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**What is ‘good care’ in a medical/surgical setting?
A hermeneutic phenomenological study.**

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Abstract

This research explores the nature of ‘good’ care in medical/surgical wards. A Heideggerian, hermeneutic phenomenological philosophical and methodological approach was used. Heidegger’s philosophy privileges ontological inquiry concerned with uncovering human being in the everyday. There were 17 study participants: three past patients, three whānau members and 11 staff members from a range of disciplines including professional and auxiliary staff. Participants were interviewed and encouraged to tell stories that demonstrated ‘good care’.

The stories of ‘good care’ revealed a depth of meaning that lies beneath the surface. The notion of how staff went about being themselves in the everyday became important. The way one responds and relates to others matters in ‘good care’. The ‘feeling’ of ‘good care’ was remembered by ex-patients as being important. Reflection on the stories of staff revealed a deep love for humanity. This love was felt and valued by patients. While difficult to describe, it was noticeable when absent. The notion of manaakitanga was demonstrated in the caring, mana-enhancing way in which care was experienced by patients.

Notions of attunement and phronesis were revealed in the ability to recognise, understand and respond to the needs of others. An ability to authentically be-with another enabled staff-participants to see the needs of others and to ‘leap-in’ where needed or ‘leap-ahead’ to smooth the way for an experience of ‘good care’. There was a sense of the sacred in many of the stories. When ‘time-on-the-clock’ became dominant, ‘good care’ tended to retreat to the shadows. This study revealed that one’s comportment or way-of-being is central to bringing the various threads of ‘good care’ together. Thus noticing, developing and rewarding such comportment has implications for the recruitment and education of health care providers.

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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 (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

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Chapter One: Orientation to the Study

*I personally, just do not love the world,
but also the process itself of getting to know the world.*
(Paulo Freire cited in Gadotti, 1994, p. 153)

The issue of ‘good care’ is high on the political and social agenda. In New Zealand, there is a groundswell of feeling about the resourcing of the health system; with a particular focus on staffing levels for health professionals in the hospitals. In essence, there are ongoing policy and organisational moves to ensure an ability to provide ‘good care’. At the same time, I hear stories from people about their hospital experience which suggest that ‘good’ is not always achieved. I too am a player in this health care system, striving to lead by example and implement policy and standards that focus on improving care.

It is assumed that achieving and maintaining ‘good care’ is an admirable goal. The question arises then: what is ‘good care’? What does ‘good’ mean? From whose perspective? Is good care about ‘caring for the whole person’? Is it completing all the tasks? Is it communication and doing the ‘little’ things well? Is it personal connection? Is it being technically and academically excellent? Is it involving the family/whānau or support people fully? Is it co-design of the care pathway and the progress along it? Is it integration across the system? Is it keeping within budget or is it just getting to the end of each day? Is it ‘safe’ staffing, or is it doing the best with what we have got? As a nurse leader in an acute hospital, these questions are asked explicitly and implicitly by patients and families/whānau, and by staff, both clinical and managerial.

To address the above questions, this hermeneutic phenomenological study will focus on illuminating the experience of ‘good care’.

The Research Question, Study Aim, and Philosophical Underpinnings

The specific question I pose is, “What is the experience of ‘good care’ in the general medical/surgical hospital setting in New Zealand”? I begin by briefly examining the meaning of ‘good care’. As an adjective, ‘good’ has its origins in old English *gōd* (with a long “o”), ‘excellent, fine, valuable...’, ‘good’ refers to actions that are beneficial, effective, righteous and when referring to people means ‘having the right or desirable quality’ (Harper, 2020). ‘Care’, from the old English *caru*, *cearu*, ‘sorrow, anxiety, grief’ has come to mean ‘charge, oversight ...heed with a view to safety or protection’. As a verb, ‘care’ originates in the old English *carian*, *caerian*, meaning to be anxious or solicitous; **feel concern or interest**. ‘Care’ developed in the 1500s to mean have an inclination; have a fondness for (Harper, 2020). This research seeks to uncover both the actions and qualities when ‘good’ is experienced in ‘care’ for those in a medical/surgical hospital ward.

Literature abounds on topics that address aspects of care in hospital. In particular, there is a body of literature that addresses various hospital settings such as the intensive care unit (ICU), emergency department, paediatric services, and mental health services. Missing, however, is a focus on pulling together the various views about ‘good care’ in the general (medical/surgical) setting. There is also a range of literature about ‘good care’ from the perspective of various professional groups. This current research seeks to reveal the whole experience of ‘good care’ from a range of perspectives: from those being ‘cared for’, those ‘providing’ care, and those who may not directly ‘see’ themselves as part of this process; yet, by their very presence, may impact care. To achieve this aim, the methodological framework will be hermeneutic phenomenology.

The approach is influenced by Martin Heidegger [1889-1976] with a focus on understanding the lived experience of those giving and receiving ‘good care’ in the general medical/surgical environment (Koch, 1995; Smythe, 2011). It is an interweaving of phenomenology and hermeneutics. Phenomenological research is described as turning to experience as lived-through. Heidegger pointed out that this is both meaningful; yet superficial (Harman, 2007). There is nothing deep and meaningful about it until the question is asked, what is this lived experience (phenomenon) *like*? (Van Manen, 2017). It is hermeneutic because participants shared their thoughts about ‘good care’ in practice, joining with me in the interpretive enterprise of finding meaning (Smythe et al., 2008).

Because the lived experience is transformed to textual expression, the aim is that “the text is at once a reflexive re-living and reflective appropriation of something meaningful: a notion by which a reader is powerfully animated in his or her own lived experience” (Van Manen, 2007, p. 36). In phenomenology, the moment an experience is experienced, it is already gone; the best we can do is to think about it retrospectively, trying to capture what it was like and how it was in our consciousness at that time. “The term ‘lived’ experience equates with living-through prereflective, prepredicative, non-reflective, athoretic experience” (Van Manen, 2017, p. 812). Attempts are made to ‘lift up’ and bring the moments of the lived experience into language. Heidegger added the layer of ‘fading’ wherein consciousness or the meaningfulness of an experience falls away and is always available to return (van der Hoorne & Whitty, 2015; Van Manen, 2017).

The Research Topic – Context

Current healthcare practice is contextualised in an increasingly complex environment that involves individuals, systems, and relationships (Gordon, 2017). While our capacity to treat

complex illness has expanded, resulting in patients living longer, the healthcare culture we live in today has been overloaded with increased demands for quantity and efficiency. The focus on production and outcomes leads to stress for practitioners and staff (Dudkiewicz, 2014). Healthcare workers also face an increase in external accountability for their work in relation to patient outcomes (McGowan et al., 2013). The needs of patients, balanced against the need to give the best care possible, can lead to staff spending additional unpaid and unrecognised time to meet the requirements of their role (Lawless, 2017).

Over the 30 or more years of my career in health, greater emphasis on treating the patient as a ‘whole person’ has emerged. Older models of paternalism are being replaced by models that emphasise negotiation and partnership (Greenfield, 2014). Historically, two distinct models of care have been in place; the first focused on diagnosis and treatment of the patient as a condition. This view of providing healthcare traditionally focused on what works for the provider of care—both individuals and the system as a whole. The second model focuses on the patient as the centre of care and includes concepts of understanding the lived experience such as patients’ emotions, struggles, and involvement in the world. There is growing interest in viewing the patient as a whole person within a context. There are attempts to co-design or deliver care in a way that does not ignore the individuality of the person and includes their family (Sidani, 2008; Smythe & White, 2017).

Care is sometimes presented as a uni-directional activity; yet, this is an inaccurate portrayal of most caring relationships. Some argue that we need to stop viewing people as merely individuals and promote caring relationships; regardless of familial ties, all are in relationship (Busby, 2013). Care could be described as “an orientation to the delivery of health care and

supportive services that considers [the] person's needs, goals, preferences, cultural traditions, family situation, and values" (Levine, 2013, p. 20). This approach recognises and addresses family needs and preferences, and integrates family caregivers as partners in care.

In setting out to reveal the meaning of 'good care' in the medical/surgical hospital setting, the question in itself becomes controversial because some would state that 'everyone cares', 'everyone is cared for' (Busby, 2013). Perhaps the focus should be on 'caring relationships' rather than the 'carer' and the 'cared for'? This idea, from the realm of the justice system, moves away from the concept of the passive recipient of care by the altruistic actions of another, to a relationship of interdependence with an underlying vulnerability (Busby, 2013).

Health professionals claim the concept of caring and 'making a difference' as the core of their practice (Alicea-Planas, 2016). Why then do so many recipients of healthcare report that they are not listened to and are unhappy with the care that they receive from health professionals (Alicea-Planas, 2016; Blom et al., 2013)? It is recognised that effective communication between all disciplines that provide patient care is essential for continuous care and safety (Pain et al., 2016).

Numerous barriers have been identified in the provision of 'good care'. There is strong evidence that lower nurse staffing levels in hospitals are linked to worse patient outcomes (Ball et al., 2013). Casualisation of nursing staff as a management strategy contributes to unstable nursing units, increasing risk to patients (Duffield et al., 2011). Alongside this, there is a body of literature referring to doctors believing they have unrealistic workloads, including staff shortages and interrupted breaks that result in fatigue. Doctors have expressed

concern about making patient care decisions while sleep deprived. In this context, there is also concern about the lack of time and release for ongoing education to ensure that doctors are up to date with best practice recommendations (McGowan et al., 2013). Physician well-being affects patient care in a number of direct and indirect ways (Shannon, 2013). Fatigue and stress can also cause team members to retreat into their individual professional silos, where there is safety, clear limits, recognition of professional value, and license to work autonomously (Hall, 2005).

In the hospital setting, a number of additional barriers to providing ‘good care’ have been identified including viewing the family as an obstacle, feelings of moral distress and perceptions of unethical treatment. Other factors are fear of making a mistake, feeling unprepared educationally, fear of not being able to give full information, and fear of crossing professional boundaries. Lack of time and private space is also identified as a barrier to communicating with families (Adams et al., 2017).

There is a small body of evidence that suggests that bias (implicit or explicit) may have an impact on the interaction between healthcare professionals and patients from different cultural groups (Drewniak, 2017). In the New Zealand context, health outcomes for Māori are poor in comparison to other ethnicities due to a range of factors including disparities in service provision, inappropriate service design, and cultural differences in values and aspirations (Barton & Wilson, 2008). In relation to this imbalance, compassion is a key construct in healthcare and is seen as the basis for the search for justice or equality for patients (Alicea-Planas, 2016).

The preceding paragraphs focus on the *deficits* of ‘good care’. It often seems easier to ‘see’ when ‘good care’ is absent. I now move to a focus on ‘good care’ when it is *present*. In turning to the meaning of ‘good care’, we lack a clearly defined truth. There are different meanings depending on the viewpoint from which this question is considered. According to Heidegger (1995), the encounter of patient and practitioner comes before language, before interpretation, before methods and models; it is simply one person meeting another (Smythe & White, 2017). From a finance and banking perspective, ‘good’ is about providing a commodity or service regarded by economists as satisfying a human need (Law, 2018). It is interesting to ask whose need, how, and for what purpose? A religious approach would be to define ‘good’ in terms of God; goodness proceeds from the love of God (Browning, 2010). In the middle ages, ‘good’ was identified as being in relationship with another entity; for example, ‘good’ and God, or reflecting the ‘good’ of creatures (Vauchez, 2005). Health professionals have a duty to do ‘good’ for patients (beneficence) (Law & Martin, 2020). In this sense, ‘good’ refers to intentions or consequences, but how is ‘good’ judged? From a social science perspective, a good can be a physical item or something related to well-being (Calhoun, 2002). Again, one wonders what the positive worth of ‘good’ is and to or for whom? From the realm of philosophy, ‘good’ is indefinable and known by intuition (Cassin, 2017).

It is interesting to ponder what things are ‘good’ and how we know them? Is there a relationship between ‘inner good’ and ‘outwardly good’ behaviour? It is clear there are a range of perspectives on ‘good care’. My aim is to uncover the experience of ‘good care’ in the medical/surgical hospital setting, enabling it to be viewed by others.

The Research Topic – Background

With the intention of providing comprehensive healthcare services to all New Zealanders, the New Zealand Social Security Act, was passed in 1938 (Keene et al., 2016). As a result, the New Zealand health system is primarily (80%) publicly funded by the taxpayer (Chalmers et al., 2017; Davis et al., 2013; Gauld, 2012). The Government has an imperative to ensure that money used for the publicly funded health system is efficiently and effectively used for the best delivery of health to the population (Davis et al., 2013). Over the last 20 years, a number of factors such as availability of new treatments, an aging population, and a widening income gap (increased poverty) have resulted in a continual rise in the cost of comprehensive healthcare for all. Successive governments have claimed that this is unsustainable. Despite claims to the contrary, the real government spend on health (as compared to GDP) has not risen. It remains at approximately 7%, placing enormous strain on the health system in relation to providing high quality and comprehensive services to the population. In New Zealand, today, everyone who is acutely unwell has access to hospital care as needed. However, access to treatment that may be considered less acute has at times been adversely affected. The public are often left waiting long periods for treatment, paying privately through insurance or using individual resources (Keene et al., 2016).

People and How They Respond

Within this context, it seems useful to explore how people function. According to Heidegger, affective experiences play a vital role in our lives. Things matter to us and affect us emotionally because we are ‘mooded beings’ (Heidegger, 2008). How is the mood of a person described or situated within the context of a hospital, and how does this collectively affect the mood of the organisation? All humans experience moods and because of this we are attuned to the world in a way that makes things matter. The concept of ‘lived experience’

is commonly used in modern health and is often reduced to the level of 'patient stories'. In New Zealand, there is a definite shift towards use of the patient story to engage staff, leaders, and governance boards in an effort to unite around a common purpose (personal experience at all levels). To adequately describe the experience of patients and staff, it is necessary to understand the context in which their experiences are 'lived'. Further, it is necessary to explore what this experience is like.

The lived experience itself is merely a way of referring to everyday life experience. The point where this becomes more than superficial and begins to develop depth is when the question of what is this lived experience (or phenomenon) like? Heidegger referred to living through the lived experience as prereflective, nonreflective, or atheoretic. However, we are unaware of these stages as we live through an experience. Any moment, any encounter may become merely an experience without any special significance until it is 'called to mind'. To lift up the experience and bring it into focus through the use of language gives orientation to the hidden meanings (Van Manen, 2017).

While motivation and personality are important aspects of leadership in health, understanding of self is required and includes understanding of limitations and the assumptions one brings that shape understanding (Johansson et al., 2010). The ability of a leader to establish a positive culture is directly influenced by the motivation of, and communication with, those who report to them through the organisational structure. Thus, the ability of the first line manager is influenced by confidence in superiors and encouragement in setting the framework for 'good care'. Further, the mood of encounter up or down the hierarchy builds and undermines trust.

What Happens When Things Go Wrong?

‘Good care’ has many components. One aspect of ‘good care’ that is dominant, and of concern to patients and staff, is what happens when, despite all attempts, things do not go as planned. Patients who deteriorate while in hospital can either do so slowly or suddenly with potentially catastrophic results. Often deterioration constitutes an emergency that is responded to in various ways. It can mean calling an emergency team, resuscitation (either cardiac or respiratory) necessitating emergency resuscitative care, a transfer to a higher level of care and/or death. This type of situation is distressing for all involved including the staff, patient, and family/whānau members. It is well known that when case-reviewed, patient deterioration has often been apparent in subtle ways several hours prior to the emergency situation. In New Zealand in 2015, the Health Quality and Safety Commission (HQSC) completed a review of early warning systems designed to recognise deterioration early (Moore & Poynton, 2015). The report predicted that 5% of cardiac arrests could be prevented with the use of a standardised early detection tool.

Is there potential for this type of approach to signal ‘good care’? A white paper by Professor Erik Hollnagel (2015) was presented at a conference in 2017. The paper describes the current safety culture in hospitals where mistakes are examined in detail to identify contributory factors that need to be eliminated. It is based on the idea that work can be analysed and prescribed in such a way that mistakes can be eliminated—referred to as work-as-imagined. An alternative way of thinking about safety is then suggested wherein the emphasis is on examining what goes right (in the majority of cases) to identify what we should do more of. The reality of the workplace where variation and adaptability need to be constantly present

and work unfolds over time is then described; and is referred to as work-as-done, the reality of the workplace (Hollnagel et al., 2015).

Heidegger referred to '*Dasein*', which in his world means "the self *as* the there (*Da*) of being (*Sein*), the place where an understanding of being erupts into being" (Davis, 2010, p. 44). Heidegger described self, being-in-the-world as *Dasein*. *Being-in-the-world* is intended to mean what it means for *Dasein* 'to be' (Davis, 2010). This concept, of Heidegger's, presents the opportunity to examine the standardised approach which means considering what might be behind individual staff responses to a situation. It assists to guard against jumping to conclusions about non-compliant actions and to examine what it might be like to 'be' people involved in the escalation of care.

Work as Imagined/Work as Done

It is hoped that reduction of unwanted incidents or accidents can be achieved by focusing on what goes wrong and attempting to minimise this through modification of systems and processes (Hollnagel et al., 2015). But is the provision of 'good care' this simple? Hollnagel et al. (2015) made the distinction between 'work as imagined'; that is, work as the policy says it should be and as those in charge imagine that the work happens. 'Work as done' refers to the reality of the day to day application of the process. In the world of practice, it is important to consider the implications of any system for staff. Reasons for non-compliance with policies and guidelines may include information overload, accessibility, policies seen as trivial (result of a knee jerk reaction), length and complexity of guidance (Carthey et al., 2011).

Rather than judging those who do not immediately comply, there is opportunity to unpack the act of judging and illuminate the reasons for actions. Heidegger argued that understanding is not just a matter of knowledge. There is also the aspect of knowing-how to operate in the world. Self-understanding informs our actions and activities; knowing what matters to us (*affectedness*) affects our actions. It is the things that matter to us that garner us to action. This ‘mattering’, then, becomes public through our actions (Weidenfeld, 2011).

It is surmised that the reason things go right so often in a complex system is not because people (*Dasein*) behave in the way they should (work as imagined) but rather that they adjust to match the conditions and behave in variable ways that match the situation (*authenticity*) (Hollnagel et al., 2015; van der Hoorne & Whitty, 2015). ‘Good care’ is provided with outcomes that are without adverse complication; an approach opposite to the predominant emphasis on investigation of things that go wrong. Yet, I would question whether we have really examined the key components when the system works well. Why, when so many patients pass through our hospitals, do things go right, meaning ‘good care’ is experienced? Such understanding could be used as a basis for explaining why things occasionally go wrong (Hollnagel et al., 2015).

The idea that ‘work as imagined’ corresponds with ‘work-as-done’, fails to recognise the complexity of the environment of health and its continuously evolving demands. By examining narratives describing ‘work-as-done’, this research seeks to illuminate the experience of ‘good care’.

