and attentive listeners and were willing to engage in a group discussion following each sharing. The stories were shared with the group at two consecutive meetings and the story telling was audio-taped and later transcribed. The stories were also presented to me in written form to take away for later reference. The participants asked that I analyse the data and present the findings to them for further consideration and their input. The final five main themes and grouping of associated sub-themes are presented below in Figure 4.

Meaning and importance of service:

1. Helping
   - an action
   - an attitude
2. Giving
   - altruism
   - spiritual connection
   - stretching of self
   - women's work
   - role model
3. Elements of service
   - working with people
   - being a servant
   - being a public servant
   - need
   - duty
4. Act of doing
   - wairuatanga
   - respect
5. Pride in work
   - motivating factors
   - problem solving
   - anticipating and being proactive

Figure 4. The components of the meaning and importance of service

The group was initially presented with a table of 19 categories and samples of direct quotes related to these categories. The final five themes were the outcome of the final group review session; the participants discussed and reached agreement on how the 19 categories fitted together, despite some overlapping of similar content. The five themes that have emerged from this study are, helping, giving, elements of service, acts of doing, and pride in work.

Chapter 5 Discussion

> *When I am called to act I do, but the calling to do so does not come from the outside, being told to do something is not a service, that's just being told to do something, it comes from within when a need is seen and an act is performed to reduce that need and for me that is service…*

The notion of service explored in this research reveals that service is a unique, intangible, altruistic, and complex phenomenon. The essence of the service experience in a public health or education setting is usually an event between people that does not involve direct payment from the recipient and usually deals in the messy landscape of feelings as drivers or motivators, or the fulfilment of needs for the giver. As the participant quote above suggests, service comes from within and involves the giving and receiving of human assistance.

The seven participants and I as lead researcher in this study had between 10 and 40 years experience as nurses and educators. Tertiary educated, professional, and articulate, they work as lecturers and senior lecturers at a university. One of the eight participants identified as Maori, one had immigrated to New Zealand from England in the 1970s, and all other participants were Pakeha New Zealanders. All participants expressed clear views on service as a complex aspect of their work as health professionals and educators. It was determined that service comprised multiple themes, which were shaped by an individual's life experience, societal influences, and spirituality.

Service emerged as a collection of five themes. These five themes were helping, giving, elements of service, acts of doing, and pride in work. The purpose of this chapter is to examine each of these five themes in detail to interpret the findings and implications of each.

The literature presents predominantly complementary perspectives of the five themes of service identified above. The two areas of contrast were the differences between identifying nursing as a calling or as a vocation. The participants in this co-operative inquiry expressed an interest in pursuing a nursing career because they felt they could help

people, and give something of themselves. A few of the participants identified this as a calling or attraction to a vocational career, which is consistent with the work presented by Siccard (1995) and White (2002).

The complementary association between the literature and service is evident in spiritual care work (Lane, 1987) and the expression of wairua, wairuatanga, and a spiritual connection reported by the participants. Emotional labour (Hochschild, 1983) and sentimental work (Strauss et al, 1982) were both expressed as components of service by the co-operative inquiry group. The participants identified listening, being with, working with, trouble shooting, providing care to another, and managing their own and dealing with others feelings from both emotional labour and sentimental work. The stressful, undervalued, and hidden aspect of this type of work, have been articulated by the participants and in the literature (Graham, 1983; Staden, 1998). Aspects of caring, for example the four types of caring work identified by Pellegrino (cited in Bishop & Scudder, 1991, p. 24), resonated strongly with participants and are complementary to the lived experience of service among the participant group. Lastly, the work on compassion presented by Frost et al (2000) accords many of the features of service expressed by the participants in this study; for example, being present, giving of self, and collaboration.

Service as helping

The first theme to surface was ‘helping’. Participants recognised ‘helping’ as a learnt behaviour, which had been nurtured in their home life and encouraged during their nursing education. As a nurse, ‘helping’ behaviour is expected by nursing colleagues, other health professionals, patients, and the general public. The expectation that a nurse will provide ‘help’ contributes to tension between the nurse and the other person when the expectation is sudden, demanding, and unreasonable. A nurse is not a machine; the literature supports the proposition that ‘helping’ is physically and emotionally exhausting (James, 1989; Staden, 1998). The notion of the strong ‘helping’ the weak or the well ‘helping’ the unwell usually begins in the home, but continues out into the working

lives of nurses. Pressure is exerted on women who nurse and have family responsibilities, they often ‘help’ others but no one ‘helps’ them (Graham, 1983). Participants described service as one person ‘helping’ another. In the not-so-distant past it was the social responsibility of the wealthy to ‘help’ the poor or under-privileged, and it was acceptable to openly admit you felt a calling to a career where you would serve others in a ‘helping’ role.

Public admission of a calling to a vocational career is currently out of vogue in western cultures. White (2002) suggests that three factors have contributed to this decline in people seeking a vocational career such as nursing. Firstly, the increase in civil liberties have contributed to a decline in vocational career choices, this has been true for western women since the 1970s. Two factors that contribute to shifts in career choices are the rise of feminism and the ascendancy of consumerism following World War II. Consumerism and civil rights movements have contributed to this shift in attitudes from community mindedness to a more self–seeking approach. The paradigm shift towards science and away from regular church attendance or spiritual practice is the second factor that has contributed to a decline in vocational career choice. Lastly, vocational career choices have declined as the attitude supporting an individual pursuing their own goals at the expense of others has gained prevalence.

The notion of service as ‘helping’ is strongly linked with the notion of service as vocation. Both ‘helping’ and vocation usually make use of specialised knowledge and skills for the care of another. White (2002) suggests that nursing is a vocational career, which involves more than just getting the job done. Nursing evolved predominantly as the work of women and like the work that women do at home it has been hidden, White calls this “the professionalization of the domestic” (2002, p. 286). In contrast to the views of White (2002), two authors – Warr (1996) and Downe (1990) – dislike the link between vocation and nursing, and describe it as demeaning. I believe it is important to recognise these

links between the domestic and public arena of nursing and ‘helping’. I also believe that by continuing to hide the complex nature of ‘helping’ work, it is those who hold power who ultimately benefit, usually men in the partnership at home as well as those in control in the workforce. Recognising the complicated nature of ‘helping’ work and addressing issues of pay parity for women could significantly improve the livelihood of many women and nurses.

The complex nature of ‘helping’ work frequently involves dealing with feelings. James (1989) describes this process of dealing with feelings as emotional labour, for which women have been stigmatised and subordinated. The participants in this study identified with this stigmatisation and/or subordination. One participant reported that she even developed caution around her nursing colleagues who were judgemental of her ‘helping’ behaviour. It is common for patients to disclose feelings to nurses who care for them. Nurses are often required to repackage these feelings into facts to represent this information to other health professionals. Stein (cited in Cheek, Shoebridge, Willis, & Zadoroznyj, 1996, p. 96) has identified this game-playing in a study undertaken in 1967 where doctors held the belief they had legitimate authority over nurses.

In a later study by Stein, Watts, and Howell (cited in Cheek et al, 1996, p. 96) the gamesmanship had become increasingly confrontational, affected possibly by the changes to nurses education and changes in women’s status. Unless the feelings are repackaged as facts it can be challenging and sometimes impossible to achieve positive results for patients. This level of gamesmanship is draining and yet it is part of the culture of healthcare because of the difficulty many health professionals appear to have accepting the relevance of feelings. Hochschild (1983) states that men are under-represented in work that requires emotional labour, and I suggest this creates tension between health professionals whose intention is to work together for the good of a patient. The synergy between nursing, ‘helping’, vocation, and emotional labour

cannot be understated. Staden (1998) reports that emotional labour receives a low level of public awareness; in fact emotional labour is hidden, ignored, poorly defined and recorded, and not scientific in nature. Emotional labour and 'helping' are similar in that they require the expenditure of personal energy or self. It is not possible to measure the amount or quality of these interactions, yet a person who receives 'help' could describe the quality of the interaction and what it meant for them, and it is likely to have different meanings depending on the context of the situation.

The 'helping' aspect of nursing will often involve the nurse suppressing her emotions. The attending nurse, in putting others before self and ensuring the patient feels safe and cared for, often masks her fear, doubt, revulsion, and pity. Suppressing or inducing emotions is a component of emotional labour and reported by Hochschild (1983) as energy sapping. It is not possible to go on, day after day, providing 'help', to people at a consistently high level without, at a minimum, feeling drained and, at worse, burning out. It is important to facilitate time for a person in a 'helping' role to regroup, recover, and re-energise so that they can continue to provide nursing care that will meet patient's needs.

Nursing is a challenging and dynamic career. There is a need be open to learning about the complexities of this career and open to developing behaviours or skills that may enhance practice. Knowledge about the demanding nature of 'helping' as an aspect of service work has implications for educators and managers of health professionals such as nurses. Educators can and do facilitate discussion about the demanding aspects of service work, the need for self care, and what this might involve. The participants in this study admitted that they role model time management, problem solving, open communication, and self-care for students. However, whether students take any notice and implement any of the suggestions or ideas or not is rarely formally measured or assessed. The manager of health professionals is also in a position to

have an impact on the wellbeing of staff. The amount of energy a manager or leader puts into coaching their staff varies from person to person. Coaching staff to take self-care seriously, take regular holidays, and seek ‘help’ of a personal nature when it is needed could reduce stress for staff. Creating the opportunity for nursing staff to share feelings with colleagues or undertake professional supervision to explore the demands of work may result in decreased sick leave, happier, healthier staff, and reduced staff turnover. Increasing awareness about the taxing nature of ‘helping’ and the strategies that are effective for self -care is a possible research project to explore in the future.

Summary of service as helping

Service is not one single entity; it is a combination of attitudes, actions, and beliefs. ‘Helping’ is the single most important theme that emerged during story telling about the meaning and importance of service in this study. Strongly linked to the work untaken by women and to the concept of emotional labour and vocation, ‘helping’ involves professional assistance between a nurse and patient. ‘Helping’ does not follow a preset formula, it is unique and the currency of feelings dominates. ‘Helping’ could be plotted on a continuum from simple encouragement to the provision of total nursing care; it involves the expenditure of energy and, on many occasions, the suppression of the nurses’ feelings. Yet in nursing the ‘helping’ work we do is often hidden, it is not valued, and nurses, I believe, continue to be stigmatised and subordinated because of this type of work.

Service as giving

The theme of ‘giving’ was the second strongest theme to emerge during this study on service. ‘Giving’ involves the sharing of self at an emotional and spiritual level with a patient or a student. ‘Giving’ of yourself emotionally was acknowledged by participants in this study as an aspect of service that nurses often demonstrated by putting the welfare of others before themselves. Hence altruism was linked to ‘giving’.