Background and Context – The Researcher

By way of introduction, I include the following:

| | |
|---|---|
| <i>Ko Hananui, ko Tākitimu ngā maunga</i> | <i>Hananui and Tākitimu are the mountains</i> |
| <i>Ko Ōreti, ko Waihōpai ngā awa</i> | <i>Ōreti and Waihōpai are the rivers</i> |
| <i>Ko Uruao, ko Tākitimu ngā waka</i> (canoes) | <i>Uruao and Tākitimu are the voyaging waka</i> |
| <i>Ko Murihiku te marae</i> | <i>Mirihiku is the marae</i> |
| <i>Ko Ngāi Tahu te iwi</i> | <i>Ngāi Tahu is the tribe</i> |
| <i>Ko Jan Dewar tōku ingoa</i> | <i>My name is Jan Dewar</i> |

Māori are considered tangata whenua (people of the land), and are indigenous to New Zealand. I am a member of Ngai Tahu. I came to the knowledge of my Māori heritage late, in my twenties. Until that time, I was raised in a Pakeha world. I appreciate the Protestant Christian values and traditions gained throughout my life. Growing my knowledge and understanding of my Māori ancestry and heritage is an interesting and ongoing process. Although I am not a speaker of te reo (Māori language), I have included a number of commonly used Māori words in this thesis. A glossary is presented, following the references, to explain the terms and provide further clarification.

I am a registered nurse with more than 30 years of acute care experience in various New Zealand hospitals. I have been a registered nurse, a nursing lecturer, nurse consultant, a nurse director, and an associate director of nursing. However, even before I was a nurse, I was comfortable with the hospital setting. My earliest memory of hospitals is as a pre-schooler being ‘looked after’ by the cook in a small country hospital while my mother (the midwife) was busy delivering a baby. My early years were spent accompanying her when she ‘relieved’ for the country midwife, which meant spending 48 hours at the hospital. Some of my thinking about ‘good care’ is influenced by my mother’s practice. One particular story stands out about the inclusion of family.

At that time, ‘fathers’ were not allowed at the delivery of a baby. The usual role for the father was to drop the woman at the door of the ‘maternity home’ and wait somewhere out of the way. Somehow, a baby was born. On one occasion, my mother needed a second person to assist. Due to the rural and remote nature of the hospital, no-one was available. She recruited the woman’s husband. As she instructed him on what to do—open this ampoule, pass me that needle—she thought he was an able assistant. Maybe having the partner present was a good idea. Only later did she find out that he was also the local veterinarian. While an amusing thought in hindsight, this is an example of the stories that have influenced my awareness of ‘good care’. The advantage of getting to know the family and whānau seems so important. It leads to good decisions about inclusion in the experience of ‘good care’, both for the patient (in this case ‘woman’), and everyone involved. In this story, are shades of attunement. My mother was able to ‘know’ what would be ‘good’. She is a practical woman. Her experience as a midwife, combined with her wisdom, is a common theme in many of her recollections of ‘good care’. Over the 30 years of my career, I have often acted as a sounding board, a safe space for debriefing. I am appreciative of my mother’s emphasis on ‘good care’, on what went right. She has helped me to see possibilities in situations; to always keep ‘people’ at the centre of my practice as I strive to understand and deliver ‘good care’.

An unfortunate moment during my polytechnic nursing ‘training’ was probably the first time that I really thought about ‘good care’. The nursing tutor walked into the patient bedspace. The impression was that I was standing, leaning on the heater, doing nothing. I was certainly not observed to be caring for the patient in the bed. The tutor took me aside and informed me that ‘they say nurses are born, not made, did I really want to be a nurse’. It was at that moment that I determined that I would be one of those nurses who was ‘born’, because being

‘made’ into a nurse clearly was not possible. Reflecting on my career, that comment was probably more influential than I realised. My determination to ‘prove her wrong’ was an early motivation for the career that I have very much enjoyed and in which I have thrived. The experience has also stayed with me, reinforcing the importance of choosing one’s words carefully, being aware of the long term effect they may have. An example occurred less than two years later as a 21 year old, in my second year of practice as a registered nurse. A 19 year old male, was admitted to the ICU. He had been a back-seat passenger in a car driven by his girlfriend’s mother. He was Māori, his girlfriend was New Zealand European. He had flown out the back window and hit his head on the road. Over several hours it became clear that he had no brain function. There was a large group of teenagers outside the door; his mother was a 2-hour drive away. I have journalled this story but essentially the care I provided included negotiation with the police to keep his body in the hospital until morning so that he would not be left alone. My awareness of Māori protocol relating to death was almost non-existent at that stage, but I did know that listening and responding with empathy and kindness were important. When his mother and auntie arrived (10-minutes after he had passed), I thought the woman doing the talking was his mother; she was not, she was his auntie. This was a lesson learned to always check to whom you are talking. I was able to listen to that whānau and meet their needs, as much as hospital and police protocol would allow. While I found this situation challenging, I felt proud of the ‘good care’ I was able to provide. On reflection, I can see that ‘good care’ was about listening, being in the background but being willing and able to step in at any time. Yet, it is often so much easier to remember examples of when ‘good care’ is missed. This story was a turning point in my early career. The feedback I received from the whānau and my own colleagues was heartfelt and reinforced the values that I held and still hold. I strongly believe that listening and

inclusion are an essential foundation for ‘good care’. The bias I bring to this research is my belief that ‘good care’ is important.

What Led to this Research

The beginnings of this study lie in my experience as a registered nurse, educator, and senior nursing leader in more than one acute hospital. Throughout my career I have observed and participated in the provision of ‘good care’, mostly in the acute hospital setting. Thinking about my research topic, I started with a subtext of what **stops** professionals engaging in what is described as ‘good’ care. I began by reflecting on possible barriers such as the requirements of professionalism, legal constraints, time constraints, and role requirements that may inhibit ‘good care’. Alongside, I reflected on whether the way patients are viewed may be a factor. Is the focus that western health has on the individuality of patients appropriate in the contemporary context of healthcare in New Zealand? The following story illustrates one situation that led to my desire to uncover the experience of ‘good care’ in the general medical/surgical hospital setting.

Contacted by the customer relations coordinator, I agreed to meet with a woman whose mother had passed away in a general medical ward two years earlier. I searched the clinical file prior to the meeting to be familiar with what had been documented about her care in the ward. The woman (I estimated to be in her 50s), along with her support person, arrived at the interview room and introductions were made. I asked her to describe her mother’s journey and to ask any questions. She was an articulate person who had thought a lot about her questions (as it had been two years of pondering). She told me that she had two questions that she wanted an answer to—if that was possible. This woman was tearful and cried for most of the hour-long meeting.

She had two memories. The first was that she had understood her mother (who was in a room with three other patients) to be dying (from discussion with the consultant), and asked the medical registrar if her mother could be moved to a private room. The answer was that this was not possible. Her mother would need to stay where she was. She wanted an answer to why that was not possible.

On reading the notes, it appeared that there may have been some miscommunication. The consultant had mentioned 'dying'; however, on closer reading of the notes, it is clear that at that time her mother was not dying. She was being actively treated with antibiotics and other treatment modes, and had been referred to rehabilitation for her recovery. Mention of dying may have been a comment not meant for her. The more private room available in that ward is for people who are dying, is without monitoring equipment, has carpet on the floor (not suitable from infection control perspective while active treatment is ongoing), and would not have been suitable at that time.

The question I am left with is, 'why was that explanation not given?' I cannot know the answer; however, it appears that while physical care may have been 'good', it did not meet the holistic needs of the family. They were left wondering if they should have advocated more. Was there something else that they had not done for their mother? This resulted in feelings of guilt and wondering, and a tearful meeting two years after the event. Again, I asked myself, why is it that 'in the moment' some staff appear to be able to meet the complex needs of all and give 'good care', while others are not? What does 'good care' feel like when it is present?

Her second question was about the nursing care of her mother. The other patients in the room told her that one of the nurses or a care assistant (she was not sure which), was being ‘mean’ to her mother. She mentioned this to the Charge Nurse who said, “I’ll look into it”. Her question to me was, did she look into it, did anything happen? Once again, I wondered whether the Charge Nurse had followed or, if not, what prevented her from investigating less than ideal care? Was reassurance given at the time? Did the individual continue to be assigned to care for her mother? Did anything change?

It all seems so simple. Why is it that some are able to provide ‘good care’ while others fail to notice the distress of the people around them? Is it ‘just’ communication? Is it the team working together? Is it something else?

On reflection, this story demonstrates that there are a number of people involved in any hospital episode. The story mentioned nurses, doctors, and healthcare assistants. I began to wonder about ‘good care’ in a broader sense which led me to seek to understand ‘good care’ in the medical/surgical ward, the setting of this story. In recognising that there is a range of people involved in any hospital episode, I have, therefore, included a range of people in this research. First, the patients and family or whānau provide important insights into their experience of receiving ‘good care’. Also included are a range of people in the hospital who directly interact with patients. Nurses, doctors, allied health team members are all familiar and expected to provide care in hospital. Perhaps less recognised are cleaners, food service assistants, and healthcare assistants. I was drawn to include such people by ex-patients who told me specific stories about their ‘good care’. I wondered what their role may be in the overall experience of good care in hospital.

This research offers an interpretation of the narratives of 17 participants. Three former patients who self-identified as having received ‘good care’ are included, along with one family member of each patient. The remaining 11 participants are members of hospital staff recognised by their peers as consistently providing ‘good care’. They include two registered nurses, and one specialist nurse, doctor, chaplain, occupational therapist, physiotherapist, social worker, cleaner, healthcare assistant, and food service assistant. Participants range in age from 20 to 70 years. Participant ethnicities included: New Zealand Māori – 5, New Zealand European – 10, Irish – 1, Chinese – 1.

There is discussion in New Zealand about how to refer to people in hospital. Some prefer terms such as consumer or client. In this study I have referred to participants receiving care as ‘patients’, which seems appropriate during a hospital stay. The word ‘patient’ is based on the Latin term *patiens*, which is translated as ‘suffering’ or ‘undergoing’ (Matthews, 2014). In a number of texts, ‘patient’ is generally referred to as someone receiving services from a health professional, usually while attending a healthcare facility (Ireland & Yeung, 2020; Law & Martin, 2020; Molineux, 2017). While I agree that a person admitted to hospital may be referred to as a ‘patient’, I do not agree that they are merely the ‘receiver’ of services. I have referred to providing and receiving ‘good care’ throughout this thesis. I believe that each person is significant in the experience of ‘good care’. The idea of *providing* and *receiving* ‘good care’ is one with which I am uncomfortable. It conveys the idea that one person is passively receiving something while another is somehow more important because they ‘provide’ care. I believe that whether ‘providing’ or ‘receiving’ care, all are important

in the overall experience of ‘good care’. Hence, when I refer to ‘providing’ or ‘receiving’ good care, I am in fact referring to the broader experience.

Thesis Structure

This thesis is presented in nine chapters. Chapter one, the **introduction**, sets the scene for the study. Context is provided. My aim for the study and its philosophical framework are outlined; including, my rationale for choosing Heideggerian hermeneutic phenomenology. My pre-understandings are identified. I describe why the topic of ‘good care’ is important to me, and ought to be for all providers and receivers of care.

Chapter two, **‘turning to understanding’**, provides additional context for the study and presents a synthesis of existing literature on the experience of ‘good care’. Published knowledge on the subject are examined and gaps identified in the literature.

In chapter three, the **‘methodology’** that informs this research is articulated. In order to place this research within a phenomenological framework, its ontological (the nature of existence) and epistemological (the nature of knowledge) underpinnings are described.

Chapter four contains an explanation of the steps I took to perform this research in the **‘method’** chapter. Ethics, recruitment of participants, interviews, the drawing out of stories from the narratives, and the reflective process used for interpretation are covered. Steps taken to establish trustworthiness are situated in van Manen’s (2007) suggested principles. Expressions of rigour as suggested by De Witt and Ploeg (2006) are described in relation to the research.

The study findings are presented in chapters five to eight. Chapter five, **‘Being me’**, examines participants’ insights into who they are in relation to ‘good care’. They reveal that traits such as being watchful, trustworthy, aware of the fragility of trust, authentic, a listener/feeling listened to, kind, and courageous are all important parts of the ‘being’ of ‘good care’. The chapter describes a relationship between ‘being’ and providing ‘good care’ with reference to manaakitanga (holding others in high regard). ‘Good care’ seems to be provided and received when participants are just ‘being’ themselves. A deep-seated love for humanity seems to be at the base of ‘good care’.

Chapter six, **‘Being me in the moment’**, reveals ‘good care’ when ‘being’ progresses further to include concepts such as noticing, attunement, tact, guidance, relationship, phronesis, reflecting, being a tool, and working as a collective. The idea of ‘leaping in’ and ‘leaping ahead’ are explored (Heidegger, 2008). The resulting ‘good care’ seems to occur when actions and attitudes are borne out of ‘being’.

In chapter seven, **‘The Sacred Space’**, the idea that there seems to be something more than merely ‘being’ and ‘doing’ when ‘good care’ occurs. This chapter reveals aspects of a deeper knowing, a sacred space. Self-knowledge and openness to the infinite seem to arise—glimpses of something more are seen.

Chapter eight, **‘Time’**, turns to a more hermeneutic approach. All participants made comments about the notion of ‘time’, in relation to their thoughts about ‘good care’. By uncovering the meaning of these comments about ‘good care’, a greater understanding of the place of ‘time’ is revealed.

In chapter nine, the **discussion** brings the findings from each chapter together. The Heideggerian concept of comportment (way of being) provides the foundation for the thesis of the thesis. Comportment enables the research findings to be linked together as a whole. Recommendations for practice and education are presented. Limitations and opportunities for further research are presented.

Summary

Much of my work as a nurse leader has focused on standards, forms, and rules for practice. I have had the privilege of working alongside wonderful colleagues who are equally committed to making a contribution to ‘good care’. I have always had a sense that encouraging others to reach for their best, to provide or influence ‘good care’, is a worthy activity. I offer my findings about the experience of ‘good care’ as a way to provide further input to the world of ‘good care’ in hospital.

Chapter Two: Turning to Understanding

Ali Smith tries to define our times, by defining summer ...its reluctance to be defined ...its elusive nature ... 'the briefest and slipperiest of seasons, the one that won't be held to account because the summer won't be held at all, except in bits, fragments, moments, flashes of memory of so called or imagined perfect summers, summers that never existed'.(Smith, 2020)

As Smith (2020) sought to describe 'summer', my ability to describe the experience of 'good care' finds congruence with her sense of summery nature of the day. Experiences arrive in different ways. One may be aware of and able to articulate aspects of the experience; or, it can be so 'everyday' that one is not even aware of the summeriness of the day. By turning our attention to a particular life experience, we achieve reflective awareness of its character. Phenomenology seeks to describe one's lived experience. Hermeneutics refers to interpretation of the 'texts of life' (Van Manen, 2007; Wilson, 2014). Any claim to understanding is made in the knowledge that it will be from a basis of fore-structures gained from being-in-the-world (Koch, 1995). To appreciate the literature and differing perspectives of the experience of 'good care', I endeavour to be conscious of my historical horizon and the effect this has on my understanding (Smythe & Spence, 2012).

Most of my career has been dedicated to providing or influencing 'good care'. I have either had a nursing or multidisciplinary focus on the role of professionals in the delivery of healthcare. As a researcher, I recognise that I come to the text as an interpreter, bringing my past understandings and experiences (Smythe & Spence, 2012). It was through reading Heidegger that I came to appreciate that there was much more to 'good care' (Smythe & Spence, 2012) than I had initially understood. For that reason, I have included dialogue about 'good care' beyond these professional groups.

As I reviewed the literature available about ‘good care’, I accessed a range of resources. Formal research, poetry, reports, opinion pieces, and other information found serendipitously have been included. I invite readers to share the journey of discovery alongside me, bringing their own preunderstandings and experiences. My aim is to promote thinking and engagement with the text. I understand that my ‘findings’ are not definitive and complete; they are merely a pointing towards an interpretation of the topic (Smythe & Spence, 2012).

Congruent with contemporary practice, a literature search was conducted using search terms: *family centred care, patient-centred care, whole person care, compassion, communication, physician/patient relations, inpatients, workload, physicians, empathy, quality with ‘caring’* and ‘good care’ in acute adult settings. The search engines Ovid, Scopus, CINAHL, and Medline were accessed to find the most relevant, recent data from a healthcare perspective. Hand searching of reference lists, as well as talking to colleagues who provided additional material, also took place.

There are many articles about family centred care and communicating with families in the paediatric and neonatal literature. There is also a range of studies about communication practice and the skills of ICU nurses in the adult setting (Adams et al., 2017). Further literature pertains to family inclusion in the care of inpatients with mental health issues or during end of life care (Gott et al., 2019; Martin et al., 2017). With regard to communication in medical and surgical nursing situations, however, there is little data about the meaning of giving or receiving ‘good care’ in this setting.

Because of the large volume of data available about care and caring, I am presenting views that are more specifically role related, applying broadly across different groups that are relevant to the acute hospital setting. I begin by presenting a snapshot of views about ‘good care’ from differing perspectives.

Good Care – The Patient’s Viewpoint

Because this research began in response to a patient’s experience, I begin by focusing on ‘good care’ from a patient perspective. Concept analysis shows that a number of attributes need to be in place if patients are to participate in their care. An established relationship, mutual engagement, and a willingness to share power, information, and/or knowledge are all important (Greenfield et al., 2014; Sorlie et al., 2006; Thórarinsdóttir & Kristjánsson, 2014; Tobiano et al., 2015). Patients consider care to be of high quality [good] if it is related to their individual need and based on respecting their values by encouraging them to participate in their own care decisions (Baillie, 2009; Ringdal et al., 2017; Sidani, 2008; Suhonen et al., 2012). According to Baillie (2009) and Kralik et al. (1997), the core of patient dignity in an acute hospital setting is feeling comfortable, in control, and valued.

Good care happens when healthcare providers work together. This means that care givers agree on their respective roles and share information both with each other and with the patient. Patients express feelings of being cared for and listened to when included (Burdick et al., 2017; Dahlberg et al., 2009; Pethybridge, 2004). When care is perceived to be good, the sense of security is increased for patients. They are affected by the general feel of the total environment of security and collegiality amongst the staff. Thus, it is important that healthcare providers do not lose sight of patient vulnerability (Sorlie et al., 2006). Factors

such as being truly present and being genuinely concerned for the patient are felt and interpreted as caring by patients (Attree, 2001; Sorlie et al., 2006).

A study of marginalised patient groups regarding what constitutes ‘good care’ found eight key components of ‘good care’: involvement in care decisions, seeing the same health professional consistently, being guided through difficult situations, having a friendly and caring attitude, having an understanding of how their life is affected, taking time to answer questions and explain things, efficient sharing of information between health providers, and pointing towards further support. While these factors are consistent with general expectations, the priority of each factor differed between groups (Ryan et al., 2017).