Kavanagh (2002) reports that there is a tension between feeling the desire to serve others, while trying not to be too subservient.

Each patient or student interaction is considered unique and, in a similar way to 'helping'; 'giving' is not performed to any set criteria. This connects 'giving' to the notion of sentimental work, which was explored earlier in chapter two. Sentimental work occurs between people and is suggested by Strauss et al, (1982) to include the creation of trust through explanations, listening, and even the simple human act of holding another person's hand. 'Giving' your time and energy to a patient may include the sharing of personal information about your own life; Strauss et al refer to this as biographic work and report that biographic work can have a motivating effect for a patient. A significant finding that came to light during the study by Strauss et al was the absence of written documentation about sentimental work, even to the extent that it is entirely unreported in the patient progress notes. The following participant quote captures this sentiment;

> *…it just doesn't get any air time and people don't realise that it's got value. [They] don't honour it [or] value it…*

The participants in the study conceded that it is important to define the working parameters for 'giving', because it is human nature to want more and more from someone; this wanting more is reported in management and marketing literature and is called the ratchet effect (Sheikh, 2001). Mapping out the service terrain for patients provides transparency and honesty about what they can reasonably expect. Being clear about expectations may help to manage or reduce the energy sapping that occurs with 'helping', emotional labour, and 'giving'.

Participants agreed that in the past women who were not in paid employment had 'given' a lot of their time and energy in voluntary work. Currently, in many families in New Zealand, paid employment outside the home has a much higher priority than voluntary work and this has had a negative impact on traditional volunteer work, where women (in

particular) ‘gave’ of themselves, their time, and their energy to the community.

A second aspect of ‘giving’ was the component of spiritual care. Lane (1987) described spiritual care as a significant dynamic that is likely to stretch us beyond our usual parameters. The stretch is likely to involve some degree of self-reflection and offers the opportunity to work on the meaning of our own life journey. Some participants acknowledged that their own life journey involved being a role model and ‘giving’ back to students and to patients. The ‘giving’ of yourself at a spiritual level has been reported to increase wisdom, teach us to live in the present, help to identify our own limitations, and enable us to lay our own ego aside (Lane). When ‘giving’ includes spiritual care it is possible to stand alongside the patient in a spirit of compassion, this often enables the patient to share their feelings and open up to you. Titmuss (1970) calls it a ‘gift relationship’ – when one person shares time and energy with another person without expecting anything in return.

Summary of service as giving

‘Giving’ to a patient or any other human being is recognised by the participants in this study as a component of service. It is likely to include sharing of emotions and a spiritual dynamic. The spiritual dynamic was not expressed individually by each participant and was accepted as being a unique and positive aspect of each person. The spiritual aspects of ‘giving’ that were identified ranged from being with the other and being human to a recognition that a connection existed, although it might not be talked about.

The concern for, and attendance to, the welfare of others was considered altruistic behaviour. Strauss et al (1982) report this behaviour was previously described as an aspect of sentimental work, ranging from a simple act of listening to more complex ongoing interactions that established trust and could have strong positive or negative effects on patients. Participants agreed that patients could have unrealistic expectations but by explaining what you could provide you created trust

and openness in the ‘giving’ relationship. ‘Giving’ as altruistic behaviour, may be in decline in our society as our lives have become increasingly influenced by self-focused and user pays ideals.

Elements of service

The melding of five sub-themes culminated in the third main theme titled the ‘elements of service’. The five sub-themes are; duty, need, being a servant, being a public servant, and working with people. Duty has strong connotations for nurses who participated in this research, reminding them of going on duty to meet patients’ needs or doing their duty as a nurse, whether they were employed in a hospital or the community. Going on duty involved turning up on time and turning up with the attitude to serve others in your role as a nurse. Like altruism, it involved putting the needs of others before your own. Dutiful behaviour has traditionally been encouraged as a desirable feminine trait in daughters and women and subsequently found expression in nursing. The consequences of fulfilling your duty are not all positive. It can be draining or depleting work and Staden (1998) suggests nurses adapt by developing the ability to wear a mask, carry out the orders, and appear caring.

Meeting the needs of patients varies greatly according to the context of a situation, and the personalities of the people involved. A patient will often perceive their need to be the greatest (of all patients on the ward), while nurses have the needs of all the patients in their care to consider when planning their work. The prioritisation of a group of patients’ needs frequently remains unspoken and is often reprioritised during the day according to changes in patients’ conditions. This internal juggling is rarely disclosed to patients who are receiving the care from the nurse. Each patient can have unique needs and meeting these is not completed to a prescribed blueprint.

The public has an expectation of nurses that their needs as patients will be addressed in a timely manner and this is a reasonable expectation. Interacting with the patient and attending to their needs is a part of the service provided by nurses, this interactional work often sets the scene and may be perceived as positive or negative by the patient (Strauss et al, 1982). Interactional work, trust work, and composure work are identified as types of sentimental work (Strauss et al), they all contribute to a patient's needs being meet.

The sub-theme of being a servant or public servant has a long historical association with service. The work undertaken by servants has tended to be menial, repetitive, labour intensive, poorly paid, and hidden. Radical changes in society over the past 200 years have altered the employment options for ordinary working people, especially women. These changes were the result of collective changes in society bought about by the industrial revolution, increasing technology, mass education, political upheavals, world wars, and a paradigm shift to a scientific world. At the beginning of the 20th century, White (2002) reports, many young women were encouraged to seek employment in nursing as an alternative to marriage. The enormous loss of life incurred during the Great War had a significant impact on numbers of men who could marry. It was convenient for men in positions of power to suggest nursing as a suitable career to many women who would possibly never marry as a result of the loss of life incurred in World War I.

The role of nurses as public servants developed in accordance with vocational models that had been applied to the other roles women performed in society (White). Unfortunately, because of the link between vocational work and public service, the complexity of the service work undertaken by nurses has struggled to gain recognition and appropriate financial reward. Larson (cited in Cheek et al, 1996, p. 103) suggests that female-dominated occupations such as nursing have been up against the medical profession, which espouses its ability to provide respectable, ethical, and disinterested service.

Working with people is the final sub-theme of ‘elements of service’. The concepts of sentimental work as a component of service and working with people are strongly intertwined. Working with people, or kotahitanga, includes the notion of betterment for both the other and self. This idea of changing something in yourself as well as something for the other person was described by participants as giving something back; when nurses work with people, the participants in this study agreed, they utilise some or all of the skills of negotiation, collaboration, facilitation, and instruction.

Negotiation involves talking with a person and coming to a mutual decision about a course of action, this is what Strauss et al (1982) describe as interaction work. This type of work with a patient can often set the scene for the duration of the relationship, and may have positive, negative, or neutral connotations. Collaboration is likely to involve dialogue and a second component of sentimental work, that is, trust (Strauss et al). Facilitation and instruction of a process or treatment are linked to composure and biographic work identified by Strauss et al . The notion of working with a patient was highlighted in the study undertaken by Strauss et al, and strongly associated with the role of nurses.

The participant group agreed that the skills of working with people are learnt and undergo ongoing refinement during their career. Both internal and external drivers influence the refinement process. Internal drivers may result from being a reflective person who has insight about what worked and what didn’t work during a patient interaction. The insight may spring from personality, life experience, or the ability to lay aside ego – Lane (1987) described this as a rare ability! The insight gained from any particular nurse/patient interaction is likely to affect future interactions with the same patient and may influence nurse behaviour with other patients.

External drivers include critique from colleagues, especially those in leadership positions, and this is similar to the aspects of supervision and control Hochschild (1983) highlighted within emotional labour. Another external driver is peer review, where a colleague gathers information about the nurse's work practice and reports on things done well and areas that may need improvement. In the educational setting, students are offered the opportunity to speak directly with lecturers about the lecturer's work. Students are also provided with the chance to complete anonymous feedback for lecturers near the end of each semester. Lecturers collect the anonymous feedback as evidence of meeting a particular standard when promotion is sought.

Summary of elements of service

Duty, need, being a servant, being a public servant, and working with people are the five sub-themes that combine to form the third theme of service called 'elements of service'. Nurses in this study had strong recollections of going on duty and fulfilling their duty as a nurse. When participants in this study trained and worked, society supported the ideal of females behaving in a dutiful manner and nursing schools of education and hospital culture endorsed this behaviour. The participants recalled meeting others' expectations at a cost to themselves, the cost being emotional, physical, or even both.

The second sub-theme of 'elements of service' is 'need'. Perceived need created a tension for nurses working with a group of patients at the same time. The tension resulted from the needs expressed by an individual patient versus the priority of needs across the group of patients. Individual needs were constantly being juggled and were consequently always in a state of flux, as a result of the changing (declining or improving) health of the patients in the wider group. Needs were unique to each patient and never preformed or fulfilled to a set formula.

The other sub-themes of ‘elements of service’ comprise being a servant, being a public servant, and working with people. Being a servant in the employment of others has been an historical reality for many working women. The work of a servant was usually hidden, underpaid, and undervalued. Up until the past 100 years, employment options for women were very limited. Women in public servant roles faired little better than household servants in having the work they performed valued and paid for appropriately. The service work undertaken by health professionals, and in particular nurses, continues this battle to fight for pay parity and for recognition of the complex nature of the work.

Working with people is substantially associated with aspects of sentimental work espoused by Strauss et al (1982), the components of sentimental work are interaction, trust, and composure work. Working with people is the result of both internal and external drivers. Internal drivers include reflection and insight with external drivers resulting from leadership and collegial critique and student feedback. Negotiation, collaboration, and facilitation were all recognised by the participants in this study as aspects of working with people.

Act of doing

The ‘act of doing’ was meaningful for participants in two ways; firstly, as a spiritual connection or sharing of wairua and secondly, as respect. Participants acknowledged the spiritual connection that can occur between a nurse and patient as a normal occurrence in our practice. This wairuatanga was not associated with religious practice or beliefs but rather a connection of spirits. The spiritual connection is not forced or forged for self-gain; it is simply something that occurs between people. On occasion it is sparkling, unique, uplifting, moving, and significant. It is not possible to predict when this connection will occur; it just happens if it happens. In my experience the patient usually acknowledges it and attending nurse as some special connection, but it does not result in favouritism, or any other extra attention. The acknowledgement is usually spoken but I have experienced non-verbal

knowing as well. This type of connection also occurs between lecturers and students and in this situation is also usually acknowledged between the two parties in conversation. Both people value the spiritual connection as a special moment in time or moments in time if the relationship is ongoing over weeks to months. Participants described this connection as something that comes from within them and is unconditional.

The notion of serving others through a vocational calling to nursing was identified by Siccard (1995) and White (2002). This vocational calling is usually linked to spiritual beliefs and practice. In my experience the discourse on spirituality in nursing is underground and covert. Having attended workshops on spirituality at a nursing conference, then being ridiculed during a feedback session by medical staff for attending them; I learnt to be cautious with any discussion of a spiritual nature. This experience was shared with the other participants during our co-operative inquiry meetings and the group agreed these tensions did exist. Nursing in the 21st century is performed in a postmodern scientific age, which has been minimising the effects of the spiritual on life and on health for many years. I believe that in a similar way to healthcare, things spiritual are part of the hidden curricula in nursing education, and are usually discussed on a one-to-one basis between lecturer and student.

Speaking amongst ourselves about spirituality in our exclusively nursing participative inquiry group, we took a risk. Our conversations on the subject were very limited and it would have been appropriate to discuss in greater depth and detail if time and old beliefs had not constrained us. Although our group ground rules created the sense of trust that I credit with facilitating a safe place for dialogue of this nature to occur, we have learnt to be cautious and for self protective reasons are often reluctant to engage in conversations of a spiritual nature.

‘Acts of doing’ is also expressed through respectful behaviour, which, the group agreed, was demonstrated in verbal communication and professional nursing actions. Verbal communication between people is affected by age, culture, gender, intellect, physical or emotional distress, and a myriad of other factors. The co-operative inquiry group believe that respectful verbal communication includes listening and responding with warmth. The professional ‘acts of doing’ that demonstrate respect include providing options and/or choice for a patient, reducing anxiety and pain, and responding in a timely, gentle, and considerate manner. Respect connects with the following components of emotional labour described by Hochschild (1983); being with someone, listening to them, and attending to them with warmth. The successive types of sentimental work reported by Strauss et al (1982) also connects with respectful behaviour; interacting in a pleasant manner, listening, and being courteous.

Nurses who fail to behave with respect toward patients, the public, their own colleagues, or other health professionals are often considered a liability in nursing. At a minimum, nurses learn to “act as if” they respect the other person and in most situations this can suffice. From time to time nurses must step outside the comfort zone of respectful behaviour at all costs to challenge a patient, a member of the public, a colleague, or another health professional. The general public rates nurses highly among professions they respect (New Zealand Reader’s Digest, 2005) and I speculate that this respect results from their own encounters with nurses and nursing and the mystique of this type of work. The mystique of nursing is, I believe, understated, but nurses are privileged to work intimately with people, stretch themselves, refine their spirit, and contribute something positive to the world. The intimacy spans a human life – from attending a birth to a death and anywhere in between. Many times I have heard others say, “I don’t know how you do it, I couldn’t”. Yet for those of us who nurse ‘the acts of doing’ nourish our soul and reinforce our individual reasons for nursing.

Summary on act of doing

'Act of doing' comprised two sub-themes, spiritual connection with another and respect. The participants agreed that a spiritual connection occurred between nurses and patients and students and lecturers. This connection was a spontaneous event; unique, unconditional, and acknowledged by both parties – phenomena that engendered no special favours. The unfortunate dilemma for nurses is that spirituality or a spiritual connection with another can be risky to disclose and usually remains covert. The nature of wairuatanga was explored minimally during this inquiry, as we were all cautious about disclosing our thoughts and beliefs on this subject.

Respect as an 'act of doing' includes verbal affirmation to another as well as actions we undertake as professionals. Respect is also demonstrated through attentive listening, appropriate touch, and courteous behaviour. These 'acts of doing' are connected strongly to emotional labour (Hochschild, 1983) and sentimental work (Strauss et al, 1982).

Pride in work

The final theme to come forth to the co-operative inquiry group was titled 'pride in work' and comprised of three sub-themes, motivating factors, followed by problem solving, and lastly anticipating and being proactive. The participants engaged in relatively lengthy discussion about the factors that motivated them to work in a service industry. Most participants have grown up in families that espoused beliefs about working hard, doing a job well, and making a difference. We all held or had been encouraged to hold strong beliefs about benevolent, public spirited, and self-sacrificing behaviour. None of the participants admitted vocational reasons as the motivating influence that took them nursing, although there is evidence that this occurs for many nurses. Both White (2002) and Siccard (1995) suggest nursing is a vocation. Siccard's small study on the reason people go nursing revealed that 90% of participants went nursing because of their belief that nursing is a vocation. Whether

or not the same findings would come to light if the study was replicated in New Zealand leaves room for conjecture.

Problem solving with and for patients emerged as another sub-theme of ‘pride in work’. The participants discussed their experiences of problem solving for patients and believed it was an aspect of practice that developed from experience. The learning to problem solve and anticipate usually resulted from collegial critique, from a suggestion made during nursing handover, or from reflective practice. This connects problem solving to supervision and guidance that Hochschild (1983) describes in emotional labour and that Strauss et al (1982) describe in their study of sentimental work. Kavanagh (2002) reports the tension that can arise “between altruism and autonomy that is trying to serve without being subservient” (p. 78).

One of the participants in this study reported that currently she felt that nurses face significant constraints of time, which affected time for problem solving and anticipating. We were all familiar with the catch-cry to work smarter not harder, but some things simply take the time and energy that they take. This is especially true for both the nursing and education environments, where each person is unique and it takes what it takes. There is a need to build in a realistic amount of time for this type of work to take place. Otherwise it can be pushed aside and ignored and later result in someone having to pick up the pieces, a type of sentimental work described by Strauss et al or the ‘oops’ described by Kavanagh.

The final sub-theme explored by participants under the theme of ‘pride in work’ is anticipating and being proactive. It is likely that participants entered a career in nursing with these skills already developed or developing. Society has long placed value on females being quiet, watchful, helpful, and anticipatory of the needs of others and participants felt that proactive should be added to this list. James (1989) suggests these skills are learnt and describes listening, being with someone,

using intuition, trouble shooting, and demonstration of warmth as some of these. James (1989) collectively calls these skills emotional labour.

During our nursing training we were instructed to be watchful, offer help, and were coached in anticipating the needs of patients. I recall receiving many instructions at nursing handover about what to be doing for patient X or patient Y and what signs to watch for and what to do about the signs if they appeared. This culture of instruction was dominant in the public hospital where I trained and facilitated by the Charge Nurses who wanted to know that we knew what to do. We were frequently asked questions about what we would do and received appraisals that made note of our ability to anticipate and respond.

Anticipatory and proactive behaviour matches what Graham (1983) and Pellegrino (cited in Bishop and Scudder, 1991) describe as caring. None of us questioned whether or not we should be anticipating and being proactive, we just accepted that we were meant to be. Graham suggests that the nature of women's caring roles have been undervalued and places importance on shattering the myth that women seek to do this work to survive in a male dominated society. The co-operative inquiry group agreed that this type of service work is hidden, rarely acknowledged, and, as a consequence, it fails to gain the recognition it deserves. Bringing these aspects of 'pride in work' out into the public arena we offer them for debate and consideration.

Summary of pride in work

Motivating factors, problem solving, and anticipating and being proactive comprise the three sub-themes of 'pride in work' that is the final theme of service explored in this co-operative inquiry. The following three beliefs shaped our motivation to serve others: firstly, our home and upbringing; secondly, the conviction of working hard; and lastly, the impression all participants had acquired that we could make a difference. The participants of this study differed from the literature in their assurance that vocational leanings played no part in attracting them to, or sustaining them in, nursing.

Participants believed problem-solving abilities were acquired from experience gathered over time and as a result of the circumstances in which we nursed and taught. Three factors were noted to contribute to the ongoing development of problem solving skills; firstly, critique from colleagues, secondly, collegial suggestions, and lastly self-reflection. These three facets of problem solving can be linked to the work of Strauss et al (1982) on sentimental work where listening, building trust, and working with a patient are explained. The work on emotional labour described by Hochschild (1983) and Graham (1983) also describes problem solving skills, listening, using intuition, and trouble shooting to name a few. One of the overarching features of problem solving is the time it takes, and one participant reported constraint of time as a significant dilemma.

The third and final sub-theme to ‘pride in work’ is anticipating and being proactive. Participants suggest this is coached into us, expected as part of our job, and has links with caring and emotional labour. Unfortunately the nature of anticipating and being proactive has been underexplored and poorly communicated; and for these reasons has remained hidden and as a consequence is not valued.

Chapter 6 The Process of Co-operative Inquiry

> Co-operative inquiry is a distinctive and wide ranging form of participative research in which people use the full range of their sensibilities to inquire together into any aspect of the human condition.
>
> John Heron (1996)

As a woman I am fortunate to live in a time and country where women have the right to vote, work, research, and be self-determining. Qualitative research is not dominated by the use of one type of methodology, although I have heard anecdotal reports that grounded theory research receives a warmer response from quantitative researchers and scientists. Perhaps this is because there is a pre-determined process to follow with grounded theory, which increases the perception of reliability. Despite this possible perception in the wider research community, I was not attracted to grounded theory or other qualitative or quantitative methods. I think it is important to use a research method that matches the research question and at the same times resonates with the researcher's beliefs, values, and aspirations. Thus my choice of co-operative inquiry as a research method has enabled me to explore a subject that I believe has been relegated to the 'too hard' basket. I have noticed that new ideas can emerge from the margins and accept that co-operative inquiry lurks somewhere out in these margins. Despite its low visibility in academia, co-operative inquiry as a qualitative research method has been evolving over the past 50 years. The purpose of this chapter is to link the guiding principles, values, and philosophy of co-operative inquiry with my study.

Co-operative inquiry appeals to my sense of adventure, and the possibility of discovery and I am grateful that the process is not prescribed but evolutionary. This type of research has been utilised to empower people and give voice to marginalised groups. According to Reason (1998), women and nurses are marginalised groups, and since I belong to both groups it made sense to use a method that is reported to be empowering.

Both participants and researchers who engage in co-operative inquiry have dual roles as co-researchers and participants. According to Heron (1996), the research is done *with* rather than *on* people, the intention is that all will be empowered from the process; everyone is seen, heard, honoured, and respected. The participants give voice to their feelings and experience and become recognised as co-researchers. The group works together to agree a way forward and this is often achieved through vigorous discussion, which hopefully culminates in a consensus; this process of discussion can run smoothly or become problematic.

Reason (1998) suggests that the following four components comprise experiential participative/co-operative inquiry; politics, epistemological issues, ecological concerns, and the spiritual dimension of life. Discussion and critique of Reason's four key components and the connection to my research is now presented and is followed by a discussion of eight major structures utilised by this study to ensure reliability and validity.