Good Care – The Family/Whānau Viewpoint

The concept of including families in discussion, planning, and care of patients while in hospital is well accepted. However, such communication is often perceived by families in hospital contexts as inconsistent, insufficient, and poor (Adams et al., 2017; Blom et al., 2013). Even when families report being generally happy with the care, they can still experience feelings of anxiety and even depression (Blom et al., 2013). For families to participate in care, they need to be invited and accepted by health professionals (Blom et al., 2013). It is vital that a positive tone and expectation of inclusion is present, and should be signalled to relatives by health professionals (Frivold et al., 2015).

Health facilities increasingly recognise that to provide good care, a focus on person and family centre care is essential to meet common goals (Levine, 2013). Families need confidence in the healthcare team. They value the team working together, with the nurse being the primary influence and the one providing day to day information about all aspects

of the care (Cypress, 2011; Frivold et al., 2015). In the New Zealand context, research by Gott et al. (2019) on ‘good care’ for older people hospitalised during the last three months of life reported that empathy, effective interactions, ‘knowing’ the patient and family, and active participation of patients and their families in care, are important for older people in hospital. Similarly, an integrative literature review of 103 articles on carer engagement (some of whom may also be family members) concluded that there are six important components for ‘good care’: patient caring, information sharing, shared decision-making, carer support and education, feedback and patient care transitions (Morrow & Nicholson, 2016).

Good Care – The Nurses’ Viewpoint

When seeking to understand ‘good care’, anything that provides a barrier to ‘good care’ becomes important. The quality and quantity of nursing personnel, for example, is an issue in healthcare because increasing the time nurses spend with patients improves the quality of nursing (Aalto et al., 2009). A number of studies have linked nurse staffing, workload, the working environment, and patient outcomes such as increased mortality, length of stay, and outcomes such as falls and pressure injuries (Duffield et al., 2011). There is some evidence that unfinished care by nurses, or ‘missed care’ could be used as an indicator of overall quality (Ball et al., 2013). A study in England showed that 86% of nurses reported being unable to deliver one or more care activity on their last shift due to time constraints. Most frequently left activities were comforting/talking to patients, educating patients, and updating nursing care plans (Ball et al., 2013). Failure to ensure adequate nurse staffing was a central factor identified in the Mid Staffordshire NHS Trust report which identified poor quality care over several years (Francis, 2013).

While such outcomes are ‘measurable’, the less visible ‘heart of good care’ seems to be more challenging to articulate. The role of caring has been, and is, a central component of nursing (Leininger, 1986; Staden, 1998; Watson, 1997). Florence Nightingale led the way with her commitment to the care of soldiers, veterans, and their families (Tye, 2020). Care as a concept is difficult to explain. Scott (2012) suggested that the development of ‘character and virtues’ in individual nurses is imperative. Caring consistently is hard; therefore, it requires engagement in the triumph and joys of human experience. Role models and an appropriate environment must be available to shape character and develop virtuous habits such as attention, compassion, and therapeutic use of self (Johansson et al., 2010; Salmela et al., 2017; Scott, 2012). In addition to physical caring, dimensions of psychological, spiritual, and social care are important (Bassett, 2002). Some suggest that ‘good care’ is found in the little things that are often missed when time is short (Pearcey, 2010). A recent study of nurses in Iran concluded that ‘good care’, resides in the dimensions of safety, patient-centeredness, accessibility, justice, effectiveness, and technical competence (Valizadeh et al., 2018). Furthermore, nurses with baccalaureate or higher qualifications appear to be linked to better patient outcomes, implying that the delivery of ‘good care’ is influenced by levels of education (Aalto et al., 2009; Aiken et al., 1994; Duffield et al., 2011).

Good Care – The Doctors’ Viewpoint

The historical focus in medicine on being a good doctor did not adequately address the complexity of the contemporary health care environment. A move to thinking about ‘good doctoring’ as a process more adequately contributes to the whole in the complex and diverse environment of individuals, relationships, contexts, and systems (Gordon, 2017; Salisbury, 2020). Globally, high quality doctor-patient communication is becoming synonymous with high quality health care in the 21st century. Yet, there is a lack of global consensus as to what

defines good communication. The prescriptively taught western ‘patient-centredness’ may not be appropriate cross-culturally (Mole et al., 2016). Literature on the changing relationship between the medical profession, patients, and society in general recognises the shift from the doctor-centred discourse to a patient-centred health improvement agenda. The changing public perception of doctors is altering the balance of power in doctor-patient relationships. A change in the language away from the use of ‘professional’ towards more common emphasis on ‘practice’ and ‘team’ signifies this change in emphasis (Gill & Griffin, 2010).

It is acknowledged that doctors gain a concept of their place within the profession from experiences in the workplace (Gordon, 2017). Empathy indirectly affects patient satisfaction through its positive effect on health outcomes. The presence of empathy directly effects patient satisfaction with their doctor. It also effects patients’ perception of their health improvement (Weng et al., 2011). Empathy seems to decline throughout medical training with repeated exposure to difficult emotions. Perhaps ‘good care’ is about giving of self as much as possible without getting burnt out or emotionally depleted (Mathew, 2019). Recognising the importance of connection while being able to accept one’s own imperfections seems to reflect ‘good care’ (Magauran & Brennan, 2008). Sharing knowledge with honesty and humility, showing empathy to all including colleagues and patients alike seems to be a key concept in ‘good care’ (Chen, 2019).

Good Care – The Multidisciplinary Team Viewpoint

Multidisciplinary teams have the advantage of providing a range of expertise. The complex make-up of these teams can also be challenging because each member will have their own set of values, beliefs, attitudes, customs, and behaviours informed by their discipline

(Carlsson et al., 2010), past experience (Gordon, 2017), personal and professional values. As well as differences in background, members of the team often have overlapping competencies and must share varying degrees of responsibility. This can lead to role blurring (Hall, 2005) and adds to complexity when interpreting information in relation to patient care. Each may view the same piece of information from a different perspective (Pain et al., 2016). At times, the nuances of a professional culture are known within the profession, but they remain a mystery to those outside it. Some have claimed that professionals can monopolise knowledge for the purposes of power and control (Hall, 2005).

Effective collaboration and teamwork are often difficult to practice. There are numerous obstacles to enabling teams to function, not the least of which are professional jealousies, role boundaries, and communication problems. The hierarchy and culture within the team can affect the ability of all staff to speak up and advocate for the patient (Atwal & Caldwell, 2005). A positive work environment has been described as comprising factors including autonomy, positive relationships between staff, teamwork, job satisfaction, and low risk of burnout. Care is more likely to be left undone in wards where nurses perceive the practice environment to be negative (Ball et al., 2013). The connection between ‘good care’ and staff satisfaction is increasingly being recognised. The impact is not necessarily only on clinical care, but engagement in the workplace and attitudes during interactions with patients and other team members (Hebblethwaite, 2013).

Good Care – The Non-Professional Staff Viewpoint

Very little literature is available about ‘good care’ in relation to the roles of non-professional hospital staff. Mixed method research in India, Bangladesh, Zanzibar, and The Gambia focused on the role of cleaners in the prevention of infection. With 105 stakeholders, the

study included management, healthcare professionals, and cleaning staff. The research concluded that training is required for cleaners to effectively ‘do their job’ to maintain a clean environment. It recommended further work on promoting respectful relationships between cleaners and other hospital staff (Cross et al., 2019). A Canadian study about cleaners’ role in disease prevention identified a lack of respect and a feeling of invisibility. Cleaners were expected to organise their work without disturbing others. Speaking to cleaners was viewed as ‘interfering with their work’, the implication being that cleaners are unable to organise their work simultaneously with communicating with those around them. Cleaners, in the study, placed value on talking to patients—recognising they spend most time in the rooms with patients. The fact that they were not given information about patients was seen to increase the risk to patients. An example was being asked to get a glass of water by a patient who was on restricted oral intake. The cleaners, therefore, developed strategies to deal with such situations including making their work visible, emphasising their competence, and expecting respect (Messing, 1998).

Research has analysed cleaning products for potential health hazards, useful information for keeping cleaners safe (Wang et al., 2019). There was also literature addressing working conditions for cleaners and other staff such as care assistants and orderlies [porters] (Lövgren et al., 2002; Toynbee, 2003). These roles are described as being ‘at the sharp end, up close and personal to patients’; yet, do not recognise the influence they have on the experiences of patients. The roles tend to be low paid, undervalued, and contracted out to external providers which results in a lack of inclusion in teams and untapped potential for influencing ‘good care’ (Toynbee, 2003).

Notions that Point to ‘Good Care’

Having addressed views about ‘good care’ from particular groups, I turn to common ideas that run across and between these groups. This could be likened to the warp and weft threads. Having addressed the weft threads of each discipline, I now address the warp threads that run across them all. The following are notions about ‘good care’ that arose as I engaged with the literature and other information available.

Communication

It is recognised by policy makers that inter-professional communication and collaboration are fundamental building blocks for meeting the complex care needs and improving quality and safety for patients (Rice et al., 2010). Engagement with employees, including physicians, is the most effective way to improve the patient experience because more engaged, satisfied staff provide better service and care to patients (Hebblethwaite, 2013). A range of evidence points to a relationship between poor communication between health professionals and poor patient outcomes (Rice et al., 2010). Improved collegial relationships between nurses and doctors, along with better educated nurses and richer skill mix, have been linked with decreased patient mortality (Duffield et al., 2011). A study examining communication between multidisciplinary groups demonstrated an inequitable interaction resulting in the achievement of medical aims, while other aspects of patient health were ignored (Atwal & Caldwell, 2005). Nurses report that communication skills improve with experience; however, studies indicate that experience alone cannot be relied on to achieve this improvement. There is evidence that communication skills can be taught but evaluation of specific programmes is limited and often relies on, in this example, nurses’ self-reported improvement. Such reports may show improvement in confidence but may not address improvement in action from the patient or family’s perspective (Adams et al., 2017).

One conceptual framework describes three interconnected phases: the human connection phase, the information processing, and the action phase. An important initial focus is on setting an inviting environment, portraying (and feeling) genuine interest and attention to show respect as an equal. The sharing of information is then possible to enable shared decision making and confidence in giving and accepting delegated responsibility. This leads to perceived control over care, thereby improving the quality of the care (Thórarinsdóttir & Kristjánsson, 2014).

The patient as a person

How should we view patients? According to Bisognano and Schummers (2014), to achieve a deeper engagement with patients and families we need to ask “what matters to you” rather than “what is the matter?” This should inform everything we do, putting the person at the centre. It is deemed important to see the person in context of their overall life rather than the narrow reason for needing healthcare. Patients indicate that the most important aspect of care is ‘authentic compassion’; patients should be the subject rather than the object of care (Greenfield et al., 2014).

It is important to recognise where one is situated in relation to support and interdependence with others and how that impacts the culture within the hospital setting (Herring, 2013). The concept of ‘lifeworld-led care’ has an emphasis on the complexity of personhood, health and illness, leading to respect for patients’ preferences and enabling families to participate in care (Blom et al., 2013; Dahlberg et al., 2009). It includes a philosophy of the person with a view of well-being. Focusing on identification of a patient’s goals, preferences, hopes and dreams,

is essential if we are going to move from treating disease to co-producing health (Bisognano & Schummers, 2014).

The connection of mind, body, and spirit is recognised by some and there is evidence that inclusion of a spiritual assessment in care planning results in better coping with illness and improved compliance with treatment (Koenig, 2014). A patient centred approach has been recognised as a key factor in enhancing patient experience. One aspect is addressing the ways that patients find meaning in their lives with a focus on the spiritual aspect of the person (Holmes, 2017). In the current context of complexity, one size does not fit all. All health professionals need to be able to look beyond the individual in order to perform safely and effectively in a complex and ever changing environment (Gordon, 2017).

Measurement and models

Integrated care models are often described from the point of view of the provider who seeks to provide person-centred care. Efforts are made to understand how the patient fits into the integrated care model, rather than how services could fit into the patient's world (Greenfield et al., 2014). Most providers will see themselves as patient centred. Patients are the reason for coming to work. However, many structures, particularly in hospital-based care, conspire against effective patient centred care. For example, restrictive visiting hours create barriers for family to support patients at times of great anxiety and limits opportunities for providers to discuss management options with patients and their families (Robb & Seddon, 2006).

As a result of the Cartwright report (Cartwright, 1988), the Code of Disability Services Consumers Rights Regulation was developed and patient centred care was established as a priority (Health and Disability Commission, 1996). It has developed in the intervening years to include emphasis on patient choice, shared decision making, and has moved on to mean

people-centred rather than patient-centred care, indicating the need to see the importance of collaboration between patients, families, healthcare practitioners, and hospital leaders in all aspects of care at all levels of the system (Robb & Seddon, 2006). The patient as an individual is best understood within the context of the person as someone involved in a complex web of relationships. Included are experiences that shape the ability of the individual to engage in the care they are designing, producing, and being involved in, perhaps even receiving. Developing and providing health care in the most appropriate way can be facilitated by a co-design approach. This approach to enabling care processes works best when there is mutual respect, active listening, and confidence built up by the development of a trusting relationship between health professionals and the recipient of care (Mark & Hagen, 2020; Mayer, 2017).

Cultural considerations and equity

Contemporary New Zealand has a dispersed and ethnically diverse population. While the health system is universally funded with the responsibility of providing healthcare for all, the delivery of equitable health outcomes for all populations groups has not been achieved (Goodyear-Smith & Ashton, 2019). How then do we progress to providing equity for patients? How do we ensure that they get what they need? “Most professions share understanding of a culture of practice epistemology (what counts as knowledge) that varies amongst its members depending on context, personal experience, age length and range of service” (Smythe & White, 2017, p. 1). Incorporating the profession’s value system into the professional’s world-view is a subtle process and unfolds in largely unspoken ways. Physicians are trained to take charge, make and assume responsibility for decisions. Sharing leadership is a challenge because they assume or are expected by others to take charge. Clergy (chaplains) may struggle to share information with the team due to the historical view

of confidentiality of the clergy/person relationship. Nurses and social workers may place emphasis on the patient story and count this alongside physical metrics as important. Physicians may be more focused on hard data to make a ‘diagnosis’ and a plan. Since values are internalised and largely unspoken, they can create obstacles that may be invisible to the team struggling with a problem (Hall, 2005).

With New Zealand’s commitment to a bi-cultural journey, one important aspect of providing ‘good care’ for Māori is to ensure that care is guided by New Zealand’s founding document, Te Tiriti o Waitangi. The principles of partnership, protection, and participation are drawn from both the English and Māori versions as an attempt to understand how te Tiriti may be applied (Kingi, 2007). Importantly, following the Wai 2575 Health Services and Outcomes Kaupapa Inquiry Stage One report (Waitangi Tribunal, 2019), the articles of Te Tiriti o Waitangi are recognised as a basis for practice. The articles are Kāwanatanga—partnering and shared decision making; Tino rangatiratanga—recognising Māori authority; Ōritetanga—equity; Wairuatanga—upholding values, belief systems and worldviews (HQSC, 2020). Cultural safety is essential for the provision of ‘good care’ (Hunter & Cook, 2020). It is more than cultural competence (Nursing Council of New Zealand, 2020). It is a commitment to attend to unconscious bias and taken-for-granted power imbalances, moving towards shared decision making (Medical Council of New Zealand, 2019). Having awareness of one’s own cultural identity assists in providing culturally safe care, as defined by the patient and their community. Cultural safety is an ongoing, reflective process focussed on ‘critical consciousness’ (Curtis et al., 2019). It is necessary at both an individual practitioner and an organisational level.

Current models of care that focus on individual patients without accounting for more wholistic, spiritual, and collective values may not be appropriate or meet the needs of Māori (Goodyear-Smith & Ashton, 2019; Mole et al., 2016). Māori models of care are based on a traditionally wholistic and spiritually based worldview. As part of addressing the bi-cultural needs of New Zealanders, Whare Tapa Wha was developed in 1982 at a Māori health workers hui. According to Dr. Mason Durie, the model includes four realms of being; taha tinana (physical), taha whānau (social), taha hinekaro (emotion) and taha wairua (spiritual) (Rochford, 2004). The health professional must understand that the Māori person, the whānau (family), and the Māori worldview are all central to the care that is given. Determining what is best for the patient is done by the patient within the context of the wider whānau. “Tikanga Māori (Māori customs) including karakia (prayers) and mihimihi (greeting rituals), help provide a korowai (cloak of protection) for whānau” (NiaNia et al., 2019, p. 335).

Looking More Specifically at ‘Good Care’

Studies about ‘good care’ in the hospital environment usually focus on the perspective of patients and families, and/or the perspectives of professional staff. Including non-professional staff such as cleaners, food service assistants, and healthcare assistants, as I have in this research, is rare. The following studies focus specifically on ‘good care’. I briefly outline their findings and comment on them in relation to the current research.

A qualitative study by McCaffrey et al. (2019) seeking understanding of patients’ perspectives about ‘good care’ concluded that the relationship between patient and provider is multidimensional. *Understanding ‘Good Health Care’ from the Patient’s Perspective* (McCaffrey et al., 2019) is a study that aimed to develop a conceptual model of ‘good health care’ that would allow measurement of care using patient reported outcome performance

measures. Group concept mapping was used with an emphasis on showing patient priorities. Important components were “individualised care, shared decision-making, and good communication of rationale for treatments offered” (McCaffrey et al., 2019, p. 93). These concepts were similarly important to researchers and clinicians, included in the study as stakeholders. Participants were not from a defined setting, with the focus being more on integrated care. In contrast, my research is focussed on a defined environment and aims to describe the *experience* of ‘good care’ from both the patient and staff member perspective.

Another qualitative study titled *‘It’s a Matter of Patient Safety’: Understanding Challenges in Everyday Clinical Practice for Achieving **Good Care** on the Surgical Ward – A Qualitative Study* (Jangland et al., 2017) used reflective interviews with ward leaders from six surgical wards in three hospitals in Sweden (four surgeons, six nurses). The study identified a gap between written documentation and the ability to provide ‘good care’ and ‘safe care’ on the surgical ward. Ethical issues and moral distress are highlighted when nurses lack the resources to deliver ‘good care’. Pressure to move patients quickly through the system increases these feelings. Further, the increasing complexity of patients cared for on the surgical ward, who may have previously been transferred to the ICU, highlighted a need for higher level education with a focus on professional values. A high turnover of nurses only served to exacerbate the issues highlighted. This study alludes to ‘good care’ by highlighting the barriers to ‘good care’. It is interesting to note that documentation did not feature in my study as an important component of ‘good care’.

Another qualitative study set in the surgical ward utilised interviews with eight nurses and six surgeons to identify opportunities and barriers for achieving ‘good care’. *Obstacles and*

*Opportunities for Achieving **Good Care** on the Surgical Ward: Nurse and Surgeon Perspective* (Yngman-Uhlin et al., 2016) identified that shifting focus away from the patient due to prioritising other work such as administration, accepting additional tasks or being interrupted, is a barrier to ‘good care’. Factors that enable ‘good care’ are emphasising good communication and using the competence of the team. Constant structured communication within the team and with patients is important. Equally, competence that includes both technical knowledge and advanced interpersonal skills are pre-requisites for ‘good care’ (Yngman-Uhlin et al., 2016). This study’s focus does not include the wider team or patients and families in the participant group.