Key components of experiential participative research

Political action

The political action related to co-operative inquiry includes taking a positive stand for self-expression, the inner journeying, and personal growth that may result. Reason suggests that humans thrive in participation and community with others and calls this human flourishing. Being realistic, Reason acknowledges that the creation of knowledge resides in established centres of power such as a university, where it is utilised by dominant groups to an exploitive end.

I have chosen to undertake post-graduate study at the newest university in New Zealand where using qualitative research methods are acceptable; we are encouraged to make sense of our world and to be inquiring (Reason). No dominant group, such as medical professionals, is employed at the university where I study. Thus my journey to utilise a qualitative research process such as co-operative inquiry has not been ridiculed, questioned, or minimised by colleagues.

I have been encouraged to choose, make sense of, and find my own research project by colleagues who work and teach in this academic environment. This type of education is described by Reason (1998) as evolutionary and liberating. My education has enabled me to share hopes and fears with other participants, and at the same time I have shared my knowledge of the co-operative inquiry process so that others may gain skills and knowledge. I have not utilised this research process for self-gain, but because it is honouring of all who participate. Both Heron (1996) and Reason (1989) talk about facilitating a collaborative process to empower others; from the outset it has been my intention to continue to facilitate the co-operative inquiry group to ensure articles are created for publication following completion of my thesis and Master's study.

All participants in this research study work in a competitive environment where 'outputs' contribute towards the university's funding status. Our collaboration is one way we can produce outputs from which all of the group can benefit. Reason (1998) has discussed the destruction of a sense of belonging that occurs when the element of competition overrides collaboration. I feel a sense of anticipation and hope that as a marginalised group we will be role modelling alternative ways of working through collaboration. The process of collaboration has been identified by Robertson (cited in Reason, 1998, p. 149) as parallel to the principles of new economics. The following features are present in new economics; all people are encouraged to take a greater control over their lives, qualitative values are considered in relation to economic choice, and the work that promotes community wellbeing is recognised. Thus emotional labour, sentimental work, and service work articulated in this thesis would find voice in new economics.

Initially we used our time in meetings to discuss how our group would work together, record the meetings, and handle any hot topics or concerns if they arose. This ground work is described by Reason (1998) as building a constitution for intentional co-operative inquiry – the first of

three principles undertaken in co-operative inquiry. The second principle is the expression of a vision towards which we aspire, and the final principle aims to engender a paradox where the group engages in cycles of reflection and action. Reason (1998) states that the purpose of these three principles, building a constitution, expressing a vision, and thirdly creating contradiction; is to achieve the elusive state of being a co-operative inquiry research group.

The process of leading and facilitating a co-operative inquiry group was daunting. Reason describes this as living on the edge, and suggests that facilitation and liberating leadership are essential for this type of research. Liberating leadership is a balancing act where the autonomy of participants, authority of the leader, and participation of the group all come together. I am active in service positions – including leadership positions in a formalised self-help group – where consensus guides decision-making. It was not dissimilar to the role I took within the co-operative inquiry group, that of being a servant leader (Reason). The participants were all strong, intelligent, opinionated women who accepted the fluidity of our process, relaxed, and appeared to enjoy the collaboration. It never felt as though we were in competition with each other; rather we each listened attentively, and were encouraging, and compassionate toward each other. I shared my vulnerability and fears with the group about the whole project, and Reason states that this sharing is the key to leading and participating in a co-operative inquiry group.

Epistemological issues

Epistemology is defined as “the theory of knowledge, especially the critical study of its validity, methods and scope” (Collins, 1992, p. 431). Urged to consider participation as a way of gathering knowledge, Reason hopes this will result in a new participative consciousness that combines masculine and feminine traits.

Reason (1998) suggests that the western worldview of separation between people and the natural world is flawed. A change is required which he believes can be bought about through researcher and participants undertaking co-operative research. According to Reason, the post-modern positivist's paradigm is imperialistic, immodest, and intolerant and perpetuates a sense of meaninglessness and rootlessness. Alternatively, he suggests that people could seek meaning through participation and describes four ways of knowing associated with a participative endeavour. The first way of knowing is described as *experiential* and may include face-to-face contact between people, or feeling energy, presence, or process. The experiential knowing is described by Reason as inner resonance. I felt an attraction to co-operative inquiry as a research method because it resonated with my beliefs and aspirations about life. This participative knowing was confirmed in ongoing dialogue that occurred with my supervisor.

The second way of knowing is called *presentational knowing*, which makes use of symbols, imagery, music, art works, and voice. I recall drawing circles overlapping each other to illustrate people interacting and suggesting to my supervisor that service occurs within the overlap as demonstrated below in Figure 5.

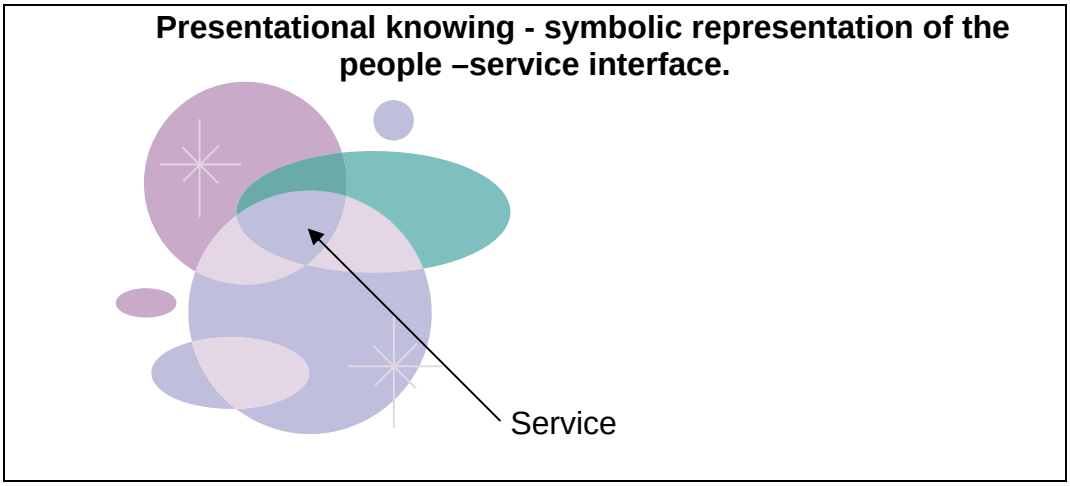

Figure 5. Presentational knowing – symbolic representation of the people-service interface.

I must admit I did not have knowledge of *presentational knowing* prior to writing this chapter, yet I see this as another confirmation that I selected the most appropriate research process by intuition. This visual image of service has been with me for many years and has helped me to explain to other people what I wanted to explore.

Propositional knowing, the third type of knowing, arises out of presentational knowing according to Reason (1998). Propositional knowing is expressed as theory and written and/or verbal statements. Propositional knowing is what the participative inquiry group have explored and endeavoured to express in this study by bringing forth the meaning and importance of service for health professionals. This process ensures that an output is produced which will meet academic requirements, and it has passed through a process of consultation, collaboration, and rigor on its journey to creation.

The fourth and final type of knowing is *practical knowing*. Reason states that practical knowing results in an outcome achieved by the performance of a skill or competence. The skill or competence has been derived from the cumulative knowing of presentational, propositional, and practical knowing. The propositional knowing related to this research evolved from reading, talking, and learning that occurred about the research method and subject under study. The practical knowing came through the collaborative process of sharing stories, thematic analysis, and subsequently the co-operative inquiry group discussion and decision-making on the final themes. Practical knowing evolved as each participant made sense of the project and collaborated on the outcomes that I have the opportunity to present in this thesis. Co-operative inquiry is described by Reason as a celebration of knowing and acting on the knowing which honours the human ability to make sense of the world.

Ecological concerns

The ecology of participation, according to Reason (1998), means that we acknowledge we are part of the cosmos and part of its creative force and evolution. Throughout history Reason reports that humans have tended to pursue short-term goals, which have caused (and continue to cause) disruption and destruction to the natural world. This pursuit of short-term goals, without regard to their impact on the whole environment, is expressed as straight line thinking; he suggests that human survival is in jeopardy if we continue thinking and acting in this manner, and proposes a participative relationship with our planet as a solution to this crisis.

This co-operative inquiry addressed ecological issues. Its participative nature was non-exploitive of those involved in the research process. Thus it contributed, in some small way, to the wellbeing of the world of knowledge creation and human endeavour.

Spiritual dimension of life

Reason advocates the healing of people and the planet through spiritual practice, although no one type of practice is articulated. Insisting that humans could resolve many problems, Reason believes we can all fulfil our greater potential in a spirit of participation with other people and the natural world. Co-operative inquiry contributes to the spiritual wholeness of participants by honouring and involving the whole person in a deeply respectful way. The co-operative process makes it possible for spiritual dimensions – rather than just the intellectual dimension – of the person to have expression.

The participants in this study identified strongly with the notion of spirit, many of us believe we have a soul/spirit. We admitted to each other that we experienced a spiritual connection with people in our care and we agreed that this connection was an important component of service. The group agreed that spiritual concerns are minimised and, on occasion, disputed in mainstream healthcare facilities in New Zealand. However, the spiritual dimension of life was important to each participant in this study and quietly attended to by us as individuals. Expression of our

soul/spirit gave us the permission, room, and space to honour each other as a whole person.

Reliability and validity

The confirmation and verification of qualitative research findings are important and Miles and Huberman (1994) suggest a variety of approaches. The use of 11 interdependent processes is suggested by Heron (1996) to enhance the validity of a co-operative inquiry. To ensure reliability and validity of data collection and the interpretation process in this co-operative inquiry study, eight different approaches have been utilised. The eight approaches are: representativeness; research subjectivity; consistency with the literature; transcription accuracy; reflective cycles; research cycling; balancing divergence and convergence; and reflection/action balance.

Representativeness

The data collected in this study was obtained from eight participants including myself; one participant identified as Maori. All participants had experiences from clinical nursing and lecturing to draw on, and could be described collectively as skilful, competent, and expert practitioners. Each participant wrote two stories, one on the meaning of service and the other on the importance of service. The stories were presented verbally to the co-operative inquiry participant group over the course of two meetings. All participants were known to each other and me but had responded individually and voluntarily to an e-mail advertisement calling for interested people to meet and consider participation in the study. The potential participants received information about the research project, co-operative inquiry as a methodology, a consent form to consider at the initial meeting, and information on co-operative inquiry (see Appendices A, B, C, & D).