*Working Conditions and the Possibility of Providing **Good Care*** (Lövgren et al., 2002) is a study using a questionnaire before and after the introduction of a new ‘care policy’ in four hospital wards. A previously validated questionnaire about job satisfaction, likelihood of burnout, and opportunities for creative and innovative practices was used. Respondent answers are reported in two groups; nurses and enrolled nurses in group one, physicians, secretaries and cleaners in group two. Good working conditions are a pre-requisite for delivery of ‘good care’. Immediately after the introduction of the new ‘care policy’, a significant budget deficit emerged with constraints placed on resourcing of the wards. This resulted in significantly less opportunity to provide ‘good care’ reflected in responses to the second questionnaire and points towards a need to have control of the environment including staff resourcing to enable ‘good care’ provision (Lövgren et al., 2002). The study included a range of staff to evaluate a new ‘care policy’ using a questionnaire. It did not seek to describe the experience of ‘good care’. However, it is suggested that another study in the same country showing decreased patient satisfaction may be linked to staff environment.

In an effort to provide a definition of ‘good care’, a concept analysis entitled *Good Nursing Care: Rodgers’ Evolutionary Concept Analysis* (Ghahramanian et al., 2020) was undertaken in Iran. Forty-one articles about ‘care’ and ‘caring’ were analysed to separate attributes, antecedents, and consequences of ‘good care’. The study concluded that the overall goal of ‘good care’ is “recovery and safety; therefore, providing a standard, safe and efficient care all patients with the aim of improving their condition” (Ghahramanian et al., 2020, p. 16). Nurse-patient relationship is highlighted indicating a need for continuing education programmes about the therapeutic relationship. This study is focused on defining ‘good care’ in nursing and does not include the views of other professions or patients and families.

Conversely, a study from England entitled *Patients’ and Relatives’ Experiences and Perspectives of ‘Good’ and ‘Not so Good’ Quality Care* (Attree, 2001) focuses on the perspective of patients’ and relatives’ only. A grounded theory approach was used that included 34 medical patients and seven relatives. Thematic analysis of semi-structured interviews identified features of ‘good care’ and ‘not so good’ care. Patients and families identified that individualised, patient focused care given by staff in a way that demonstrated involvement, commitment, and concern was ‘good care’. A caring relationship was important to deliver ‘good care’. Identification of aspects of ‘not so good care’ helped to illuminate the features required for ‘good care’. Essentially, ‘not so good care’ was delivered in a routine, impersonal manner lacking relationship or a relationship to patient need. The experience of ‘good care’ focused particularly on the feeling of relationship as a central issue in the delivery of ‘good care’ (Attree, 2001). This study does not seek to integrate patients’ and families’ views with those of staff working with them.

Turning to Other Views about ‘Good Care’

According to Smythe and Spence (2012), “in a hermeneutic study it is the philosophical insights, and the thoughts stumbled across, that can most powerfully call one into thinking and thus shape the analysis and findings of the research (p. 41).” I have included a range of ‘other’ views about ‘good care’ discovered over the course of this research that seem important.

The link between professional practice and ‘good care’ can be discovered in founding documents such as the Hippocratic Oath. Accepted as a basis for medical practice, the Hippocratic Oath has been updated from its roots in the middle ages with the removal of pagan references. Today it favours ideas of humanism and the great religions (Jotterand, 2005). The Oath contains some interesting notions that may relate to ‘good care’—seen in statements such as ‘I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon’s know or the chemist’s drug’; ‘above all, I must not play God’; ‘my responsibility includes these related problems [family and economic stability], if I am to care adequately for the sick’ (Tyson, 2001). These references give a glimpse of what may be needed to provide ‘good care’.

We can also turn to Florence Nightingale, the founder of nursing as a profession. Her view of the patient as a person points towards notions about ‘good care’. Florence saw service to the “sick poor” as her main mission. For her, the sick pauper was no longer a pauper; that is, someone deserving harsh treatment, but a “fellow creature in suffering” who deserved the best care (Nightingale et al., 2009).

References to ‘good care’ can also be found in reflective recollections about care received in hospital. It seems that in recalling the failings of care, ‘good care’ is illuminated. Melissa McCullough recounted her experience of being a patient in hospital. Her memory is of the things said and implied that highlight a lack of ‘good care’. She recalled ringing the bell for 20-minutes, to be told she would have to wait as she was not a priority; being wheeled from her bed into a waiting room in her pyjamas (the other 25 people fully dressed) and having her request to be moved declined because she had to be seen by the doctor. Nurses who were task focused, loud, uncaring, unhelpful, and unprofessional. Her overall impression was that some issues could be solved by additional resources, others require attitudinal and culture change (McCullough, 2011).

Likewise, Michel Villette described his journey in hospital for a hip replacement. His experience was of no-one offering a ‘simple welcome’, feeling like a customer or a number (not an anxious pre-operative patient). In contrast, the hospital brochures speak of the patient being ‘at the heart of the system’, of a patient’s right to pain relief, and the right to complain (but no details on how). Obstacles like a broken light cord, a broken ice machine add to Villette’s misery. He talked of the relief when a skilful, supportive, sensitive nurse attended to his pain (Villette, 2011). His experience finds congruence with studies highlighting the disconnect between what is promised and what is achievable when resources and competence may be lacking (Jangland et al., 2017).

I turn now to a more positive focus on factors that contribute to ‘good care’. In his book *Gray Matter*, neurosurgeon David Levy describes his journey towards ‘good care’ through a decision to offer to pray with patients as part of their pre-operative visit. He recounts his

initial apprehension about offering to pray and his surprise at the positive heartfelt reaction of patients and their families. He leans on research that 75% of doctors (from a sample of more than 1000) agree that religion and spirituality are important to help patient cope and feel positive (Curlin et al., 2007). Levy sees his role as a doctor as using his skills to aid physical and emotional health, concluding that spiritual health affects emotional health so is therefore important. Through his experience he writes of his conviction that spirituality is a crucial element in a person's overall wellbeing. He reflects that offering to pray before surgery takes humility and honesty; as in the Hippocratic Oath, it is signalling to patients and families that while highly skilled, he is not God. 'Good care' seems to encompass physical, emotional, and spiritual health (Levy, 2011).

Surgeon, Atul Gawande, described the profound differences in approach of three physicians during his father's struggle with life-threatening cancer. One knew technically the right thing to do (surgery), he could answer questions but offered nothing more. Another listened carefully, attempting to genuinely understand his father's questions and values to reach towards shared decision making. A third delivered complicated information so quickly that the family could not understand it, finishing with an unrealistic prognosis. In the end, with the assistance of a skilled palliative nurse who truly listened, his father was able to crystallise his life goals and the family witnessed "the consequences of living for the best possible day today instead of sacrificing time now for time later" (Gawande, 2014, p. 173). He marvelled at what 'having a hard conversation' can achieve when care according to the patient's needs and wants is in place (Gawande, 2014). 'Good care' can come from surprising places.

In his book *Things That Matter* (2016), New Zealand intensive care specialist David Galler reflected on changes in medicine. The growing expectation that clinicians share their thoughts with patients and their families, spend time and decide on the best course of action together. He reflected on the care of a complex patient, weighing up the choice between full intervention including surgery, intensive care, and invasive treatment versus simple intervention (fluids, medication) and allowing time for her body to respond. He explained that “in almost every way she is no different from you or me: to our family and friends, we are simply irreplaceable” (Galler, 2016, p. 176). In this story, ‘good care’ is found in less technical intervention, backing off and allowing a little more time without suffering. ‘Good care’ seems to be found in valuing the person.

After spending 310 hours stranded in an ice cave on Mount Cook Aoraki, New Zealand, Mark Inglis had both legs amputated due to the effects of frostbite. He alluded to ‘good care’ with his comments about honesty. Many people painted a rosy picture of his future; however, the advice of one registrar was memorable. This doctor

stood at the end of the bed and said, ‘This isn’t going to magically heal up in weeks or months, this is something that you will learn to master over the coming years ...this is going to be painful and frustrating ...but it will improve week by week. (Inglis, 2013, p. 60)

Mark ‘knew’ this was good advice; he commented that it was the first truthful and complete advice he had been given. Mark’s story points to the power of a very difficult conversation held honestly and with compassion. It feels like ‘good care’.

Summary

There is a lot that is known about ‘good care’. There are a large number of studies that promote one approach or another. The literature is clear about the benefits of person and

family centred care for organisations, patients, families, and staff. However, the extent to which the needs of patient and family care are included in staff training, implemented, or evaluated remain unclear (Levine, 2013). For successful participation in a multidisciplinary team that benefits patients and adds to the overall care, health professionals need the body of knowledge that shapes their own professional identity and specialty area. This may go some way towards challenging and changing the apparent hierarchy within and across teams that discourages equal participation (Atwal & Caldwell, 2005). In the ongoing work on values and their articulation, we must acknowledge the provisional, untidy, and necessarily incomplete character of our understanding of the meaning of health. All aspects of health within the broader context of society need to be examined to find new relationships and ways of working within the complex and dynamic environment of healthcare generally, and specifically within the general hospital setting.

There are gaps in our knowledge of ‘good care’ and how it is experienced. ‘Good care’ is alluded to and mentioned without achieving an accepted definition or specific description. It seems to be ineffable; so difficult to elucidate. As soon as there is a sense of grasping it, it is lost. Once again, I go to a description of summer as a metaphor for ‘good care’.

And summer’s surely really about an imagined end. We head for it instinctually like it must mean something. We’re always looking for it, looking to it, heading towards it all year, the way a horizon holds the promise of sunset. We’re always looking for the full open leaf, the open warmth, the promise that we’ll one day soon surely be able to lie back and have summer done to us: one day soon we’ll be treated well by the world. (Smith, 2020, p. 289)

In times of challenge, complexity, and resource limitation, it is tempting for leaders to ask organisations to work harder, put in longer hours, and cut budgets. We owe our patients and communities more. We owe them innovative ways to take advantage of the social gains in the sciences of medicine and nursing, in new technologies, and new partnerships between families and providers. Changing the way healthcare is perceived and provided could be the way to better care and lower costs (Bisognano & Schummers, 2014). But we first need to understand the meaning of ‘good care’ in the current context.

What is offered in this review, is ‘what came’ from a broad reading of available literature. It aims to collate the thoughts that emerged in attempting to make sense of what it means to give and receive ‘good care’ in the current context of New Zealand health care. Patient-centred care, co-design, and integration present a challenge as to whether we should even describe care as being ‘given’ or ‘received’, suggesting an interdependence that invites further exploration. These concepts seem to be leading us to a whole new way of approaching health, an approach that recognises people within the complex and broad settings that they live their lives. As we look towards capturing the experience of ‘good care’, perhaps it is wise to keep in mind the diverse experience of each and every individual. Perhaps the definition of ‘sonder’ helps to understand the complexity inherent in the seemingly straight forward – the experience of ‘good care’.

Sonder (n), “the realization that each random passerby is living a life as vivid and complex as your own—populated with their own ambitions, friends, routines, worries and inherited craziness—an epic story that continues invisibly around you like an anthill sprawling deep underground, with elaborate passageways to thousands of other lives that you’ll never know existed, in which you might appear only once, as an extra sipping coffee in

the background, as a blur of traffic passing on the highway, as a lighted window at dusk”. (Dictionary of Obscure Sorrows, 2013)

‘Good care’ can be given in a moment, in a single interaction and/or longstanding relationship. The experience of ‘good care’ can be similar and simultaneously completely different for each individual and family. It is difficult to predict or quantify and may never be completely fulfilled. What we do know is that there are qualities, situations, relationships, and actions that seem have a place in the everyday lived experience referred to as ‘good care’.

Chapter Three: Methodology

The aim of this research is to reveal the experience of ‘good care’ in the general medical/surgical hospital setting in New Zealand. I seek to reveal the experience of ‘good care’ from a range of perspectives: those who are being ‘cared for’, those ‘providing’ care, and those who may not directly ‘see’ themselves as part of this process yet by their activities impact care. To achieve this aim, the methodological framework is hermeneutic phenomenology.

Phenomenology is used to retrospectively bring an experience that has been lived through to awareness, enabling reflection on the living/ed meaning of this experience. The concept of ‘lived experience’ points back to everyday life experience. The notion of lived experience is an attempt to understand what the day/event/moment ‘is like’ through the stories of the person experiencing it. Phenomenological research can be described as turning to experience as lived-through. Heidegger pointed out that this is both meaningful, yet superficial (Harman, 2007). There is nothing deep and meaningful about it until the question is asked, what is this lived experience (phenomenon) *like*? (Van Manen, 2007, p. xi).

As the lived experience is transformed to textual expression, the aim is that “the text is at once a reflexive re-living and reflective appropriation of something meaningful: a notion by which a reader is powerfully animated in his or her own lived experience” (Van Manen, 2007, p. 36). In phenomenology, the moment an experience is experienced, it is already gone. The best we can do is to think about it retrospectively, trying to capture what it was like and how it was in our consciousness at that time. “The term ‘lived’ experience equates with living-through prereflective, prepredicative, non-reflective, athoretic experience” (Van Manen,

2017, p. 812). Attempts are made to ‘lift up’ and bring the moment of the lived experience into language. Heidegger added the layer of ‘fading’ where consciousness or meaningfulness of an experience falls away and is always available to return; also described as concealment and unconcealment (van der Hoorne & Whitty, 2015; Van Manen, 2017).

History of Phenomenology

Phenomenology as a research approach was first developed to enable a ‘rigorous science’ appropriate for providing insights into humanity (Cohen, 1987). Although rigour is present, phenomenology is not a ‘method’ with a defined set of rules. It is more open, involving pondering and discussing a particular phenomenon in order to place it in the realm of research (Dahlberg et al., 2008). Defining ‘phenomenology’ is challenging; it has had a variety of meanings because the movement has changed and evolved. It has been enhanced and changed by different philosophers, some of whom have changed their own view over time (Cohen, 1987). One description of phenomenology is that it is “the study of phenomena, the appearance of things” (Cohen, 1987, p. 31). Put another way, it is the study of what ‘shows itself’ as knowledge (Dahlberg et al., 2008). First used in a scientific context by Immanuel Kant in 1786, phenomenology had historically been used in the fields of religion, philosophy, and physics. Franz Brentano followed on from Kant furthering the desire to make psychology ‘truly scientific’, introducing the idea of *describing* a phenomenon *before* looking for causal effect. He also introduced the idea that inner perception could be reliable. His student, Carl Stumpf, further developed the ‘scientific rigour’ of phenomenology (Cohen, 1987).

Phenomenology grew out of a desire to explore and provide answers to deep human concerns. The approach involves going ‘to the things’; that is, to the source of the experience. The

phenomenon is the starting point (rather than the theories). Individuals are consulted and trusted as they tell of their everyday lived experience (Cohen, 1987; Dahlberg et al., 2008). Insightful descriptions of the every-day as it is experienced pre-reflectively, before we have categorised or analysed it, are sought. In phenomenology, 'things' refers to the things of experience which keeps the research in close contact with the every-day world (Van Manen, 2007). To take a purely scientific approach, according to Husserl, runs the risk of separating research from the everyday world. It would become all about 'facts', missing the nuances of human existence and, therefore, becoming meaningless (Dahlberg et al., 2008; Van Manen, 2007). In phenomenology, there is always a deeper goal, to reveal the nature of the phenomenon ('good care') as an essentially human experience (Van Manen, 2007).

Another concept important in early phenomenological study is the idea of 'eidetic reduction' or 'bracketing' (Cohen, 1987). Early in the study, it is important that researchers using phenomenology examine their own prejudices and preunderstandings so that there is an awareness of them. For some, this examination is in order to 'bracket' or keep aside one's own prejudices in an attempt to see the phenomenon as it is without the lens of preunderstandings (Cohen, 1987). Husserl was a believer in this approach. Others, such as Heidegger, held the view that bracketing is not possible as we are all 'being's' in the world sharing a common experience. Gadamer further proposed that preunderstanding should be placed alongside the phenomenon. As interpretation occurs through the examination of both preunderstandings and the phenomenon, expanded understanding will result at the point where the two horizons fuse (Crotty, 1998).

Phenomenological Appropriation

In order to place this research within a phenomenological framework, knowledge of the ontological (the nature of existence) and epistemological (the nature of knowledge) underpinnings is required (Annells, 1996). Husserl is recognised as founding phenomenology in 1900-1901, albeit others before him, such as Schleiermacher and Dilthey, pointed the way (Crotty, 1998). Husserl's writing brings forth a requirement for the researcher to attempt to interpret experiences from a neutral viewpoint, setting aside personal attitudes and life experience (Annells, 1996; Dann, 2014; Dowling, 2004; Walsh, 1996). Husserl desired a foundation for science that was without influence of presuppositions. He posited that this would lead to truths that were not tied to a particular time or culture but would be true for all time. As a detached observer, the aim is to produce new insights that are not tainted by presuppositions (Walsh, 1996). Husserl's phenomenality has the element of 'intentional consciousness' and focused primarily on epistemology (Dowling, 2004; Walsh, 1996).

Heidegger was a pupil of Husserl who went on to disagree with his teacher. He argued that it is not possible to be un-influenced by the world around us as that is part of the human condition (Van Manen, 2017; Walsh, 1996). Heidegger's view was that being is not presence because being is time, and time is constantly changing (Harman, 2007; Walsh, 1996). A key notion from Heidegger is 'withdrawal'. He asserted that all things are in the background until we notice them. Knowledge is interpretation; things are never completely present to us. "The world is a constant passage back and forth between shadow and light ...this is called time" (Harman, 2007, p. 2). For Heidegger, one cannot begin to analyse the self [and others] while holding a perspective of isolation. One is always involved in the world; therefore, it not possible to separate from the world, one will always have an unconscious knowing. We

do not live our lives primarily by ‘knowing’ the world, we live by ‘experiencing’ it (Walsh, 1996).

Heidegger follows the tradition of Immanuel Kant [1724–1804] who asserted that humans cannot know what lies outside the human experience, so we cannot really say whether time and space exist. They are just possibilities in the human experience. Heidegger remained consistent with this and focuses on the human experience (veiling and unveiling) rather than the relationship between or of things (Van Manen, 2017).

Heidegger referred to ‘*Dasein*’, which he explained as “the self *as* the there (*Da*) of being (*Sein*), the place where an understanding of being erupts into being” (Stapleton, 2010, p. 44). Heidegger described self, being-in-the-world as *Dasein*. *Being-in-the-world* is intended by Heidegger to mean what it means for *Dasein* ‘to be’ (Leonard, 1989; Rolfe, 2015; Stapleton, 2010). This concept of Heidegger’s presents the opportunity to examine the topic of ‘good care’ and consider how it is lived (offered) and experienced (received). The approach guards against jumping to conclusions and rather explores what it might like to ‘be’ people involved in providing and receiving ‘good care’. The stories within this thesis remember what it was like to ‘be there’ at a time when care felt ‘good’.