Research subjectivity

From the beginning of this research project I have been upfront with my bias and subjectivity toward the topic of service. I informed the participants that this study would result in the compilation of a thesis; I stated that I was committed to continue the collaborative group following completion of the thesis to ensure creation of journal articles for publication. My desire is that all participants benefit from the study.

Consistency with the literature

The experiences shared by participants in this study were predominantly consistent with the literature. Service work for nurses and educators involves spiritual care, emotional labour, caring, compassion, and sentimental work. The one area of contrast emerged in the literature on vocation; in this co-operative inquiry none of the participants believed nursing to be a vocation, although they were able to identify with the notion of being called to nurse. One small study of South American nurses undertaken by Siccard (1995) suggests that nursing is a vocation to which nurses say they are called.

Transcription accuracy

All participants in this study received a paper copy and an e-mail containing the full transcript document of our audio-taped story telling. The participants provided me with their written stories following the story telling co-operative inquiry meetings. The stories provided me with an opportunity to check and compare the audio-taped transcript for accuracy. The participants were invited to review the transcript for accuracy and provide me with their feedback. No verbal or written feedback has been received to date. The participants were also provided with paper copies of the thematic analysis.

Reflective cycles

The reflective cycles of this study occurred during two consecutive monthly group meetings. At the first reflective meeting we considered the initial thematic analysis, which contained 19 categories. Vigorous group discussion reduced the number of themes to five. Before the second meeting I reworked the thematic analysis material to represent to

the participants. The second meeting considered the five themes and each participant confirmed their agreement with the analysis.

Research cycling

The process of research cycling proceeds through “as many cycles as possible by as many group members as possible” (Heron, 1996, p. 131). Initially the research cycling would result in a pruning of irrelevant material from the research proposal. The participants in this study were not invited to participate in the preparation of the ethics proposal or writing up the results. Group discussion occurred about these two matters and participants agreed that these were the responsibility of the lead researcher because the final work would be submitted as a thesis for partial fulfilment of a Master of Health Science.

Following ethics approval to proceed with the study, there was a time delay due to personal health issues. Voluntary self-selection of participants occurred over the summer of 2004-5 with the consent process completed in early February 2005. Monthly meetings occurred thereafter with stories gathered, transcribed, and e-mailed to participants for their consideration prior to each subsequent monthly group meeting. The co-operative inquiry group was able to utilise individual research cycling time between monthly meetings. In this time they wrote their own stories, had an opportunity for reflection, critique of transcripts, and subsequent thematic analysis occurred in this time.

Collective research cycling occurred whenever the group attended monthly meetings and expressed their thoughts and feelings about the transcripts and themes. These processes of individual and collective research cycling and expression of thoughts and feelings are consistent with Heron’s validity procedures. He suggests that balance is achieved using a combination of individual and collective research cycling. When the following ‘four-fold interactions’ occur Heron suggests that an inquiry is effective and influential; the four-fold interactions are; the cycles of action and reflection, opposite individual autonomy, and group

interaction. The outcome of this four-fold interaction is empowerment for all participants.

Balance of divergence and convergence

Another validity procedure that was applied to this co-operative inquiry is called the balance of divergence and convergence. Divergence refers to participants all finding out something different while convergence means the participants explore the same subject. These two approaches are used during group action and reflection. It is desirable to have a balance of both types of finding out, to ensure diversification and depth of data.

The co-operative inquiry group members had agreed to participate in the study to consider the meaning and importance of service for health professionals. We were not exploring a problem or practice issue but something more intangible. The validity of our co-operative inquiry is perhaps open to some question because we used total convergence to formulate and report our thoughts and feelings. Total convergence is described by Heron (1996) as each participant doing the same kind of thing in each action phase. Total convergence results in data that is progressively refined to provide in-depth information on the topic under study. When the topic is considered in isolation it promotes ”conformity and following behaviour, which is the absence of true co-operation”

(p. 77).

Reflection/action balance

Heron would describe the action phase completed in this inquiry as an outside inquiry. This means that participants undertook the action independently in their own personal time. All participants had discussed both action and reflection phases and agreed our process before we commenced either phase. We allowed a month between reflection meetings; this allowed time for the audio-tapes to be transcribed, printed, distributed, and considered before each reflection meeting. The reflection phases occurred with participants meeting together for two hours at a time and we scheduled a total of nine consecutive meetings during the year. As it turned out we actually met a total of six times in our

reflection group. Given that all participants were in full-time employment and with busy personal lives, it was an achievement to have met together on these six occasions.

Heron (1996) urges the use of divergent conceptual mapping to display participants' perspectives. Our group made use of conceptual mapping following thematic analysis when I was able to present the co-operative inquiry group with pages of tables that displayed the 19 categories. We collectively reviewed the thematic analysis table and narrowed the 19 into five broad themes. He suggests this is an essential process for valid reflection.

The balance between cycles of reflection and action contribute to the validity of a study. Prolonged phases of action and minimal times of reflection result in the possibility that the findings might have a lower validity and be described as a supersaturated inquiry. The opposite also produces low validity, too great a time of reflection and too little time for action, and Heron refers to this as intellectual excess. Unfortunately there is no formula that can be applied to achieve perfect balance between action and reflection, Heron suggests it is desirable to have a good ratio between the two, this ratio can really only be achieved through trial and error in most inquiries.

In this co-operative inquiry I believe that we found a well-balanced ratio between action and reflection. In our busy lives we each found one to two hours to write our stories, attended the inquiry reflection meetings for two hours and would have spent one to two hours in private contemplation when considering the themes that emerged. Taking into account the commitments we each have, the process we achieved is realistic by Heron's expectations.

Summary of the process of co-operative inquiry

Co-operative inquiry is a collaborative process where participants become co-researchers and the researchers become participants. It is described by Heron (1996) as research done with people rather than on people. Co-operative inquiry is honouring of people, empowering – especially for marginalised groups, and enables flourishing of human potential. Four components make up co-operative inquiry, firstly a political element, secondly epistemological issues, thirdly ecological concerns, and finally the spiritual dimension of life. The political dimension suggests that human beings thrive in a participative community; this is called human flourishing by Heron. According to Heron, dominant groups use knowledge to exploit the less dominant in society. As a lecturer I work in a competitive research arena. By choosing co-operative inquiry as my research method I have made a political stand and identified myself as someone who believes in collaboration and empowerment for all. Identifying as a woman and a nurse I am classified as a marginalised person on two counts. By utilising co-operative inquiry, our group gives voice to an alternative way of being and emphasises the importance of service work. Robertson (cited in Heron, 1996, p. 149) describes validating and giving voice to the service work of women as part of the new economics.

Being a co-operative inquiry group is an elusive state to achieve according to Heron. The co-operative inquiry group can be achieved by creating a constitution – our group called this ‘ground rules’ – expressing our vision or goals and utilising contradiction to keep the group operational and focused. I believe that our co-operative inquiry group achieved this elusive state. We followed our ground rules, focused on our goals, and when paradox arose it was acknowledged and harnessed to invigorate discussions. Being a servant leader is a paradox in co-operative inquiry research. It means that I, as the lead researcher, juggled being a researcher, participant, and working in collaboration with autonomous participants in a functioning inquiry group. Consensus was used to make decisions and I expressed delights, concerns, and worries

openly to the participants. The other group members were offered the opportunity to express their delights and concerns as well. Anecdotally, our co-operative inquiry group worked and we each derived satisfaction and pleasure as participants.

The second component of co-operative inquiry is epistemological issues related to ways of knowing. Heron (1996) suggests our current positivists ways of knowing are flawed and contribute to restlessness and meaningless in our communities. Strongly advocating participation, Heron suggests its four ways of knowing as an alternative to intolerant and imperialist knowing. The four ways of knowing are: experiential or inner resonance with a person or thing; presentational knowing or use of voice, music, art and symbols; thirdly, propositional knowing expressed as theory that is written or verbalised; and the last way of knowing is practical knowing, through the acquisition of skill or competence. The knowing achieved in this co-operative inquiry on service has been a combination of all four participative ways of knowing. Two examples include the image of overlapping circles outlined as presentational knowing and the thoughts and feelings expressed by each participant about the actions and attitudes they express as service – an example of practical knowing.

Ecological concerns, as the third component of co-operative inquiry, were appropriately attended to in this study. This research was non-exploitive of participants, it encouraged creative thinking and sharing of deeply held experiences and values. The co-operative inquiry group hopes to have contributed knowledge to the wider community and intends to continue this collaborative and sharing process.

The final component of participative research is the spiritual dimension. This component emerged as a strong feature of the study, and was valued by all participants. We may have missed an opportunity to explore spirituality as it related to our personal and working lives; whether such an exploration would have been empowering for us is relegated to pure speculation.

Eight reliability and validity procedures were utilised in this co-operative inquiry; representativeness, research subjectivity, consistency with the literature, transcription accuracy, reflective cycles, research cycling, balancing divergence and convergence, and reflection/action balance. Representativeness was achieved in this study with a total of eight women collaborating on the subject under study, one identified as Maori. Research subjectivity was acknowledged upfront to participants and was not able to be avoided with this type of methodology. Consistency with the literature was strongly demonstrated; no specific study on the notion of service for health professionals was identified for comparison with the subjects areas selected to review in the literature for this study.

Transcription accuracy was rigorously maintained through frequent consultation with participants. Two major reflective cycles occurred and were constructive and rigorous. Research cycling was partially achieved and adequate for this study, participants met at a total of six out of the nine scheduled meetings to hear stories and review findings. Heron (1996) advocates that participants be involved in writing the research proposal, this was not considered appropriate by the lead researcher for this study. Balancing divergence and convergence was not demonstrated in this research. Our study utilised convergence to all explore the same topic area, Heron suggests a balanced approach with this component to ensure the topic has been considered as widely as possible. The co-operative inquiry group used total convergence with all participants expressing thoughts and feelings on the same issue at the same time. Heron states that the validity be questioned if balance between divergence and convergence is not evident.

The final validity procedure utilised in this inquiry was seeking balance between reflection and action. Our co-operative inquiry group did achieve balance between the time spent reflecting in a group and individual time writing or reflecting. A thematic analysis was presented to the participants in the form of a conceptual map. We worked

collaboratively to match similarities and differences with the themes and 19 categories were reduced to five themes and sub-themes.

Chapter 7 Conclusions

> Every end is a new beginning.
>
> Susan Hayward (1985)

The following chapter concludes the findings of all participants on the meaning and importance of service. As the quote above suggests, endings are also beginnings, as it is often at the end of a project we are able to see the beginning of the next. This chapter is presented in four distinct sections. The first section reports the conclusions of the participants on each of the five themes and sub-themes that emerged in this study. In the second section participants reveal anecdotal personal experience of the co-operative inquiry process and topics for possible future research are presented. My personal journey as the initiating researcher concludes the third section of this chapter and in the final section I share my closing thoughts about this whole venture with the reader.