Heideggerian Hermeneutic Phenomenology

While phenomenology describes one’s orientation towards lived experience, hermeneutics guides one on how to interpret the ‘texts’ that describe the lived experience (Van Manen, 2007). “Hermeneutics is defined as a method for deciphering indirect meaning, a reflective practice of unmasking hidden meanings behind apparent ones” (Kearney, 1991, as cited in Crotty 2010, p. 88). It refers to the process in which people interpret and make sense of

experiences according to their pre-existing values and ways of seeing the world (Walsh, 1996). Heidegger is considered to be the prime instigator of modern hermeneutics (Annells, 1996).

According to Heidegger, hermeneutic phenomenology requires researchers to 'ek-sist' to dwell on the language of participants in order to gain an understanding (Heidegger, 2008). As a registered nurse, and a patient and family member, I am required to reveal the 'taken-for-granted' understandings that exist in my thinking to enable other possible ways to interpret the world to emerge (Ho et al., 2017). One way to achieve this is to 'dwell' in the language of the participants to enable arrival at a theme (or themes). However, the presence of language means that I will not be totally free from taken-for-granted thinking. For Heidegger, language shows and veils the multiplicity of interpretations (Ho et al., 2017; Walsh, 1996). For thematic analysis to be useful, I must be able to preserve the ontological possibilities by showing the unspoken possibilities revealed in language (Gadamer, 2004; Ho et al., 2017; Walsh, 1996). I must go beyond description, to recover the theme or themes to recover the structure of meanings embodied in the human experiences in the text (Koch, 1996; Van Manen, 2017).

Phenomenology is concerned with meaning rather than informational content. Using the term 'data' to describe what is collected is not consistent with the context of the study. The research is about what 'gives itself' within the lived experience. The 'data' or 'evidence' can only be presented as examples (Van Manen, 2017). Examples are then studied and can be provided to support insights gained. However, in phenomenology, 'examples' do not add new knowledge but merely assist to make something knowable that may not be directly

sayable (Van Manen, 2017). Examples are not used as a ‘case in point’ to back up an argument; rather, they are a methodological device that lets the singular be seen. A strong theme in Heidegger’s hermeneutics, expressed as *temporality*, is the idea of connectedness (rather than linear time) (Annells, 1996). This idea is particularly applicable to the current research as an attempt to reveal connectedness of aspects of ‘good care’ is central to the study. I went to the interviews with participants recognising that it was likely that while they would offer stories of their experience of ‘good care’ they would also share their views on what is ‘good care’. For this reason, it is necessary that the approach is one of hermeneutic phenomenology to provide a way to examine both the lived experience within the stories and the thematic analysis of the views expressed.

Heidegger’s approach recognises that the researcher brings interpretation that is not divorced from the subject. Unlike Husserl, who aimed to have an approach untainted by presuppositions, Heidegger’s phenomenology is hermeneutic, it is interpretive (Walsh, 1996). I feel much more comfortable with this idea than a methodology that tries to divorce researcher experience from interpretation of the subject. I am also drawn to the historical roots of hermeneutics in biblical interpretation as I have a lifetime of experience and exposure to sermons that attempt to do this through exegesis of the biblical text. Like Heidegger’s hermeneutics, this is always interpretative (Leonard, 1989; Walsh, 1996). Returning time and again to the text is a way to obtain interpretive thinking, to notice what matters, to uncover more understanding of the concept of ‘good care’ (Smythe, 2011). This is similar to my experience and observation of biblical exegesis where new understandings are uncovered with re-looking at a previously seemingly well-known text. Heidegger points us towards uncovering meanings, what it is to ‘be’. Finding an appropriate way to comport

oneself toward the phenomena is the focus (Walsh, 1996). Any perceived dichotomy between facts and interpretation is “resolved via the hermeneutic circle and the philosophy and method of hermeneutics” (Walsh, 1996, p. 233). The influence of Gadamer is presented to explore these concepts.

The Influence of Gadamer

Hans-George Gadamer was a student of Heidegger during Heidegger’s early years at Freiburg (Harman, 2007). His work built on the ideas found in Husserlian phenomenology and Heidegger’s ontological project. Heidegger’s perspective on the phenomenon (what presents itself) and on what the phenomenon ‘means’, how it is interpreted, implies that facts and the meaning of facts are not separate (Walsh, 1996). Gadamer posited that understanding of phenomena is found through language and tradition (Walsh, 1996). Applied to my research, means that the language and traditions found in my background in nursing as well as personal understanding through ‘being’ in the world are pivotal to understanding and interpreting the stories shared by participants. Gadamer (2004), in his book *Truth and Method*, presented a philosophical approach. His hermeneutic concepts include prejudice, the fusion of horizons, and the hermeneutic circle (Walsh, 1996). I will give a brief outline of each concept.

Prejudice or pre-understandings

For Heidegger our pre-understandings come from our language and history. As a researcher, I am not naïve to the world of my research participants. In order to ask my research question, I already have some understanding of what I seek to know—my seeking is already influenced by what is sought. To enable me to interpret, I need to have some preunderstanding or forestructures of understanding (Walsh, 1996). Following on from Heidegger’s thinking and

the ideas of Weinsheimer, that having some pre-understanding is essential for interpretive understanding, Gadamer broadened this idea to the concept of ‘prejudice’ (Walsh, 1996). A judgement that is arrived at before all elements of a situation have been examined is seen by Gadamer as prejudice. There is no negative connotation to this ‘prejudice’. It is a first step in developing understanding (Walsh, 1996). For my research it would mean using my prejudgements or preunderstandings as a nurse and as a person to arrive at initial understanding of meanings within a narrative. My initial understandings are merely my first impressions of meanings within the narrative or, as Gadamer referred to it, the first horizon of understanding. As I further examine the narrative, my understanding will broaden and expand as I remain open to possible other meanings or interpretations of the narrative. As I further examine my own ‘prejudices’ or preunderstandings, and consider possible other meanings, my horizon is expanded. This is a process of placing the other understandings alongside my own meaning in relation to them. As I seek to interpret the ‘lived experience’ of my research participants, using my own ‘prejudice’ as a tool, the narratives become *my* interpretation anchored in the ‘facts’ or experiences of participants. Thus, enabling me to gain a richer understanding which is more than the original individual understandings (Walsh, 1996); similar to what Gadamer (2004) called ‘fusion of horizons’.

Fusion of horizons

We each have our own horizon in the present that projects back to our historical past, including our past traditions. As we continually test our past prejudices or pre-understandings we are continually forming new horizons (Walsh, 1996). As a metaphor, ‘horizon’, according to Gadamer (2004) refers to everything that one can ‘see’ from a particular point. The point at which our understanding (horizons) fuse with the understanding (horizons) of another leading to a changed horizon or extended vision is where *understanding* occurs. In

order to reach new *understanding*, it is necessary for me to remain open and aware of my pre-understandings that make up my prejudices. This includes my historical and cultural background. As I place my prejudices alongside the text (or narrative) my aim is to illuminate it. According to Walshe (1996), this is not an automatic process, the development of a 'hermeneutic attitude' is required. A continual process of interpretation then, becomes a circular process. As my horizons expand, I continue to form new horizons from which to interpret the narratives of others.

The hermeneutic circle

A circular process has no beginning or end, it is dynamic. Gadamer's hermeneutic circle refers to a continuous flow of interpretation. It is where my understanding (horizon) based on my background, fuses with the ideas that I discover through interviews. Because the fusion of horizons occurs as a result of an active process of interpretation, the subject-object split has no place (Walsh, 1996). A necessary feature of my interpretation is that I move between the individual words and concepts and the setting or environment that forms the bigger picture. This will help to move towards understanding the experience of 'good care'. In my interpretation, I aim to situate my prejudices or preunderstandings of being a nurse and a person alongside the narratives of my research participants. In this way, my horizon and theirs are fused to become a new horizon, altering the horizon of both (Crotty, 1998; Dahlberg et al., 2008). This new horizon is the point where I may discover my view of the experience of 'good care'. Attempting to eliminate pre-understandings is to move outside the hermeneutic circle. Focusing solely on the words of narratives provided, risks a loss of background meanings. The broader picture must be held in focus, as I situate the experience of 'good care'. Alongside is the interpretation of the experience of 'good care' through individual concepts identified.

My aim with this research is to take readers along with me, to encourage previously uncovered or unstated understandings of ‘good care’. To do this, I will be as alert as possible to my own ‘already there’ understandings. By understanding my pre-understandings and situating these prejudices against or alongside the text, I seek to illuminate the text to form new horizons of understanding as described by Gadamer (Bradshaw, 2013; Walsh, 1996). I accept, however, that the phenomenological world of practice means that what is still to come is unknown (Smythe, 2011). This research journey will be one step along the way.

Heidegger’s Involvement with the National Socialist Party

It is difficult to conduct research using Heidegger’s teachings without referencing and exploring his membership of Hitler’s National Socialist Party. Heidegger was appointed rector of the University Freiburg in April 1933, seeing himself as assuming spiritual leadership of the university. Shortly after, on 1 May 1933, he joined the Nazi party. At this time Germany was changing, and people were looking for leaders. Heidegger, in his position as rector, saw himself as potentially one of their great leaders (Harman, 2007). He held the position of rector for one year and during that time is recorded as being a supporter of the party in both his writings and reports of his personal behaviour. He attempted to support some colleagues of Jewish background but, for the most part, seemed to support the direction of the National Socialist Party. His support seemed to be more in the way of dramatic speeches and the tone of his university communiqués (Harman, 2007). His first Rectoral Address urged the following of the National Socialist Party, describing academic freedom as “lack of restraint” (Dreyfus, 1991). Over time, the Nazi party hierarchy came to realise that there appeared to be members who engaged in ‘playacting’ or ‘dress-up games’ but without substance. Heidegger was recognised as one of these and by the end of his tenure as rector,

he had virtually no influence within the party. Heidegger withdrew to a more private life after this end to his public role at the university. He delivered various lecture series and worked privately on his writing over the following years (Harman, 2007).

In the preface to a series of protocols, conversations, and letters from Heidegger, Medard Boss describes his personal journey (in 1947) in regard to Heidegger's membership of the Nazi party (Heidegger, 2001). He observed that following World War II, Heidegger was much maligned and characterised as a 'typical Nazi'. Boss confirmed a short period of membership of the party, describing this as a misjudgement in the mistaken belief that Hitler would be able to protect against the "spiritual darkness" threatened by political communism (Heidegger, 2001, p. ix). Over the following 10 years, Boss got to know Heidegger as a friend, with the exchange of 256 letters. Heidegger visited his home two to three times each semester to lecture. Heidegger is not known to have defended himself publicly about his period as a Nazi party member. However, Boss recorded Heidegger's wish to associate with him (a doctor) being motivated by a desire that his philosophy might benefit people, especially those in need. Boss described Heidegger as having concern for his fellow beings, exemplifying "selfless, loving *solicitude*, which *leaps ahead* of the other [human being], returning him to his own freedom" (Heidegger, 2001, p. xi).

Unlike some of his contemporaries, Heidegger's writing does not seem to contain any "systematic doctrine of biological racism" (Bambach, 2010, p. 110). Heidegger is reported to have described his membership of the party as "the greatest stupidity of my life" (Bambach, 2010, p. 110). Although reported to have made this comment, Heidegger is also known to have defended Nazi Germany's position and has never acknowledged complicity

with the terror reign of the National Socialist Party. He has never clearly addressed the horrors of Auschwitz and his “unwillingness to honestly address his mistakes constituted insularity at best and prideful arrogance at worst” (Bambach, 2010, p. 114).

It seems difficult to reconcile these caricatures of Heidegger. On the one hand, a great thinker and philosopher focused on the wellbeing of others; on the other, a man with seemingly immense personal failings. Heidegger’s membership of the party cannot be discounted; however, neither should his contribution be exaggerated. There are many arguments both for and against Heidegger and his decision making in 1933 and beyond. These range from portraying him as a bad man, an original philosopher with a kink, naïve, acting understandably for the times, going against his own philosophical texts, preparing the way for Nazism or succumbing to Nazism—equating liberal democracy with fascism (Polt, 2013).

Thinking about the actions and thoughts of Heidegger during this period, I find myself not completely comfortable with the contradictions that seem to appear. With that in mind, I can accept that Heidegger was human and susceptible to the influences of his time, with all the propaganda, horror, and violence present in Germany. Heidegger is recognised as a pre-eminent philosopher of his time (Harman, 2007; Large, 2008; Polt, 2013). I relate to the advice from Polt (2013) that “the most fruitful way to read any philosopher is to wrestle with and against what the philosopher says” (p. 164). In relation to my study, the philosophy espoused by Heidegger, as I seek to understand the experience ‘good care’, seems helpful. Many before me have tried to reconcile Heidegger’s involvement as a member of the National Socialist Party (Thomson, 2005). I am relatively new to the philosophy of Heidegger and even now, at the beginning of my journey, it is clear to me that I may never

understand fully the thinking, actions, or writing of Heidegger in relation to this time. The best that I can offer is to maintain awareness of it as I utilise Heidegger's philosophy to help deepen my understanding of the experience of 'good care'.

It seems prudent to acknowledge that during the same time period Hans George Gadamer was a student of Heidegger's at Freiburg University. Gadamer, while keeping to the premise of *Being and Time*, added his own emphasis viewing historicity and its effect on preunderstanding as a way to understanding (Shalin, 2010). During those years, Gadamer turned to the field of classical studies in an effort to avoid full participation in the Nazi regime. He did, however, enrol in a Nazi rehabilitation camp for aspiring scholars and also took over a role vacated by a Jewish colleague who was removed. This indicates that he may not have been quite as removed as he later claimed. Gadamer is quoted as saying that "even a master of historical method is not able to keep himself entirely free of the prejudices of his time, his social environment and his national situation" (Shalin, 2010, p.7). Perhaps, an acknowledgement that he also was influenced in some way by the times in which he lived.

The Philosophical Notions of Heidegger

In this section I outline the philosophical notions of Heidegger that have become important as I seek to illuminate meaning within the narratives of my research participants. As caring has been described as the 'presencing' of being, I begin with Heidegger's philosophical notion of 'Being' (Nelms, 1996).

The Question of Being

In his book *Being and Time*, Heidegger first seeks to bring to understanding the concept of 'being', which he feels has been long forgotten and overlooked because it is undefinable, self evident, and universal (Harman, 2007).

'Being' means the Being of entities, then entities turn out to be *what is interrogated*. ...Everything we talk about, everything we have in view, everything towards which we comport ourselves in any way, is being; what we are is being, and so is how we are. (Heidegger, 2008, p. 26)

Being is never able to be fully seen as some parts will always remain hidden. We may attribute external qualities to 'being' but miss internal qualities. Even within ourselves, we are never truly aware of all that is hidden (Harman, 2007).

Heidegger distinguished between the *ontological*, meaning anything to do with being; and the *ontic*, meaning specific beings. In an *ontic* way, Dasein is close to us; however, *ontologically* Dasein is far away. This is because we are mainly absorbed in the world of *others (ontologically)* rather than seeking to understand Dasein's existence within (*ontic*) (Harman, 2007). According to Heidegger, without the question of time *Dasein* would have no channel to *understand* being. Gadamer observed that to Heidegger, time is not only a *horizon*, being *is* time. This is always to be understood within the threefold structure of time encapsulating past, present, and future (Harman, 2007). The way people live is governed by the knowledge that time is limited, that lives have many possibilities but will always be incomplete. The way humankind lives with these incomplete possibilities results in an ever-present need for care (Scott, 2010).

Heidegger writes about the 'being' of Dasein. Dasein is a German word that literally translates as 'being-there'. Dasein is never truly present; instead, Dasein is represented in a threefold way. It is ecstatic time, standing outside itself "simultaneously swinging towards the past and future" (Harman, 2007, p. 59). Dasein is used in the context of 'human being' but is thought to refer more closely to 'human beingness'. It is used to describe individual beings while at the same time referring to a state of all people (Dreyfus, 1991). This means that there is a kind of struggle always going on between the situation one finds oneself in, the possibilities of the future, and the way one tries to manage. We are always illuminating presuppositions of life as we simultaneously live life (Harman, 2007).

Facticity (thrownness)

According to Heidegger, human beings find themselves 'thrown' into the inevitabilities of being human, this cannot be avoided. However, the way we live in our thrownness can be authentic or inauthentic. For Heidegger, the presence of 'the they', as in, 'they' say we should..., or 'one' should always..., is inevitable as Dasein is thrown into a culture without choice. This type of talk lacks specificity and any concept of the individual. According to Heidegger, Dasein are ruled by 'the they', enjoying the same things, having the same opinions, keeping watch to ensure 'the they' are not upset. The outcome of this is that 'the they' know everything, and are not surprised by anything because 'they' already knew it (Harman, 2007). To live according to 'the they' is described by Heidegger as inauthentic living (Scott, 2010). Though we are 'thrown' into an unpredictable and unknown culture, we seem to have a self-understanding of how to survive. We seem to share an indebtedness to the future (Scott, 2010). According to Heidegger, Dasein "summons itself to care for itself by heeding its own feeling of mortal temporality" (Scott, 2010, p. 65). A conversation about 'care' is indicated here.

Care / Sorge

At the root of what it is to be a human being is *care*, before any action has been taken. All action is infused with care. According to Heidegger, care is expressed in authentic existence. It is based on being-there and gives meaning to existence (Cestari et al., 2017). Presence is a structural relation, not synonymous with man or human. It is expressed from an understanding of human existence as Being-in-the-world. “The exercise of presence promotes relationships with two modes of being of existence: occupation (occupy from or with) and concern (solicitude, caring actively for someone who needs help)” (Cestari et al., 2017, p. 1114). Presence does not refer to ‘being present’ as in this moment. It is when we “draw most authentically on the future and past dimensions of our being” (Polt, 2010, p. 72). In my desire to illuminate the experience of ‘good care’ both occupation—being with another, and solicitude—showing signs of active caring, seem relevant.

According to Heidegger (2008),

Being-with is such that the disclosedness of the Dasein-with of Others belongs to it; this means that because Dasein’s Being is Being-with, its understanding of Being already implies the understanding of Others. This understanding, like any understanding, is not an acquaintance derived from knowledge about them, but a primordially existential kind of Being, which, more than anything else, makes such knowledge and acquaintance possible. (p. 161).

Being-with is an essential part of Dasein (Nancy, 2008). Within my research, ‘good care’ may be revealed through notions that point to an ability to make acquaintance possible. The experience of *being-with* may be connected to the experience of ‘good care’.