The meaning and importance of service – group conclusions

Meaning

The eight participants in this study are all articulate, experienced, and well-educated women. They volunteered to participate in this study because of personal interest in the topic under investigation and to learn something about the rarely used qualitative method of co-operative inquiry. They all have rich and diverse past experience in clinical nursing and in the education of nursing students. One participant teaches nurses at post-graduate level. From their past experiences, they have developed their own skills in writing and reflection. These skills were well utilised in this co-operative inquiry on service. All participants acknowledged that their childhood and working and personal lives had shaped their values and attitudes to service.

In this study we collectively reached the consensus that service means ‘helping’, ‘giving’, ‘elements of service’, ‘acts of doing’ and ‘pride in work’.

These five themes and sub-themes were agreed following discussion and consideration of 19 original categories. It may be helpful at this point to revisit two definitions of service selected from a total of 25 definitions; ‘an act of help or assistance; an organized system of labour and material aids used to supply the needs of the public’ (Collins, 1992, p. 1228). It is reassuring that our themes and the definition provided in the dictionary are similar. I would have been curious and disconcerted if our study had produced radically different themes. Service is provided in many forms to all of us; bringing the service work of health professionals such as nurses out into the public arena may contribute in a small way to the knowledge and understanding of service work.

‘Helping’ those less fortunate than ourselves was identified as an expectation that participants experience as women and nurses. The ‘helping’ in nursing is often called caring and Graham (1983) suggests that many psychologists believe that caring provides women with a sense of fulfilment and femininity. The participants in this co-operative inquiry expressed fulfilment in their ‘helping’ roles. They did not discuss or link this fulfilment to their other roles as women. ‘Helping’, and the fulfilment the group experienced and shared, was seen as a spin-off from the job. Perhaps we have been so conditioned to our ‘helping’ roles that we do it unconsciously. This question about being conditioned to help would justify further investigation.

‘Helping’ was sometimes reported by participants to evoke a spiritual connection between the ‘helper’ and the recipient. The spiritual connection was labelled a positive experience. The spiritual dimension of life is one of four significant components of co-operative inquiry (Reason, 1998). We did not follow through with any discussion on what we each meant by a spiritual connection and about what happened for us when we connected on a spiritual level with another person. Spiritual connection as a component of ‘helping’ also possibly warrants additional analysis.

‘Giving’ the second theme of service, stretched participants to ‘give’ when their own reserves were not always at full capacity; but they agreed that ‘giving’ in these circumstances had taught them about their own limitations as people. Altruistic behaviour was a component of ‘giving’ but participants recognised that it required careful self-management to avoid burnout. We identified that society is in a constant state of flux and that the role of women has undergone significant change in the past 100 years. ‘Giving’ free time and energy to altruistic community work is less prevalent today as many more women work in paid employment. We acknowledge that we live in a user pays economy which means that people are expected to pay for services that were once voluntary or provided by the state. The notion of a spiritual connection was also evident when participants talked about ‘giving’ and was not explored in any detail as with its appearance in ‘helping’. A very positive aspect of ‘giving’ was the potential change that could result from facilitating a dialogue with a person about different options they might consider.

The third theme of service is titled ‘elements of service’ and comprises five sub-themes. The first sub-theme ‘working with people’ was associated with carrying out orders and doing what has to be done. Sometimes this was done in a spirit of compassion; at other times you did what you did as a professional. In either situation the co-operative inquiry group agreed that ‘working with people’ could not be performed to a formula, that each event was unique. This created its own stress for the people providing the service. Hochschild (1983) has called this ‘working with people’ emotional labour. ‘Being a public servant’ was the second sub-theme and participants agreed that this meant the state paid for your services. The third sub-theme ‘being a servant’ acknowledged the work of all women within their families or in employment as a servant. The participants acknowledged that many women are also in servitude to men and that the work they perform is undervalued, not understood, or remunerated appropriately. Applying the principles of new economics outlined by Robertson (cited in Reason, 1998, p. 149) to

the work of many women may bring about pay parity and changes to the way we live in community. The last two sub-themes of ‘elements of service’ are ‘need’ and ‘duty’. The ‘needs’ of others were put before your own and the group acknowledged this to be the case for many women. The group acknowledged that tension can arise for women who meet others’ need in the home and in the course of their paid employment; and that frequently no-one meets the needs that women have. The notion of doing your ‘duty’ resonated with all participants. It seems likely that this idea of ‘duty’ had permeated into the culture of nursing from the military and was fostered to promote nursing as a respectable career.

The fourth theme of service is titled ‘act of doing’. It was separated into two sub-themes by participants; firstly, wairuatanga or connection with another person, and secondly, respect. The unconditional sharing of ourselves with another person is very similar to the spiritual connection identified in the theme of ‘giving’. The actions of wairuatanga are offered in a timely, gentle manner and – similarly to the sub-theme ‘working with people’ from the theme ‘elements of service’ – there is no prescribed formula to connecting with another person. Emotional labour (Hochschild, 1983) and sentimental work (Strauss et al, 1982) resonate with the theme ‘acts of doing’. The second sub-theme ‘respect’ bought forth dialogue from participants about being professional. The co-operative inquiry group agreed that the work nurses do is largely hidden from public consciousness. Despite this the participants were delighted that nursing was rated as the second most respected career in the July edition of the *New Zealand Reader’s Digest* (2005). Facilitating a study to explore what constitutes respect for nursing as a career could prove very interesting.

The last theme that emerged from this study on service is ‘pride in work’. Three sub-themes comprised this theme: motivating factors; anticipating or problem solving; and being proactive. The participants expressed a desire to make a difference in other people’s lives, and believed they could do this by providing nursing that anticipated others’ needs and, on

occasion, providing solutions to patient concerns. Being proactive was considered to be part of the culture of nursing; participants did not articulate exactly what they would do, but linked being proactive with reflective thinking that created a smooth pathway for patients to travel.

Importance

The participants in this study were asked to write a story on the importance of service; but everyone ended up covertly implying the importance within their stories on the meaning of service. If we were under observation in our practice as educators or nurses it would be noted that we all provide service to others in our own unique way. I believe it would also be obvious to others that all participants believed strongly that service and its delivery matters. The participants have expressed the importance of service in stories about the giving of self without expectation of a return, the joy derived from spiritual connections that occur with patients and students, and the reduction of ego and stretching of self into the best we can be. The notion of service has captured my interest as a topic to study for a long time; I was pleased the topic of service was significant enough to attract participants to form a co-operative inquiry and undertake the research.

Participants' experience of co-operative inquiry

The following anecdotal information is the result of conversations with participants about their experience in our co-operative inquiry group. The participants held varying views on the meaning and importance of service and were interested in exploring these with a like-minded group. Participants expressed the subject of service in both similar and divergent ways; there was appreciation for the divergent opinions and opportunity to enhance knowledge and understanding about an aspect of work that is integral to our practice as nurses and educators.

The group valued the discussion and agreement of a constitution or group process (also 'ground rules') at the initial group meeting. This discussion set the scene for genuine, meaningful, and vigorous dialogue and facilitated a smooth journey for group members. Several of the

participants had recently completed their own Master's thesis, and it was valuable to hear them talk about their interview experiences and listen to their suggestions, although none of them had utilised a group process in their research. Participants expressed their enjoyment of the collaborative process where what they had to say was heard and where they could listen to the views of others. The sharing often resulted in an interesting discussion on matters nursing and educational. The information that was generated was made available to all participants and I feel sure that this transparency engendered trust and bonded us together as an effective group.

The leadership was not over-powering or intrusive; I juggled being a leader and co-researcher in a constructive and consultative manner with the group. Each participant had equal power or authority within the group despite their status outside the group. We were empowered by this collaboration to share with candour, honesty, and openness. It felt safe to tell our truths and be ourselves with each other. There was a real sense of doing something innovative, challenging, and meaningful without it being an onerous task. The following comments come from participants on their experience of the co-operative inquiry process;

> *Being a participant in Sue's research was stimulating and inspiring because the topic of service is something I value so much yet it seems to be discussed so rarely.*
>
> *As this form of research was unfamiliar to me I was intrigued with the amount of debate about subjects that was permitted and felt a sense of always being heard and able to 'dig' into issues.*
>
> *Co-operative inquiry has been a new and interesting approach to qualitative research for me, rather like a focus group with a difference. The group involvement in the whole process has been novel and interesting. The notion of each member being involved in the research findings and later publications has been a great spur for further research activities. The group was well set up. We felt supported and free to express our own beliefs and ideas about the meaning of service. My perspective of service has been broadened by the discussions that took place, particularly about the different background experiences that influence each person's notion of service. The whole process has reinforced the challenge ahead for nursing to identify what it is that nurses do that makes nursing different from other health professionals.*

> *I loved the process for its inclusiveness, being able to review ideas from other participants immediately and able to discuss, debate and add to the inquiry as it went along. It opened up opportunities in relation to knowing other participants rather than being anonymous from each other and was a very positive and useful experience.*
>
> *I found this experience very enlightening not only to hear and discuss colleagues' views on service but also having to reflect, explain and defend my own views. What I felt – I became more open to exploring this concept and adjusting what service can mean / might mean and how this affects my practice as a teacher / nurse and human being. Perhaps it has helped me become more holistic? The co-operative inquiry research style supports reflection, self-growth, and critical analysis in a safe environment.*

The limitation of time helped to keep us focused on the task at hand, we did not expend unnecessary energy and we allowed for difference between participants. We created a safe haven to express ourselves and respected each other's anonymity. No one raised their voice, disputed, or created tension within the group. Rather we had a sense of moving together following discussion along a consensual pathway. It was a positive experience and a journey that is yet to be completed. Our co-operative inquiry group is going to continue meeting following the completion of this thesis to collaborate on writing articles for publication. I believe that in one of the articles it could be beneficial for all participants to write about our personal experiences of participating in a co-operative inquiry. As it is not a widely used qualitative research method, it may be helpful for others to know about it – especially marginalised groups such as nurses, solo parents, the unemployed, and new immigrants. The group will discuss disclosure of identity at the beginning of the writing collaboration; I had previously raised this issue with them at an early co-operative inquiry meeting, but they asked to defer discussion on this to a later date.