Heidegger (2008) stated that:

the Being of Dasein means ahead-of-itself-Being-already-in-(the world) as Being-alongside (entities encountered within-the-world). This Being fills in the significance of the term, “*care*” [*sorge*], which is used in a purely ontologic-existential manner... Because Being-in-the-world is essentially care, Being-alongside the ready-to-hand could be taken in our previous analyses as *concern*, and Being with the Dasein-with of Others as we encounter it within-the-world could be taken as *solicitude*. (p. 237)

The German word *sorge*, is translated as ‘care’ as in ‘worries, troubles and travails’ (Harman, 2007). Heidegger’s term *Fürsorge* (literal translation, ‘caring for’) is translated here as *solicitude*. Caring can be divided into caring-for-others and care for things. This is to make it clear that other people exist, the same as we do and are not things to take care of. Other people are also in the world the same as we are. When we care-for-others, it is important to recognise that it is in the context that we may share a mutual concern (Spier, 2019). According to Heidegger, there are different ways to care. As a consequence of being-in-the-world, we are constantly open to others as “mattering” or “not mattering”. Authentic living is found where people “care for the Care of others” (Scott, 2010, p. 66). Heidegger (2008) goes on to describe the extreme possibilities of positive modes of care, “leaping in for” and “leaping ahead of” others (p. 158; Spier, 2019).

Leaping in/Leaping ahead

Both ‘leaping in’ and ‘leaping ahead’ are ways that humans show caring for each other (O’Brien, 2014). ‘Leaping in’ is acting for another and can result in the removal of their responsibility for the act (O’Brien, 2014; Spier, 2019). This is not to say that ‘leaping in’ is wrong. Sometimes ‘good care’ may be experienced when ‘leaping in’ occurs. The carer may judge the moment when ‘leaping in’ is felt in a positive way by the other. An example may be when a person’s health is deteriorating and intervention is needed with urgency. According to Heidegger, we live with an understanding that we are finite, that life does come

to an end. Ignoring the reality of finite being, feeling confident to leap in and take over, according to Heidegger, can lead to inauthentic living (Scott, 2010). Inauthentic living is seen when ambitions and understanding of self is drawn from what the public thinks; or, put another way, taken from the beliefs of ‘the they’ (Harman, 2007).

Leaping ahead is aimed at paving the way for the other to take responsibility for their act in the future (Spier, 2019). Leaping ahead can have the effect of encouraging confidence and growth (O’Brien, 2014). Described by Heidegger as authentic solicitude, leaping ahead as ‘good care’ may be found in encouraging independence in recovery. Authentic and inauthentic living as described by Heidegger are not the opposite each other. Authentic living is when a person takes responsibility for their actions and attitudes and is attuned to the way things are meant to be. They do not hand over responsibility for their lives to others. They remain as individuals, attuned to Dasein, “to the temporal structure of the way human beings have to be” (Scott, 2010, p. 63). An authentic person is one who cares for others in the knowledge that life is an incomplete possibility.

Time

Whereas Care is the origin and meaning of human life in the world, time constitutes the origin and unified structure where Care takes place. People have to care because worldly life is always coming to pass; nothing escapes the impact of time. Time rules the appearance and passage of human being. (Scott, 2010, p. 58)

Time, rather than being ‘on the clock’, or as Heidegger called it, ‘world time’, is a way of being. I am my past, present, and future (rather than ‘in’ these entities), and to live authentically I am orientated toward my future which is only possible because I am there

(Large, 2008). Put another way, traditionally ‘time’ has been conceived as a ‘series of nows’. Heidegger unifies the three modes of past, present, and future. The future and the past are both held apart and at the same time held toward each other. Stambaugh (1974) outlined that “man projects into the future ...returns to himself to find the past which is still an integral part of him, and experiences the present (p. 93).

Attunement

It is thanks to our attunement that we find ourselves positioned in a certain way in the world (Polt, 2013). Heidegger described Dasein not only as being in the world as to a place to be, the world is an inseparable part of ‘being’. Essentially, Heidegger’s *Being and Time* is an exploration of Dasein’s way of being (Dreyfus, 1991). The way we find ourselves in the world is shown or ‘disclosed’ by our mood. Some are more attuned to recognising the significance of ‘moods’ than others. According to Heidegger, “one’s attunement discloses one’s *thrownness*: attunement is our way of finding ourselves thrust into the world” (Polt, 2010, p. 65). As we have discovered, Heidegger’s threefold description of future, past, and present illustrates that to have an attunement we must have a past. It is not possible to have no attunement as this would make it impossible to be fully part of the world. Our thrownness is always a part of us. Heidegger termed this ‘always already’ (Polt, 2010). In this research, aimed at illuminating the experience of ‘good care’, attunement, that is, ability to read or understand a mood, and by extension our ability to respond appropriately, seems important. As Polt (2010) put it, “I recognise that I am responsible for choosing my own defining possibility and that I have to do so on the basis of what I already am” (p. 71).

Summary

In this chapter I have discussed the background to phenomenology and hermeneutics. A selection of Heidegger's philosophical notions has been explained and the influence of Gadamer outlined. I have also delved into the relationship of both Heidegger and Gadamer to Hitler's National Socialist Party in 1933 and onwards. In the words of Van Manen (2007), "we tend to get a certain satisfaction out of grasping at a conceptual or "theoretical" level the basic ideas of phenomenology, even though a real understanding of phenomenology can only be accomplished by "actively doing it" (p. 8). With this in mind, I move on to outline my research method.

Chapter Four: Method

To call one to thinking is not to 'tell' but rather to take the reader on their own journey of seeing, that they too may have their own call to think.

(Smythe & Spence, 2012, p. 21)

The aim of this research is to reveal the experience of 'good care' in the general medical/surgical hospital setting. In chapter three, I outlined the philosophical underpinnings of my study. I now discuss the 'methods used. I must recognise, as Van Manen (2007) pointed out, there is no pre-determined set of procedures that govern phenomenological research. There is, however, a body of knowledge and insight from those who have gone before me. These provide a body of methodological themes and features to guide the unfolding of the phenomenon of 'good care'. This study has used phenomenology to retrospectively bring experiences of good care to awareness and to reflect phenomenologically on the lived meaning of this phenomenon. As discussed in chapter three, the concept of 'lived experience' refers to ordinary everyday life experience. Researchers attempt to understand what the experience 'is like' through the stories. Phenomenological research can be described as turning to experience as lived-through. As I embark on this research journey I am mindful of the complexity of human experience outlined by Van Manen (2007):

Rationality expresses a faith that we can share this world, that we can make things understandable to each other, that experience can be made intelligible. But a human science perspective also assumes that lived human experience is always more complex than the result of any singular description, and that there is always an element of the ineffable to life. (p. 16)

Beginning this Research

I began this research journey thinking that I was going to focus on restorative justice, a concept from the justice system, and how it could be applied in health. As I thought about it and placed more emphasis on understanding the environment in which I work, I came to understand that we lack understanding about experiences of patients, families, whānau, and staff in the current system. How could the introduction of something new help patient experience without first understanding what already works well (Hollnagel et al., 2015)? As a senior nursing leader, I was involved in meetings with dissatisfied patients and their families, staff having various issues, and governance more generally. I was also aware of the many compliments hospital services received by the hospital's services. I became more and more interested in the underlying drivers of the two. A desire to understand more fully the positive aspects of hospital experience developed, a need to dig deeper and see what 'good care' in hospital is like.

My interest in hermeneutics began 30 years ago when I was introduced by a theologian to what was described as the 'already, not yet tension' of the kingdom of God (Marshall, 2015). I am drawn to the concept of the 'in between' space. It was against this background that I was introduced to the philosophy of Martin Heidegger. I particularly like Heidegger's phenomenology and the idea of walking forward into a future that is already present. This aligns with another part of my life that is becoming increasingly important. My exploration of my own Māori heritage is ongoing. The following whakataukī (Māori proverb) resonates: Kia whakatōmuri te haere whakamua: "I walk backwards into the future with my eyes fixed on my past' (Rameka, 2016).

Ethics

I followed the Auckland University of Technology's (AUT) PGR9 process which included written and verbal presentation of my proposed research. I then applied for ethical approval via AUT's ethics committee (AUTEC). The approval from AUTEC is appended as Appendix A.

The initial proposal included my intention to include at least one Māori ex-patient and at least one Māori staff member. Feedback received from AUTEC was that it would be advantageous to have greater representation of Māori amongst the participants. In response to that feedback and to ensure protocol requirements were met I consulted with the General Manager Māori and Pasifika from the District Health Board (DHB) area of primary focus. I also consulted with members of the Pae Ora Māori Health Team and a member of the Māori Ethics committee from the same DHB to ensure that support and advice was available as I proceeded with the study. A letter of support from the Māori Ethics committee can be found in Appendix B. Because I also wanted to recruit current staff members, I gained approval from the DHB Ethics Committee which involved sign off from professional and operational leads (see Appendix C).

In addition to the formal ethics application processes, I discussed my proposed research with the Chairperson of the DHB Consumer Council to further ensure that my approach to patient recruitment was appropriate. The research was also discussed with the professional leaders of nursing, medicine, and allied health; and the manager of auxiliary services to ensure that they were supportive of staff participating in this research.

The research was conducted with the following ethical principles in mind.

Partnership

Although this research does not specifically seek to focus on Māori health outcomes, my aim was to include a minimum of one Māori staff member and one Māori patient as participants. I sought to recruit all participants through a third party. To recruit patient participants, a recruitment notice was sent to one community organisation and one church group (Appendix D). All participants were given an information sheet prior to agreeing to participate in the research (Appendix E). The information sheet outlined the purpose of the research and invited contact with the researcher to discuss participation. Participants were informed that they could withdraw from the research at any time, but that if the withdrawal occurred after data analysis had begun, their contribution could not be separated from the data.

Participation

Participants were involved in the study both as providers of information as well as for verifying that the transcription of their experience had been captured accurately. Therefore, following minor editing, transcripts of the conversations were returned to participants for checking. They were asked to feedback either by email, phone, or hard copy if there was anything that they wanted to add, change, or remove from the narrative. This was completed before their experience information was included in the data informing the research outcomes. Patients are potential stakeholders in the outcomes of this research to the extent that it influences practice in medical or surgical hospital care, should they become patients at some point in the future. Staff are stakeholders because they continue to provide care in the medical or surgical area and seek to improve the experience of care in this setting.

Protection

Past patients and staff who engaged in this research first received an information sheet to enable them to make an informed and voluntary decision to participate. Cultural diversity was respected by following cultural advice from the Pae Ora Māori Health team to ensure that protocols were respected. The team also assisted with identification of an ex-patient who had self-identified to them as having received ‘good care’. They made suggestions and assisted with recruitment of Māori staff for the study by offering the information sheet to identified staff. It was reiterated, at the beginning of each interview, that anything said was confidential to the researcher, supervisors, and would otherwise only be seen by the transcriber. Reassurance was given that information shared would not influence any care provided in the case of ex-patients, or future staff development in the case of staff. To maintain confidentiality, all identifying information was removed from participants’ stories. Names were replaced with pseudonyms. Roles and settings have been described in broad terms so that individual identification is minimised (e.g. occupational therapist, physiotherapist, nurse working in a general medical or surgical area).

Choosing and Recruiting Participants

My original intention was to speak to staff from more than one geographical area; however, as the research progressed, I was able to recruit sufficient staff from the central North Island region. Staff participants with a variety of backgrounds and varied previous work experience met the inclusion criteria of being recognised as consistently providing ‘good care’ in a medical/surgical ward. Over the course of the data collection period, some staff were recent additions to the organisation and others moved on to other roles or places of employment. Ex-patients were recruited from the central North Island. All had experience of more than one central or lower North Island hospital.

Patient participants

Criteria used for inclusion of patient participants were:

- Patients who had a minimum of three days in a medical or surgical ward in a public hospital setting who perceived that they had experienced ‘good care’;
- Family/Whānau of patients who wished to participate in an interview who perceived that their family/whānau member had received ‘good care’ during a medical or surgical hospital stay;
- Patient participants were recruited and selected as they offered once it had been confirmed that they fitted the inclusion criteria. Recruitment continued until sufficient participants had been identified and sufficient information was obtained from a broad range of participants. This included the requirement for at least one patient participant who identified as Māori. Interviews were held with three patients (each with one family/whānau member).

Charge nurses of medical and surgical wards were asked to identify potentially suitable patients on discharge and provide them with information about how to contact the researcher should they wish to participate. Although all were supportive and helpful, recruitment of patients to a study was not their highest priority and this was not successful. The charge nurses were, however, very helpful in identifying and offering the opportunity to staff. As recommended by AUTEK, I approached the customer relations team and reviewed complimentary letters in an effort to identify suitable patients. Personal networks were also used to identify patients who believed that they had received ‘good care’ or had ‘good experience’ during a hospital stay. I placed a short notice in one church and one community organisation newsletter, offering an invitation to those interested to contact the administrator

or secretary. After receiving an information sheet, they then contacted me by phone, email, or in person. One patient participant and a family member were recruited this way. One patient participant, inclusive of her daughter, was recruited by the Pae Ora Māori Health Team. A third patient participant with her husband heard about the research through personal connections and volunteered to participate after a significant hospital stay. Patient interviews were commenced first in order to gain a patient perspective about who had impacted their perception of receiving ‘good care’.

Staff participants

I sought to include staff recognised as consistently providing ‘good care’ in a medical or surgical setting in a public hospital. I wanted a range of health professionals as well as auxiliary staff who had contact with patients including cleaners, healthcare assistants, and food service workers.

Staff selected were those recognised by their peers and professional leads as providing ‘good care’. For nurses and auxiliary staff the charge nurse(s) made recommendations. For medical staff, recommendation came from the clinical director; and for allied health staff, from their professional lead. Permission for charge nurses to approach auxiliary staff, such as cleaners or food service workers, was gained before commencing participant recruitment. Participants were invited by their appropriate leader and given information about contacting the researcher if they wished to participate. The Pae Ora Māori Health team assisted with recruitment of Māori staff participants who met the criteria after checking with professional leads or managers. Staff participants were accepted for the study in order to have at least one staff member from each professional group, and to ensure that at least one staff member

identified as Māori. Nursing staff who operationally reported to the researcher were excluded.

As I worked through interviewing patients, I also began staff interviews. I found that a patient would tell a story about the impact of an occupational therapist or social worker so my decision to include each professional group was reinforced this way. Another participant might mention the great job a cleaner or food service assistant did during their hospital stay, reinforcing my decision to include these people in the study. As I worked through the staff interviews, staff would mention other members of the team who had contributed ‘good care’ or whom they admired for their consistently ‘good care’. This served to reinforce the inclusion criteria of staff recognised as giving consistently ‘good care’.

It is pertinent to note that I had considered asking the patients who the providers of ‘good care’ were in their stories, to enable identification of staff participants. I rejected this approach because this could potentially lead to the identification of staff whom the patient ‘liked’, which might be different from one that provided ‘good care’.

Who are the Participants?

There were 17 participants (inclusive of three family/whānau members). Each participant was given a pseudonym and their role was broadly named to protect confidentiality. All participants (including family/whānau members) signed a consent form (Appendix F) and provided a small amount of demographic data. Table 1 provides information regarding the participants arranged alphabetically.

Table 1. *Study Participants*

| Name | Status | Age range | Ethnicity |
|-------------|------------------------|------------------|------------------|
| Andrew | Doctor | 31-40 | Chinese |
| Debra | Patient | 51-60 | NZ European |
| Dorothy | Patient | 61-70 | NZ European |
| Eleanor | Physiotherapist | 20-30 | Irish |
| Geoff | Family member | 51-60 | NZ European |
| Grace | Cleaner | 61-70 | NZ Māori |
| Jackie | Registered nurse | 41-50 | NZ Māori |
| Jenny | Registered nurse | 21-30 | NZ European |
| Lisa | Senior nurse | 51-60 | NZ European |
| Marama | Whānau member | 41-50 | NZ Māori |
| Margaret | Food service assistant | 51-60 | NZ European |
| Robyn | Chaplain | 61-70 | NZ European |
| Ron | Family member | 71-80 | NZ European |
| Ruby | Patient | 71-80 | NZ Māori |
| Sam | Occupational therapist | 41-50 | NZ European |
| Sandra | Healthcare assistant | 61-70 | NZ Māori |
| Sarah | Social worker | 51-60 | NZ European |

Ethnicity

I kept in mind the feedback from AUTECH that a greater proportion of Māori would be preferable, purely in relation to reaching a minimum when recruiting. The final ethnicity breakdown of participants is 5 New Zealand Māori, 10 New Zealand European, 1 Irish, and 1 Chinese.

Gender

There were 4 male and 13 female participants in the study. This may be because women tend to feel more comfortable speaking about personal experiences (Street, 2002).

Researcher Considerations

I am a registered nurse with more than 25 years experience. I am familiar with the context of the medical and surgical areas having worked as a registered nurse in both of these settings at various times during my career. At the time of the study, I held a professional leadership

role for acute and elective services and, for some of the time, operational leadership of the Care Capacity Demand Management (CCDM) team. I had frequent opportunities to talk with both staff and patients in the medical and surgical areas of the hospital and I was aware of the challenges and opportunities of working in these areas. I also have past experience as a patient in a general surgical ward. At the time of recruitment, I was responsible for leading a district wide focus on prevention of falls and pressure injuries. I also led a programme of work aimed at detecting and managing the deteriorating patient. To this end, I am familiar with working with all professional groups within a public hospital setting.

Interviewing

I am experienced in interviewing staff and patients in my role as a certified auditor and tap root trained investigator; yet, being a phenomenological researcher was a new role. The interviews were face-to-face for approximately 60 to 90 minutes. I have used the term 'interview' loosely because what actually took place was more of a 'conversation'. As suggested by Smythe et al. (2008) my intention was to reflect "Heidegger's understanding of Dasein as being-there, being-open, being in-the-play, going with what comes" to allow 'space' to "fall into conversation" (p. 1392). Participants were encouraged to suggest a setting for the interview that best suited them to enable comfort and ease of conversation. Setting the scene and creating an environment where mutual respect, honesty, and a genuine 'hearing' of the participant's story is a key aspect of participant interviews. This was achieved by providing refreshments and by asking open questions. Attention to body language and tone of voice using a relaxed approach sought to provide participants with space and plenty of time to describe their experiences of 'good care'.

I went to each interview knowing that ‘listening’ was essential and achieved this by guiding the conversation to the topic of interest. I invited the participant to recount a story of an episode (or episodes) of ‘good care’. As van Manen (2007) suggested, “the art of the researcher in the *hermeneutic interview* is to keep the question (of the meaning of the phenomenon) open, to keep himself or herself and the interviewee orientated to the substance of the thing being questioned” (p. 98). There were indicative questions (Appendix G); although these were only a guide, mainly used to orientate the participant back to the intent of the research. Participants were encouraged to tell the story in the manner they wished to tell it; too much direction runs a risk of missing hidden meanings as the story unfolds. The purpose of the interview was to both gather and reflect on lived experience material, aiming to have the participant become a co-investigator of the phenomenon (Van Manen, 2007).

Face to face interviews with patients and family/whānau members took place in the patient’s home. This was at the request of each patient participant and meant that a relaxed approach was enhanced. Each patient participant also chose to have a family or whānau member contributing to the discussion. I began by checking that participants were comfortable and understood the purpose and process of the research. The use of a general and open-ended question was aimed at gathering broad exploratory data. I usually began by asking them to tell me about their experience of hospital. After the initial question, the conversation ‘just flowed’ and it was encouraging to hear stories about ‘good care’ that went beyond my expectations. I was surprised and delighted at how little redirection was needed to keep participants talking about ‘good care’.

Staff were interviewed in a meeting room or office within a hospital, or on a ward in a meeting room chosen by the staff member. Once again, the conversations flowed easily. Many staff talked about their views about ‘good care’ before proceeding to stories that provided more detailed examples of ‘good care’. If a person struggled to think of a situation where they had provided ‘good care’, asking them to think about a patient who had received ‘good care’ recently seemed an easy way to begin the conversation. Once again, I was surprised and delighted with the depth of feeling and description of episodes of ‘good care’ that participants shared with me. One example that stands out was my interview with the cleaner. After a very brief chat to reassure me that she knew all about health and safety, she spoke deeply about human interaction. Her wisdom as a person was illuminated. Another was my interview with the doctor. The conversation was initially about the specific blood results and tests that resulted in a complex diagnosis but quickly moved to a heartfelt description of complex relationships. As with any phenomenological conversation, you never know what is going to ‘come out’ (Smythe & Spence, 2012). As the interviews progressed, I became aware of unexpected themes emerging, in particular the number of people who spoke about spirituality in some way. Although I know that it is unavoidable, I worried that I might be unknowingly influencing the direction of the conversation. I was very conscious that I wanted to ‘hear’ from the participants and was reassured that “what matters most is openness to what ‘is’” (Smythe et al., 2008, p. 1392). I made my best effort to ‘hold the space’ and to be ‘open’ to hear.

Transcripts

The interviews were digitally recorded and then transcribed following signing of a transcriber confidentiality agreement (Appendix H). Each transcript was then read and re-read to pull out stories using the words of the participants. This method removes grammatical errors and

lapses and seeks to coherently crystallise meaning (Smythe, 2011). Lightly edited transcripts were returned to participants to provide an opportunity for participants to make changes or add clarifications. Only one participant returned the transcript with some minor changes to provide additional clarity.

Working with the Data

Due to the timing of other life events, I had not had the opportunity to work with the data as I went, so started with 14 full transcripts (14 interviews that included 17 people). I began by reading through each transcript, and identifying separate stories within each transcript. As I read, I thought about possible themes and was alert to any frequently mentioned notions. I kept a note about the main ideas and feelings in each story. There were 52 stories to recraft, refine, and consider. I began to notice a strong emphasis on ‘the person’. It was often necessary to follow through one story from a particular participant to understand the experience fully. This resulted in a series of stories from each individual being linked together, rather than jumping back and forward from one participant to the next.

First steps

We are told by those who ‘know’ that thinking happens and ideas ‘do come’ (Smythe & Spence, 2012). In the beginning, when I read transcripts and attempted to write about them, it seemed difficult to do anything more than restate the main points in the stories. As I began working with a particular story, I felt that I already understood the main thrust of what the person was saying. Yet, I was encouraged to ‘keep going’ by my supervisors. At the heart of phenomenological research is the idea of ‘reading-writing-dialogue’ in a continuous cycle (Smythe et al., 2008). As I read and re-read each story, beginning to dig deeper to try to illuminate what might be behind the story, new understandings emerged. At first, I found it

difficult to uncover meanings. It was as I read and re-read the stories and wrote first drafts of my interpretation of the story that I slowly began to ‘see’. An example of working with a story is found in Appendix I. I realised then that taking a ‘leap’ to new understanding was indeed possible. According to Van Manen (2002b), somewhere along the journey the self steps back without completely stepping out of context. I was surprised and delighted to find that a seemingly ‘simple’ anecdote could transform itself and become a significant learning. I recognised that my understanding of a hospital’s culture gives me access to ready-made understandings. However, as Heidegger (2008) advised, I needed to rid myself of a tendency to interpret too readily: “The achieving of phenomenological access to entities ...consists in thrusting aside our interpretive tendencies ...which conceal those entities themselves *as* encountered of their own accord in our concern with them” (p. 96). I clearly recall the first time I managed what is knowingly called the ‘interpretive leap’, to write something vaguely interpretive. The email from my supervisor said, “congratulations on your first piece of phenomenological writing”. That was both inspiring—hooray, at last; also sobering—so what has all the other writing been? The shaky start and first steps fit well with idea that with “very attentive attunement to ‘thinking’ and listening to how the texts speak” (Smythe et al., 2008, p. 1389) progress happens. This progress seems to come in the form of deeper thinking and more dialogue to uncover what the experience of ‘good care’ *is like*. I found it to be true that reflectively writing made it possible to engage in yet more reflective writing. Put another way, new insights came through ‘action with thought and thought with action’ (Crotty, 1998; Van Manen, 2007).

Keeping going

“To illuminate hidden meanings, one sometimes has to work hard with the data. One way to discover meanings and to see structures of meanings is to make clusters of meaning, which

is an important intermediate stage on the way to a final description” (Dahlberg, 2011, p. 30)

As I worked with the narratives, there seemed to be more and more stories. As previously mentioned, I had ‘pulled’ more than 50 stories from the interviews. I engaged and diligently considered story by story, writing about each one. Realising that I was feeling overwhelmed, I gave the stories a ‘name’ corresponding roughly to what the story was about. I then clustered them together into a table so that I could get a sense of where I was up to (Appendix J). It was a kind of drawing back, taking a breath and getting ready to dive back in.

Making progress

Later in the year, I remember coming towards the end of my ‘data analysis’ (knowing there really is no particular ‘end’). In one session with my supervisors I commented “I have been reading some of my early writing. Both of you were *so good* at giving feedback without looking horrified”. They both laughed and said words to the effect, ‘that’s the journey of a supervisor’. I found that as I read alongside, and dwelt in the stories, notions seemed to spring to mind. I would get ‘stuck’ and think that I had completed writing about a particular narrative or topic, only to have other possibilities come to mind later in the week. It was useful to think about the hermeneutic ‘as’. Reflecting on a narrative and being open to the possibilities of new meaning takes concentrated effort. Every experience is interpreted ‘as’ something. I came to know and accept that each time I considered a piece of ‘data’, there would be nuances that came to the fore and other things that I did not notice. They were in the shadows. Discerning the ‘as’ is an important part of finding new meaning (Smythe, 2011). Reading and writing, re-reading and re-writing led me to find insights that were unexpected.

Putting it all together

As I read texts by Heidegger and others alongside the narratives, I found that things/meanings appeared. As I stood back, the narratives seemed to fit together in natural ways. There were a group of narratives that seemed to be about being-in-the world. Some looked like attunement or *phronesis*, where Heidegger's notion of 'leaping in' and 'leaping ahead' seemed to be illuminated. Another group seemed to have deeper meaning. A look deep into the person, a kind of sacred space where 'good care' was a deeply felt experience. These became my first three 'findings chapters'. Yet, there were also comments that 'time' was the main barrier to 'good care'. As I read and re-read the narratives, I deliberately kept open to this concept. I noticed that each participant had something to contribute about 'time'. This, then, became a fourth findings chapter.

I have described my journey to illuminate phenomenological notions within the narratives of the participants. Although there is no 'method' as such, I move now to situate my experience of working with the narratives within van Manen's (2017) six research activities.

Establishing Trustworthiness

Van Manen (2017) described the need to be prepared to live with uncertainty and risk when researching lived experience. Engaging in phenomenological research can be broadly described as centred around formulating the phenomenological question, gathering the lived experience materials, investigating the experience, reflecting on the experience(s) gathered, with the end result of authoring a text that has insight on the topic. What follows is my application of the six steps outlined by Van Manen (2007) to this research topic.

Step one concerns identification of the phenomenon of interest or concern that will drive the phenomenological question and govern the research process. Identification of this question and a genuine deep desire to understand the phenomenon is key to the sustainability of the research (Koch, 1995; Smythe, 2011). As described, the phenomenon of ‘good care’ is important to me. My professional life has been dedicated to ‘good care’ in practice. The context of my study, the medical/surgical wards, is important because this is a setting often overlooked by researchers. The participants are health professionals, non-professional staff, and people who have been patients in a medical or surgical ward within the past year. Once again, bringing together a wide range of experiences from both sides of the health care encounter is rare.

Step two is the investigation of the experience as it is lived through the lens of conscious consciousness. There are layers upon layers in every experience making investigation of the experience complex. This requires recognition and acknowledgement that there is no universal truth that is ‘once and for all’ (Smythe et al., 2008). While each of us have our own world that we are situated in, sometimes described as Heidegger’s concept of ‘thrownness’, we also have aspects of the world in common seen in the shared skills and practices within the culture that we find ourselves (Leonard, 1989). What shows us as ‘mattering’ is a characteristic of Dasein (Leonard, 1989). I have remained focused on reflecting further and understanding the components of what ‘matters’ to enable discovery of the specific elements that are contained in the reflection (Dreyfus, 1991; Leonard, 1989). This has been described as viewing the world with a lens that has awoken an awareness of the world, through some destruction of awareness of the normal view of the world. In the context of this proposed research, it was to uncover and describe the experience of ‘good care’ differently from the

way it was previously taken-for-granted as already-understood. It was to awaken the view of ‘good care’ by understanding the nature of the experience as it is experienced. This step involved data gathering using an open interviewing style where listening is essential. I was deliberate in my aim to maintain a focus on the experience in a non-directive way, facilitating the patients and staff to share their stories and experience of ‘good care’ (Koch, 1996).

Step three involved the art of reflection with regard the essential themes characterised from the phenomenon. The aim as described was to reflect on the data from the interviews in order to not only hear the stories but to listen. I focused on allowing the emergence of the experience to be revealed in a manner not previously recognised (Gadamer, 2001; Smythe et al., 2008).

Step four was the process of writing and rewriting through various levels of questioning to produce a description of the phenomenon precisely as it is: “When something no longer takes the form of just letting something be seen, but is always harking back to something else to which it points, so that it lets something be seen as something” (Heidegger, 2008, p. 57). Throughout this process there was rhetorical movement, correcting and modifying existing fore-structures through the hermeneutic circle of interpretation in order to gain understanding (Koch, 1995; Leonard, 1989; Walsh, 1996). Through fusion of patient and staff voices; literature, the notions of hermeneutics underpinned by philosophers such as Heidegger; and my own understanding and prejudices, a written work is now being constructed to illuminate understanding of the phenomenon of ‘good care’ (Koch, 1996; Norlyk & Harder, 2010).

Step five was the requirement that I, the researcher, remain focused on the original phenomenological inquiry. Because there is potential for distractions or issues not relevant to my research question to arise, I needed to ensure that I did not become distracted or engage in abstract theorising (Van Manen, 2007). This was a challenge at times as the stories told were often inspiring and humbling to hear. Staying true to the exploration of the phenomenon of ‘good care’ took discipline.

Step six is described by Van Manen as a process of stepping back from the research and providing my own critique by viewing the parts balanced within the final whole. This final part has been the most exciting step. I have taken on Heidegger’s view that my understanding is already there and any attempt to bracket it away is futile (Smythe et al., 2008). I have been exposed to an enriching of my own understanding of ‘good care’ through reflection on the narratives of others.

Expressions of Rigour

De Witt and Ploeg (2006) used the term ‘rigour’ as opposed to ‘trustworthiness’ and proposed a framework to express rigour in phenomenological research. I have outlined the steps I have taken framed by the five expressions of rigour suggested.

Balanced integration. I have read widely on the topic and the philosophical approach taken. I have outlined my reasons for choosing Heideggerian hermeneutic phenomenology, and attempted to stay true to ‘finding’ insights within the narratives while ensuring that the participants’ voice comes through. I have made an effort to situate my reflections within the narratives, returning to the text when describing and reflecting on the lived experience

(Errasti-Ibarrondo et al., 2018). I have had the guidance of my supervisors to assist me to ensure that the research is well balanced.

Openness. By describing the methodology and steps taken to carry out this research, I have maintained an openness to others ‘seeing’ how the research was conducted and the rationale for decisions made. An example is my decision to include a greater balance of Māori participants than first envisaged. I have also maintained an awareness of my own bias towards ‘good care’ and endeavoured to be aware of my personal views and potential bias by describing my pre-understandings. As notions have arisen, I have read widely to ‘open’ my thinking to a range of other perspectives (Errasti-Ibarrondo et al., 2018).

Concreteness. Examples are given throughout my ‘findings’ chapters that situate the narratives within the everyday setting of the medical or surgical ward. I have drawn on my own knowledge and experience of the context to deepen reflection on the narratives. An example is seen in my interpretation of the way doctors’ patient responsibilities work in practice.

Resonance. As I have progressed with the research, I have held frequent and in-depth discussions with colleagues and friends (who may have had hospital experiences) about my ‘discoveries’ and ‘findings’. This has helped reassure that the notions illuminated resonate with those working day to day in the hospital setting, and those experiencing hospital care. I have kept a journal and focused on writing and re-writing the text because “writing gives appearance and body to thought” (Van Manen, 2007, p. 127).

Actualisation. This refers to the idea that “phenomenological interpretation does not end when a study is finished” (De Witt & Ploeg, 2006, p.226). While it is not possible to see into the future, my interest in the phenomenon of ‘good care’ continues. I feel energised and excited about the notions discovered in this research, and look forward to continuing to reflect on and seek to influence ‘good care’ in the future.

My Experience of Framing the Notions

Four data analysis chapters contain a number of phenomenological notions that ‘came’ as I reflected on the participants’ varied experience of ‘good care’. As I went about reviewing the stories gifted to me, I recognised that I was not only *looking at* the stories, I was *in* the stories. What I mean by that is that at times when I was doing other things, not even conscious of the stories, ‘things’ would reveal themselves as relevant or new to take me in new directions. It felt as if I was ‘living’ the experience of reflecting on stories, while my own story progressed. In chapter five, a chapter about ‘being’, British Prime Minister Boris Johnson’s comments about his care during COVID-19 became important. In chapter six, a chapter centred around attunement and phronesis, a comment on a zoom call about a poem by W.B. Yeats helped frame my understanding of Heidegger’s notion around past, present, future. A poem by T.S. Elliot helped to unpack thinking about spirituality in chapter seven. According to Smythe and Spence (2012) “in hermeneutic study, it is the philosophical insights, and the thoughts stumbled across, that can most powerfully call one into thinking and thus shape the analysis and findings of the research” (p. 21). I have found this to be true as I have read widely and remained open to what seems to ‘matter’, what ‘things’ draw me in and what ‘things’ do not.

Summary

In this chapter I have described the research journey I undertook. I have outlined the process of gaining ethics approval, reflecting on ethics committee feedback, and recruiting participants. I have described how I worked with the narratives and the engagement in the 'hermeneutic circle' that occurred as part of my phenomenological journey. Steps taken to establish trustworthiness have been addressed and I have endeavoured to be true to the notion of 'openness' both in my interviewing style and my reflection on the stories gifted to me. I have followed the lead of those who have gone before me to dwell in the stories, as Heidegger (2008) would say to 'ek-sist', to dwell on the language of participants in order to gain an understanding. My aim is always to invite the reader to 'journey with' me in the data. It is the reader who will judge the trustworthiness of the findings through reading and understanding the discussion that follows.

Chapter Five: Being Me

The idea for this research was born when I reflected on a formal conversation in response to a complaint from a woman about the care of her mother in a medical ward. Her questions were simply answered and centred around the care provided in the days prior to the death of her mother. Her main wondering was whether she should have pushed harder, asked more questions, or should have acted differently somehow in that time period. The grief and suffering at the root of her experience sat with me. I pondered what it was that led to her deep feelings of grief, self-doubt, and regret; feelings that had continued for the two years since the passing of her mother. I wondered what it is that makes one person able to care in ways that lead to an experience of ‘good care’, when another follows a different path. Having listened to the stories of the research participants who hold a variety of titles across the spectrum of care, I wonder if some of the answer is deeper than the preparation for the role each of the participants play, whether a health professional, other worker, patient or whānau. All seem to have a role in the giving and receiving of ‘good care’.

In relation to care, Heidegger (2008) asserted that care is the “formal, existential totality of Dasein’s ontological structural whole” (p. 237). All cultures have a common structure to being human that includes ‘care’ (Dreyfus, 1991). Heidegger goes on to write:

Because being-in-the-world is essentially care (sorge), being-amidst the available could be taken in our previous analyses as concern (Besorgen), and being with the Dasein-with of others as we encounter it within-the-world could be taken as solicitude (Fürsorge). (p. 237)

Whether giving or receiving ‘good care’, each participant is involved in the experience of ‘good care’. Each is cast in a role, how they carry themselves in the role seems to play an

important part in how ‘good care’ is performed and felt. Almost like a wonderful play where the plot line is but one part, the acting out of the parts is dependent somehow on the people in the costumes. The following collection of stories draws out some of the ways of being that seem to result in an experience of ‘good care’. They shine a light on the experience of giving and receiving ‘good care’.

Being Watchful

Boris Johnson, British Prime Minister, on COVID-19, said, “for every second of the night they were watching, and they were thinking, and they were caring, and making the interventions I needed.” (13/04/2020, TVNZ/BBC)

Healthcare professionals are taught to watch in their educational preparation, watching for signs of change so that the right interventions can be actioned and implemented at the right time. We have different names for the watching, assessing, diagnosing, monitoring, evaluating. There are technical skills required to do this well; however, it is interesting to dwell on what the patient makes of this. Nurses have frameworks such as the nursing process to follow assess-diagnose-plan-implement-evaluate. Doctors have differential diagnosis; allied health staff members have a range of frameworks for assessing and intervening. In physical health areas, such as medical and surgical wards, emphasis is placed on teaching the skills for effective monitoring, watching, and reacting to signs of change. However, according Boris Johnson, reflecting on his COVID-19 experience in ICU, it seems that, for the patient, it is the very act of watching that is an important part of the feeling of ‘good care’. Debra, a study participant, found the constant watching gave her a security, a kind of permission to relax, to allow her body to follow its lead.

The night nurses particularly they were just, lovely, they were like a little ray of sunshine really and you just knew that they were happy to be there, and then

they crept in because I was needing pain relief quite a bit through the night and they were very attentive to that. (Debra)

What is it that the night nurses were watching for that made Debra feel cared for, feel secure in that knowledge, and how exactly were they watching? In the course of our usual everyday lives, the idea of being watched would, for many people, be an uncomfortable and unwelcome activity by another; yet, when unwell, as Debra and Boris both were, it is welcomed, sought after, and comforting. Patients notice this keenly. Although they may have no way to gauge whether the person watching is skilled in acting on what they observe, the very act of being watched seems to bring security and comfort. Debra has fond memories of being watched. Describing the nurses as ‘a ray of sunshine’ is not something one would normally assign to being surveilled. She notices the demeanour of the nurses; she feels some of who they are from the way they are with her.