One of the participants informed me that she had joined the group to find out from the inside what research is all about; I hope her experience was valuable. Another participant advised me she had written a research report on co-operative inquiry so it was now complementary to her knowledge that she participate in an inquiry; the two of us have

subsequently discussed other topics that we might research using this method. Some issues we might consider include:

- Are women conditioned to ‘help’?
- What comprises the ‘spiritual’ component of helping?
- The experience of being a participant in a co-operative inquiry study.
- Is nursing a vocation or not?
- Do people feel ‘called’ to a career in nursing?
- What constitutes ‘respect’ for nursing as a career?

Personal conclusions as the initiating researcher

I have divided this section into four distinct areas in an effort to capture the essence of this experience for me. In the initial section I have identified the skills I believe assisted me with the organisation and management of this study. The journey was a challenge but peak moments did occur and these comprise the second section of my personal conclusions. It is challenging enough to be putting this thesis out into the public domain, yet personal thoughts and feelings often bring another persons experience ‘to life’ for a reader. The third section is titled ‘valleys’ and aims to provide balance to these conclusions, by revealing the times of despair and hopelessness I sometimes felt. The last section reflects on my relationship with my supervisor who has been a witness, colleague, and mentor on this journey. I believe that such a personal self-disclosure is congruent with a method that pays so much attention to the process of the research undertaken.

Skills

A multitude of skills were utilised during this venture and enabled me to switch between the roles of initiating researcher, co-researcher, participant, Master’s student, and colleague. Some of these skills include listening, communicating with passion, expressing ideas clearly,

thorough planning and organisation, following up and completing tasks, and attention to detail. These skills have been acquired and refined in my professional life as a nurse and educator. Past leadership roles have shaped my style and enabled me to develop and refine the skills mentioned. I feel comfortable with a consensus style of leadership, where the best others have to offer can flourish and receive recognition. Finding the balance between leading too softly or too firmly is a skill that servant leaders pay ongoing attention to; I hope others might have seen me as a servant leader.

Having had a close prior working relationship with all but one participant contributed positively to the group bonding. By close I mean I had worked in the same team with at least six of the participants for a minimum of two years. This meant that we knew each other's styles, foibles, and weaknesses. Yet in the role of initiating researcher, they looked to me for some guidance and direction. I believe that I was very explicit with instructions, willing to hear others views, and open to consensual collaboration. In short, I was willing to lay aside my ego and allow the group to evolve. I was sensitive to undercurrents and encouraged those who I noticed waiting their turn, to share their thoughts and feelings with us.

There were never any grumbles or complaints to me about how our group work progressed and was managed. I endeavoured to create an atmosphere where participants could turn up, feel welcome, share, and go on their way until our next meeting. I wanted it to be an enjoyable and easy process for participants to be involved with, minimising roadblocks for participants was one of my objectives as the initiating researcher.

The refinement of skills and competence is an ongoing process, no one is ever perfect and nor would I aspire to be. As time went by, my intuitive reflective nature allowed me to relax and trust the process would progress as it was meant to. Some people feel the need to direct life and others. I have learnt that others contribute most when they feel valued for their contribution and the contribution shapes the process for the

whole group. I am not fearful of conflict or tension and although these emotions did not occur, I felt secure in the knowledge that these emotions can bring forth creative ideas, resolve undercurrents, and dispel anxieties. I am essentially an optimist who encourages others and tries to focus on being up beat; I believe this contributed favourable energy to our group dynamic.

Peak moments

The first peak to scale was coming up with the idea to explore the notion of service. I allowed myself time to let ideas percolate and surface for consideration. I wrote down all the ideas and gave each genuine consideration. It was an achievement to trust myself and go with the flow until the concept of exploring the meaning and importance of service emerged on the top of the list.

Writing the research proposal for ethics committee approval was another milestone that required time, rewrites, thinking, shaping, and energy. I heard horror stories from other Master's students about their ethics approval process; on reflection I had considerable anxiety about writing and submitting my proposal because of these stories. I needn't have worried, I was guided through the process and only had to delete one sentence for approval to be granted. The ethics approval process somehow made the project seem more real, as if something was going to happen; until then the research journey had felt like an intangible idea.

The exploration and gathering of literature was a satisfying process. I read widely and admittedly went off on tangents at times. However, eventually I created a large spreadsheet composed of multiple pieces of paper that were sellotaped together, and which continued to grow in breadth and depth as the literature was reviewed. I am glad to have identified a method that works for me. It is so helpful to be able to review all the literature at the same time to identify the similarities and differences. The final spreadsheet is like a very large map that guided me through the literature. Colleagues generously provided me with

interesting relevant articles to read and integrate into my literature review.

The examples described by Reason (1988) about other co-operative inquiries were inspiring and thought-provoking and contributed to my motivation for the methodology. Being financially challenged from time to time, I felt a sense of achievement to save the money and purchase both definitive texts on co-operative inquiry (Reason, 1988; Heron, 1996). Both of these texts have been an invaluable guide to me, I have dipped in and out of them and they are now like well-thumbed old friends.

I have appreciated the fellowship, warmth, and closeness we created within our co-operative inquiry group. The opportunity to participate and be the lead researcher is unique in qualitative research. We have shared deeply, created memories, and told stories about our work and ourselves. Much of what we shared is usually hidden so I was proud to create a place where it was heard, valued, and recorded.

Valleys

Life is a roller coaster and curved balls have certainly come from left field to shake my resolve and purpose during this research project. Sometimes when we look back it becomes obvious that in the valleys we learn some significant lessons if we are open to the learning. The valleys can also help us to recognise and celebrate the peaks. The major valley I have encountered was having a sister diagnosed and treated for oesophageal cancer in the past 12 months. It was distressing to watch my sister undergo major surgery followed by chemotherapy. Being a nurse it was very difficult to stay on the sidelines and to hear mostly disappointing stories about the service she received. During this time I found it a challenge to remain positive and my focus with this study slipped off the radar. As far as I was concerned this project could take a back seat; working full-time, providing support and meals to my sister and her family took precedence. The willingness and energy to write thankfully resurfaced and my sister's health is stable and improving.

Self-doubt about my ability to string two or three coherent sentences together was intermittently paralysing throughout this endeavour. On many occasions I just made myself sit down and write whatever came out the end of my fingers. Then on the following day I would rigorously prune my writing. Thus, through this free writing and rewriting, have I constructed this thesis. I have had one day when I experienced what I call a serious 'melt down'. Not surprisingly, it came near the end when doubt about the content and quality of my work mounted in my head to a crescendo. I made contact with my supervisor, sent relevant work through for some feedback, and backed off writing for 48 hours. Before my supervisor replied with feedback my courage to continue and self-confidence had returned. I re-read work I'd thought was rubbish a day or two before with fresh eyes and it looked ok. With huge relief and renewed energy I will persevere to the end. I trust this experience will, from time to time, remind me to treat others who express self-doubt with kindness and patience. It's all a normal part of writing and going beyond our comfort zone to a new locale.

Supervisor relationship

I had listened carefully to stories other colleagues shared about their supervisors, and did my own homework before I was fortunate in being able to identify and select my supervisor. I must admit that I have undertaken a trial run with my supervisor; I set up a meeting with him and explained that I would like his supervision for a special topic Master's paper I was completing. He was agreeable and explained what he could offer me as a supervisor. I suggested we each take the opportunity to get to know each other and find out whether we could collaborate on the longer thesis journey while we worked together on the shorter venture. From my perspective the trial run was successful and we agreed we could work together on my thesis. The success of the trial run and subsequent thesis project is related to our effective communication with each other. I accept responsibility for doing the work, I ask my supervisor for realistic time frames that would suit his work, and have endeavoured to work within this guideline. I accept my

work will be critiqued – sometimes very rigorously, at other times more gently – and I accept suggestions made that improve my work or challenge me to dig a little deeper. When I have expressed doubt I have been uplifted with encouraging words, poems, and stories. This has helped enormously to reframe my thinking and fan the flame of belief that I can do this.

My journey with co-operative inquiry has been stimulating, engendered hope, and is congruent with my way of being. I discussed the possibility of using this method with my supervisor for some time before making a commitment to it and launching in. I had not received any formal instruction on this qualitative methodology, but learnt about it from my supervisor and my own reading. I had no fear of trying a method few others do, rather I felt excited and inspired about what might emerge. I was prepared to live in uncertainty with few signposts, trust the process, and be guided by my supervisor.

Advertising for participants was daunting; I asked myself what I would do if no-one was interested in my topic. The comforting reassurance provided by my supervisor at this stage would allay the anxiety for approximately 48 hours. Then the old self-doubt would surface again. My concerns, however, were unfounded and 15 people originally expressed an interest in the topic. I expected this number to reduce as we approached commitment time and this is exactly what occurred. Eventually seven eager potential participants committed themselves to the venture.

Prior to the initial group meeting I had a planning meeting with my supervisor. We discussed how I might plan and manage the inquiry, group process, and the way forward from there. This meeting was extremely helpful in planning out the way ahead and considering alternatives.

At our initial co-operative inquiry group meeting I provided the potential participants with an overview of co-operative inquiry. I told them two

stories about two vastly different studies that had utilised this method, to illustrate its wide application. They were all supplied with a participant information sheet (Appendix B) and a consent form (Appendix C) to consider prior to our second scheduled meeting. This allowed potential participants time to reflect, without coercion, on their interest and willingness to participate in this research. I was relieved and grateful that all seven committed to the journey.

And so the journey with participants began at the second meeting following the collection of signed consent forms. The second meeting was dedicated entirely to a discussion of our intended group process; something Heron (1996) calls a constitution and what we called ground rules. The participants were supportive of my dual roles as researcher and participant. Five of the participants had completed their own Master's study within the past five years and they were encouraging about the journey. It was exciting for them to learn about another qualitative method first-hand and they offered valuable suggestions to me from their own journeys.

Closing thoughts

For all the participants in this co-operative inquiry, service is clearly extremely important, although in personal and different ways. Similarly, while there were many shades of meaning given to service by participants, it was possible to distil these into a focused collection of five themes. This has enabled the creation of a clearer sense of what service means to this group of people.

The decision to use co-operative inquiry was an important one that made it possible to honour deeply held and shared values of empowerment, collaboration, and learning. It made it possible to conduct worthwhile research in a way that was, in Reason's (1998) terms, epistemologically sound, politically potent, ecologically non-exploitative, and spiritually respectful. I believe all those involved in this process have in some way been nurtured, affirmed, validated, heard, respected, and nourished. We have also given voice to an extremely important, yet so

often undervalued, aspect of work in the health and education sectors. The message is clear; service is important and it has much meaning for those involved in this research. I have been privileged to have the opportunity to initiate, guide, and participate in such a worthwhile venture.

Appendix A – *an e-mail distributed across the Faculty of Health, AUT*

>>> "Sue Raleigh" <sue.raleigh@aut.ac.nz> 26/08/2004 2:33:59 p.m. >>>

Greetings,

Is 'being of service' important to you in your work as a teacher and health professional?

Do you seek to foster empowerment in yourself and others?

If you answered yes to these questions this invitation could really interest you.

My name is Sue Raleigh and I invite you to participate in a research project as a co-researcher / participant. To complete my master's I am planning to explore 'the meaning and importance of service for health professionals'. The research will utilise the method of Co-operative Inquiry which involves collaboration between researcher and participants. It is research done with people rather than on people. Heron (1996) calls this the fifth paradigm of participative reality.

Using co-operative inquiry, it is usual to cycle through phases of reflection, action and discussion. Until the group is established it is not possible to predict the exact way ahead any further. The group will make these decisions collaboratively.

If you are interested in the topic area and in experiencing co-operative inquiry first hand then please reply 'yes' to this e-mail. I will collate responses and identify a time and date to meet and discuss in detail what this project might involve. Respondents to the meeting will then select themselves in or out of the co-operative inquiry group.

Thank you for your time. I look forward to your response.

Sue Raleigh
Lecturer
School of Nursing
Division of Health Care Practice
Faculty of Health
AUT

Reference

Heron, J. (1996). *Co-operative inquiry: Research into the human condition*. Sage: London.

Appendix B – Participant Information Sheet

Date Information Sheet Produced
31st March 2004.

Project Title
'The meaning and importance of service for health professionals'.

Project aims
The primary purpose of the study is to explore and record the meaning and importance of service for health professionals, related to experiences from their personal and professional working lives.

People are chosen to be part of the study in the following manner.
Participants are selected on the basis of:

- stated interest
- working as a health professional in the Faculty of Health, AUT.

What happens in the study?
Following agreement to participate a meeting will occur to:

- clarify the purpose and intent of the study
- discuss and agree an appropriate group process
- explore and confirm plans to become familiar with co-operative inquiry method
- decide on subsequent meeting structure, frequency, location, data recording method
- plan initial data gathering phase

The study may cycle through several group discussions, until consensus is reached. The study findings will reflect a collaboration of views, values, experiences and beliefs. The principal researcher will write up the project and ensure an accurate representation of the findings, through consultation with the group.

What are the benefits?
There are four possible benefits that may result from participation in this research project:
(i) achieve a research output as a co-researcher with publication of article(s) following thesis completion
(ii) gain expertise in the use of co-operative inquiry research method
(iii) validation through sharing with colleague's understandings about the importance of service in our work
(iv) a deep awareness of the significance and meaning of service for participants

How will my privacy be protected?
Your privacy will involve commitment from the participant group and protection will occur in the following manner:

- The co-operative inquiry group participants will discuss the issue of confidentiality and group anonymity. We will all have a role in ensuring that privacy is achieved and maintained.
- Heads of departments, Schools and Divisions are excluded from participation in this study.
- Consent forms will be stored securely under lock and key for six years.
- The only people with access to the consent forms are my supervisor Tony MacCulloch and myself.
- Research data will be coded, and stored securely under lock and key.
- The only people with access to the research data are Tony MacCulloch and myself.

How do I join the study?
You are likely to join this study in the following manner:

- Contact Sue Raleigh to identify an interest in the topic
- Attend an exploratory meeting
- Agree to participate
- Sign a consent form

What are the costs of participating in the project?
The main cost of participating in this study is your contribution of time and energy.
The total time commitment required of participants is estimated as follows:

• Exploratory meeting	1 hour
• Co-operative inquiry meeting	2 hours
• Co-operative group meetings (2 x 8 hours)	16 hours
Approximate total time commitment	**18-20 hours**

Opportunity to consider invitation
You my require time to read this information sheet and decide whether or not you would like to participate. If you would like to participate please telephone me on ext: 7338 or send an e-mail to sue.raleigh@aut.ac.nz and I will send you a consent form and notification of our first group meeting.

Opportunity to receive feedback on results of research
It is my intention to summarise the research findings and provide all participants with a copy.

Participant Concerns
Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor.

Project Supervisor Contact Details:
Tony MacCulloch
Senior Lecturer
School of Nursing
Auckland University of Technology.
Private Bag
Auckland.
E-mail tony.macculloch@aut.ac.nz
Telephone: 917-9999 ext: 7116.

Concerns regarding the conduct of the research should be notified to:
Madeline Banda
Executive Secretary
AUTEC.
E-mail madeline.banda@aut.ac.nz
Telephone: 917-9999 ext: 8044.

Researcher Contact Details:
Sue Raleigh
Lecturer
School of Nursing
AUT.
E-mail sue.raleigh@aut.ac.nz
Telephone: 917-9999 ext: 7338.

Approved by the Auckland University of Technology Ethics Committee on 28 April 2004.
AUTEC Reference number 04 / 76.

Appendix C – *Consent to Participation in Research*

Title of Project: 'The meaning and importance of service for health professionals'.

Project Supervisor: Tony MacCulloch.

Researcher: Sue Raleigh.

- I have read and understood the information provided about this research project (Information Sheet dated 31st March 2004.)
- I have had an opportunity to ask questions and to have them answered.
- I understand that the Co-operative Inquiry group discussions will be audiotaped and transcribed.
- I understand that I may withdraw any information that I have provided for this project and or myself at any time prior to completion of data collection, and without being disadvantaged in any way.
- If I withdraw, I understand that all relevant tapes and transcripts, or parts thereof, will be destroyed.
- I agree to take part in this research.
- I wish to receive a copy of the report from the research.

Participant signature: .....……

Participant name: ……

Participant Contact Details (if appropriate):

……

……

Date:……

Approved by the Auckland University of Technology Ethics Committee on 28 April 2004.
AUTEC Reference number 04 / 76.

Appendix D – *Participant information on Co-operative Inquiry*

Co-operative inquiry: A radical paradigm with promise

By Tony MacCulloch

'The primary purpose of research/practice is to enhance human flourishing. To do this it must generate valid information within action situations so that those involved can understand them more thoroughly and act in them more effectively. Research/practice is not only about collecting empirical information but about a whole range of information based on the experience of those involved – intuitive inquiry into values and purposes, conceptual inquiry into the frames and sense-making we as actors are bringing to the situation, and practical sensuous inquiry into our actions as individuals and members of groups and communities'. (Reason & Torbert, 2001).

Presentation themes
- Critique of orthodox research
- Personal journey
- Features of co-operative inquiry
- Challenges and gains

Critique of orthodox research (Heron, Reason, Torbert)
- Excludes 'self-determination' of subjects
- Excludes the subjects from choice about topic, method or interpretation of the research
- Epistemologically unsound

Critique of orthodox research (Heron, Reason, Torbert, Skolimowski)
- Contributes to the impoverishment of our world
- Treats living beings as things to be manipulated and exploited
- Alienates people from each other, the world and knowledge

Personal journey
- Original plans for a masters thesis using co-operative inquiry
- What actually transpired was a modified participatory approach
- Thesis title…"Countering hegemonic oppression in tertiary education: risks and strategies for the transformative educator"

Personal journey
- Doctoral research commenced with a desire to honour values within critical theory; empowerment; humanism; transformative education
- Intent to include co-operative inquiry
- Working title – 'Critical determinants in educating the emotionally competent nurse'

Co-operative inquiry - Features
- Overview of method
- Beginning a co-operative inquiry group
- Types…Internal / external initiation; Full / partial form; Closed / open boundary; Informative / transformative; Apollonian / Dionysian.

Co-operative inquiry – Outcomes
- Personal transformation
- Presentations of insights gained
- Propositional reports
- Practical skills

Co-operative inquiry – Purposes

- Developing professional practice
- Liberating disadvantaged groups
- Exploring human experience
- Institutional change and development
- Development of theory

Co-operative inquiry – Stages and cycles
Stages

1. Reflection, planning, decision making.
2. Action, recording data
3. New awareness's
4. Review topic focus, plan second phase

Cycles recycle for 5-8 sequences
Conclude pulling threads together and decide re final reporting
Collaborate on writing agreed report

Co-operative inquiry – Inquiry skills
Radical perception

- Being present
- Imaginal openness
- Bracketing
- Reframing

Co-operative inquiry – Inquiry skills
Radical practice

- Emotional competence
- Dynamic congruence
- Non-attachment

Co-operative inquiry – Validity processes

- Research cycling
- Divergence and convergence
- Reflection and action
- Challenging uncritical subjectivity
- Managing unaware projections
- Chaos and order
- Authentic collaboration

Co-operative inquiry – Challenges

- Letting go of power and control
- Planning / time constraints
- Participant time / energy demands
- Researcher skills required as co-participant / co-researcher
- Negotiating academic hegemony

Co-operative inquiry – Gains
Humanistic

- Promotes human flourishing and realization of potential
- Respecting diversity
- Supports human capacity for freedom and growth
- Values the human dimension

Co-operative inquiry – Gains
Educational

- Fosters self determination
- Facilitates personal development
- Empowers all involved

Co-operative inquiry – Gains
Political

- Upholds human justice
- Fostering human rights
- Strengthening community
- Shares power and control
- Democratic process

Co-operative inquiry – Gains
Epistemological

- Reconnecting research with the world
- Reflecting reality and grounding in experience
- Correcting epistemological errors
- Full range of forms of knowing – experiential, presentational, propositional, practical

Co-operative inquiry – Gains
Ecological

- Connects us with the environment
- Encouraging balance and harmony
- Re-visions positivist mindset
- Enhances peoples connectedness with each other

Co-operative inquiry – Gains
Spiritual

- Heals alienation
- Contributes to wholeness
- Celebrates human presence

Concluding thought
'The primary purpose of research / practice is to enhance human flourishing' (Reason & Torbert, 2001).

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Tony MacCulloch is a senior lecturer at Auckland University of Technology in the Faculty of Health Studies. He lectures on interpersonal skills and counselling in the BHSc and Masters programmes, supervises Masters students, and is currently undertaking research into teaching of emotional competence to nurses. These notes accompanied a paper presented at the Auckland University of Technology Conference '*Health Policy and Practice and research in the 21st Century – Making a Difference*' in Auckland, May 6-9th 2002.

Glossary

These terms are drawn from Maori culture. The definitions were provided by a Maori participant.

Kotahitanga - “to be one with another for the betterment of self and the other person”.

Manaakitanga - “acts I do, to care for unconditionally”.

Pakeha - “as distinct from Maori, usually refers to a European New Zealander”.

Wairua - “spiritual”.

Wairuatanga - “the connection that you have with another person”.

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