Being Trustworthy

Debra gains confidence and trust in the nurses because of this watching:

Having someone who I knew was staying attentive, there beside me because I couldn't be attentive, I'd fall asleep in the middle of talking sometimes, I just couldn't stay aware, but I knew whoever was with me, they were staying aware and they had my back and were watching out for me and because they were doing that I could let go of watching out, that was really very, very reassuring.... I wanted to be more present, but I couldn't be and that would have been tiring, but I was able to just let go. (Debra)

Debra was always able to have a member of her family with her. This is another aspect to the watching that she is referring to in this setting. In a general ward, one to one care is not the norm; however, Debra was reassured by the frequent but intermittent watching of the nursing staff coming and going, and the constant reassuring presence of her family. She

trusted that if something were amiss, her nurse or her family would notice. This feeling of trust grew through the developing relationship with the nurses who cared for her and was strengthened by the constant presence of her family members. The trust was based on a presence, a demeanour rather than on knowledge of any particular technical skill. In fact, Debra's husband Geoff commented about a staff member that "*he gave the impression that he knew what he was doing, whether he did I've got no way to judge that*". Such trust is built over time through presence and certain ways of being, an attitude, an openness to listen, act, be available, and willing to help no matter the reason. The actions and building of the relationship on previous nights when the nurses had acted to prevent damage to Debra's swollen finger by the removal of her ring led to this feeling of trust.

I remember showing her my ring on the second night, because I was having a lot of fluids and my hands were getting really puffy, and said I'm really worried about this ring and she went oh we need to do something about that. And she went down to ED, she got the ring cutter, she brought it back and for the next three hours her and her colleague took turns cutting it off. (Debra)

The action of removing the ring was not the part that built the trust. It was the willingness to do this, the lack of any sign that it may be a burden, the unquestioning move to action that was noticed by Debra. She realised that they would do whatever else might be needed to keep her safe. In any trusting relationship, there needs to be trust and trustworthiness (Flores & Solomon, 1998). The constant presence, watching, and noticing made that trust possible; however, the unencumbered action of cutting off the ring built on this feeling to become an impression of trustworthiness. In both Debra and Boris' situation, the watching, noticing, listening, being present, being focused led to an action that presented itself as trustworthiness. It seems that the inner qualities of the nurse, made the action seem effortless. The willingness to respond in a way that made it seem as if the nurse was pleased to be able to help. It felt

like good care, gave a feeling of trustworthiness and led to the patient feeling trust in the nurse.

It was a big job but they were so happy and supportive and enthusiastic to do it, there was no sense of 'oh this is a nuisance'. I mean it needed to come off, it was going to cause harm but I never was made to feel I was a nuisance to them. (Debra)

Debra repeatedly mentions not wanting to be a 'nuisance' to the staff. One wonders what being a 'nuisance' feels like. There are many ways a person might subtly convey either being a 'nuisance' or 'not being a nuisance'. The idea of 'nuisance' can be conveyed easily and quickly by hesitation, a subtle roll of the eye, lack of attentiveness, a stony look, hunch of the shoulders, and/or tension in the body. It seems Debra experienced none of these in her interactions with the night nurses. Rather, she felt their willingness, the quick response to help and to deal with the smallest thing. She describes the nurses as 'happy to be there'. It is apparent that the nurses did not come in and say "I am happy to be here"; so how did Debra feel that? She talks of them 'going the extra mile' and feels that cutting the ring off was an example. In fact, the cutting of the ring was necessary to prevent harm and, in terms of clinical care, was not really an 'extra mile' activity. The way that this was done, with willingness, speed, time committed to it, cooperation between staff, perseverance over the three hours, these are the elements that conveyed a feeling of 'good care'. There was no hint from the nurses, over the three hours, that this was a burden; no conveying that there was not time for this activity. Debra was acutely aware of how it 'felt' to be cared for in this way, an extension of the actual activity being undertaken.

It's hard to put in words but that emotional connection you feel it when it's there and you notice it when it's not, and you feel more cared about and more valued by that nurse when it's happening. But, they all gave good technical care, so there's technical care and then there's caring care. (Debra)

Debra's description illustrates that patients cannot always find words to describe the experience of good care, but they know when they feel it. Her description of the nurses' removal of her ring leads one to wonder about how Debra could feel the care. She described interactions wherein nurses would share something of themselves. It felt reciprocal; perhaps a feeling of trust and trustworthiness had been built on both sides of the relationship. The character of the patient and the nurse is evident in the sincerity of the interaction, of watching and noticing and doing one's best at that. To enable relationship to develop takes a sincere effort. Although taught to health professionals as part of therapeutic communication, to share of oneself is not in any job description. What to share, how, and when is complex; let alone the many possible ways that a scenario could play out. Debra had a sincere expectation of care and concern, of trustworthiness, and of being cared for. The nurses in this story made a sincere and heartfelt effort to share themselves, to build relationship, to show themselves as trustworthy by the way they just 'are'. The heart of good care is felt by the person. It is not an act or a formula. It is responding in the moment in a way that 'feels' caring. When this occurs the patient feels it, recognises it, and with this comes a feeling of trust, being able to rest in this care, a giving over of control to those who have proven themselves trustworthy. It seems this is an important aspect of what good care feels like or, as Debra put it:

When I was lying in the bed the things that touched my heart, the things that made me feel better, the things that made me feel valued and cared about, was actually, the acts of kindness, the acts of going the extra mile and I guess to me that said, they care enough to put their effort in, so if they're putting their effort in thoughtfully this way I imagine they're putting their effort in thoughtfully in the technical parts of caring for me. (Debra)

Debra talks of the things that touched her heart while she was lying in the bed. The words she uses, 'lying in the bed', seem to indicate a lack of action, a vulnerability, a kind of lying

back and not feeling in control of the situation. Perhaps this position and role of being the patient led Debra to see more deeply what was happening around her. She mentions the things that touched her heart; she seems to refer to the feeling she had when she knew she was being offered 'good care'. Debra lists off some of her observations around the 'acts' that the nurses undertook to help her, the acts of kindness, of going the extra mile, these acts came out of the noticing, the watching, these are the skills that the nurses used to 'know' what was to come next. Their unwavering willingness to help led to the actions they took revealed an underlying 'care' for Debra as a person. From Debra's perspective, lying in the bed, this felt like 'good care'.

Heidegger (1962) used the term 'concern' as an ontological term for a possible way of Being-in-the-world because he felt that the Being of Dasein itself was to be revealed as 'care' (Sorge) and that because Being-in-the-world fundamentally belongs to Dasein, its Being concerning the world is fundamentally concern. (Hornsby, 2012, p. 2)

Good care for Debra was a feeling, reinforced by actions and attitudes revealed as 'care'. Because of this 'good care', trust was built; a confidence in the trustworthiness of the nurses took hold and seemed to allow Debra to feel valued and cared about. 'Good' was felt before it was observed; perhaps this 'feeling' is where 'good care' begins.

Being Aware of the Fragility of Trust

The trust between Debra and the nurses was built over time and evolved to be a reciprocal relationship. Debra developed trust in the nurses and this two-way relationship may have been what led Debra to describe her overall experience of being a patient in the hospital as 'good care'. However, though Debra described her care while in hospital as 'good', not everything went to plan. Debra was started on a medication that had a side effect of severe

constipation. It resulted in pain that she described as “the worst pain I’ve ever had in my whole life”.

There’s a point where the nurse needs to take the lead and for my bowels, they should have taken the lead sooner. I shouldn’t have got as constipated as I did but I’ve never had tramadol before, so it took me by surprise how constipated I got. It was really traumatic. They asked every day, have your bowels opened and I would say no... I mean we really worked in partnership and maybe because of that they trusted my judgement, but I wasn’t thinking straight.

(Debra)

Trust is a reciprocal concept. Debra trusted the nurses and it appears that the nurses trusted Debra. Providers of health care are taught that the therapeutic relationship is important, that a patient directing their own care is a positive concept and that shared decision making is an important key to good care. As Debra reflects back on her care in hospital, she remembers the trauma and pain of the side effects of her medication. She wonders if the partnership was indeed a positive aspect of her care. Debra is herself a registered nurse. One wonders if the nurses were in any way influenced by this or was the issue that was developing for Debra overlooked? Did the medical and nursing staff miss the significance of her daily answer ‘no’, to their question about bowels. Or perhaps the person asking each day was different and nobody looked at the stream of ‘no’s’. It seems that the nurses may have been expecting Debra’s decision making to be better, that she would take a lead or highlight issues. It seems that the opportunity for ‘good care’ was missed, possibly in favour of working in partnership and a reciprocal trusting relationship. By the sixth day in hospital, things came to a head.

On day six, Daniel was my nurse and he came in the morning to see me, and we chatted about what we’re going to do for the day and he asked about my bowels and I said to him then, no they haven’t opened, yesterday I had a day of lactulose but I think that’s not going to work, and he goes no I agree and we’ll get the enema sorted. So he got that sorted. (Debra)

On day six, Daniel, a very experienced senior nurse, was assigned to care for Debra. He was able to immediately recognise the need for action, seeing the potential for bigger problems. Debra commented that she “*wasn’t in any pain, my tummy wasn’t distended, so they could have left me a lot longer, technically*”. Heidegger (2008) described the caring presence of ‘authentic solicitude’ as ‘leaping ahead’, a way of smoothing the way and supporting another (Glover & Philbin, 2017). Daniel appears to know the seriousness of the complication that would result from a lack of action. He takes the lead in a way that is supportive of Debra’s thinking but is also decisive. She is appreciative of the direction. He shows a confidence in his decision making and acts quickly. Feeling heard and working together may be important but sometimes ‘good care’ requires knowledge, decision making, and action. By the next day, Debra was feeling much better and more in control of her thinking.

On day seven, [Saturday] when they came in, I thought I’ve had enough of this. I want quiet, it’s so noisy here. And I want dark, we can’t get this room dark. That’s when I said let me tell you what’s going to happen now! I’m going home and Geoff is going to give antibiotics and this is how you’re going to organise it. And they were really good, they were gracious, they let that happen. (Debra)

He seemed to go out of his way, to sort things out and to make things happen, especially once you started getting stropky. (Geoff)

You can hear the renewed strength in Debra’s voice. She is now in control of her future and knows what she wants. There is nothing tentative in her request. She does not phrase the plan as a question; she is now giving the orders. After the trauma of the day before, she is now feeling decisive and ready to move forward. If giving and receiving trust strengthens relationships (Lewis et al., 2017), perhaps the knowledge or intuition of knowing when to trust and when not to, is also where ‘good care’ comes to the fore. Perhaps trusting at the

right moment builds confidence and results in care that is ‘good’. On day six, support and decisive action to recognise when Debra needed help seemed to build the relationship and result in Debra’s positive view of her care. The next day, recognising the tone and intent of Debra’s decision that she was ready to go home became important. Going home for a husband to administer intravenous antibiotics is not usually arranged on a Saturday afternoon. Daniel was aware that Debra had worked as a nurse in the community, she knew what was possible. He seemed to have the confidence to weigh the risks, see the need, and get whatever needed to be done to make this happen, happen. What Debra describes as being gracious, would also have involved clinical knowledge and weighing up of the options available. It was not merely a response to someone being “*a bit strop*py” as Geoff described it. One gets the feeling that if Daniel did not agree that this was possible and safe, he would not have facilitated it. He would have found a way to get a different plan. ‘Good care’ sometimes requires leadership and confidence in one’s judgement. It seems that because of his demeanour of calm confidence, Daniel’s leadership revealed itself with focused listening, clear thinking, reading the mood. and leaping ahead to see what is possible.

Being a Listener/Feeling Listened To

How important is listening properly and clearly when faced with the unknown? Sarah, the social worker, describes her involvement in a very complex situation.

We have Rihi, she’s 30 and has a terminal diagnosis. She’s Māori, and comes from quite a complex background, dynamics in the family are strained. And, the tricky thing has been trying to work out how as health professionals we can get her engaged. Being given a terminal diagnosis, so phased out by that. But only in the last few days have we come together to go oh my gosh what are we doing for this young woman? Are we actually making things worse by being involved? And the good thing is that I had just connected with her mother in

the passageway. You know how good corridor conversation happens and I snaffled her literally, asked her if she would like to meet with me and we caught up and made a connection. Having a bit of a conversation then pulling Rihi and her mum aside and going 'let's have a talk here' and we just narrowed it right down. Let's name two people to go in and have a talk, and that was myself and the consultant.

Working on what's going on for her as mum, and how is it for her to have her daughter like this. I'm a health professional but I'm a mum so what is this for you? 'What's the impact for you'? 'What's your support'? 'How do you want to run this ship'? Because the situation's not going to change with Rihi, but what can we do now to support? So, it's engaging, you have to engage so that they trust. Bringing them on the journey, not leading them on the journey, walking alongside. (Sarah)

According to Levinas, to be listening is to be empty and full at the same time (Lipari, 2010). To be truly listening is to diminish the self and increase awareness of emptiness and unknowing. Sarah finds herself in a situation where all the usual approaches, the teamwork, the figuring everything out, has failed. She wonders if it has been more than a failure and may even tip towards being harmful. All the activity may in-fact be achieving nothing but running in circles. She reflects on how to break this cycle—it all seems so surface, so meaningless. She happens upon a 'chance' encounter with Rihi's mum in the corridor and seizes her opportunity. This all sounds so simple and obvious; however, one can tell that this is not easily managed. One imagines her tentative and respectful approach, taking the risk of sharing some of herself in order to get to the heart of the situation. One imagines the running around, the office conversations to try to figure out what is going on with Rihi, the young woman who will not 'engage'. One can almost feel the anguish of the staff, faced with such a young person, with such a serious story, and with young children as well. Each one may be able to see themselves in the story but seem powerless to make it any better. As

Sarah reflects on all the activity, she somehow manages to ‘leap ahead’ to a solution that might offer a way forward. She imagines herself in the situation of not the patient, Rihi, but of Rihi’s mother. Sarah seems able to acknowledge to herself that she is at a loss. As Heidegger (1975) pointed out, hearing is primarily gathered hearkening. We hear when we are “all ears”. This comes from genuine concern for the other, referred to by Heidegger (2008) as ‘*sorge*’ or caring. Her listening needs to step up to another space; it needs to include ‘hearing’. She finds a space where she can place herself alongside Rihi’s mum, relate to her as ‘just another mum’. Perhaps ‘good care’ is about peeling right back to just ‘being’ oneself. For Sarah, bringing forward the ‘mum’ in her was the key to beginning the journey of understanding and of unlocking the potential for ‘good care’ to occur.

Being Kind

With good listening there comes the opportunity to respond to what is ‘heard’. Dorothy tells the story of the wait for her husband Ron to have surgery.

But once again the lady that was in the admitting office, that sends out all the letters, she and I got on to first name basis because she was feeling for us as well having to wait. So each time I rang I said look he’s not getting any better. And she promised me, she had his records right there ready for when the doctor got back and told us the date. And sure enough she rang us on the day that Dr C got back and said I’ve spoken to her and it won’t be very long now, you’re at the top of the list. So I really appreciated her, because I hated ringing. I only rang two or three times and I told her that. I said, ‘oh I hate worrying you but it would put us more at ease if we know we’re still down the bottom or we’re nearer the top’. And she was very, very kind as well. Mavis I think her name was but she was extremely patient! I’m sure she must get a lot of people screaming down the phone, why haven’t I got my surgery yet, but I didn’t do that at all. So, I felt I could trust her and that’s all part of it, feeling like you can trust the staff too. (Dorothy)

“I felt I could trust the staff”. Dorothy describes her relationship with the booking clerk as she and her husband Ron awaited his surgery. It is a relationship of trust based on kindness. Kindness implies the recognition of being of the same nature as others, being of a kind, in kinship (Campling, 2015). Dorothy seems to hear something in the voice of the booking clerk that she interprets as kindness. Not only does she feel this in her voice but in her actions of reassuring, making promises, and following through. One can hear the anxiety in Dorothy’s voice, she is apprehensive and worried. She does not find it easy to call the hospital time and again to check on progress but her anxiety about her husband drives her on. She minimises, tries not to be a bother. Perhaps she is worried that constant phoning will somehow affect the care Ron will receive. She was expecting impatience, to feel like a nuisance. Instead she struck Mavis, the booking clerk. Mavis seems to sense the anxiety, the worry about a sick husband. She sees through the surface request for an update. She seems to be attuned to the feelings just below the surface; she is attentive and listens carefully. Her response is gentle and reassuring. Dorothy senses that Mavis was ‘feeling for us’, a sense of kinship was brought to the surface. Dorothy no longer feels like a name on a list, there is a connection made. The caring concern, or Heidegger’s (2008) *‘sorge’*, is present. There seems to be a feeling of being alongside. Heidegger described the idea of being thrown forward into the world:

In this state of thrownness, pre-understandings taken with Dasein and are already there. In the projective disclosure or such possibilities, it already has a mood in every case. The projection of its own most potentiality-for-Being has been delivered over to the Fact of its thrownness into the ‘there’. (p. 103)

As Dorothy describes her interaction with the booking clerk, one can hear the anxiety that she takes with her into that relationship. Amongst the many possible responses, the booking

clerk is understanding, stands alongside and gives the impression of ‘working with’. It seems to be this sense of working with, a kind of kinship that is felt and received as kindness that lays the foundation for the coming hospital visit. ‘Good care’ seems to be built on a foundation of kindness and trust. This seems to enable a feeling of trust for not only the booking clerk but the whole team.

The kindness and trust laid down is so easily disrupted, Dorothy goes on to describe their encounter before hip replacement surgery.

I struggled with the doctor. Just came straight in, shook Ron’s hand, hello and nothing. He didn’t talk to me, I might as well not have been in the room! And because Ron does struggle with remembering things I had one or two questions, not many, because I didn’t know what the surgery was going to be about, more about the recovery. And he didn’t really answer so I was left feeling a little bit shattered. And the nurse was absolutely lovely. She just put her arm around me and she said, ‘this is what’s going to happen, what are your questions?’ And she answered them all for me which was really nice, because he was busy and he’d obviously gone onto the next person but she was delightful, she was just rubbing my arm and telling me it’s going to be alright, what the procedure was going to be, which were the things that I needed to know for my own sanity. Ron was just going to take it as it came but I wanted to know. She was absolutely lovely. And I think when we went back again she was on again and said a nice hello. She obviously remembered us and that makes you feel a lot more comfortable with the place. Because I don’t like hospitals at all. Always had an issue with them but she was very kind.
(Dorothy)

Kindness is not a temptation to sacrifice ourselves; it is more of a process of including ourselves with others (Campling, 2015). Dorothy experiences the devastation of a conversation not well managed, where perhaps kindness, listening, or even noticing her

presence as the spouse is absent. Jenny, the nurse, notices this and immediately acts to restore the relationship. Kindness is something that is generated by an intellectual and emotional understanding that self-interest and the interest of others are bound together. Jenny immediately recognises a need and an opportunity to help. Perhaps she is aware that good care begins with relationship and understanding. Perhaps she has seen that people do better with kindness and trust. Her small and immediate act of kindness, stepping in to fill a void, overshadows what has gone before and re-establishes the sense of kinship. Her action repairs the trust, lost in a moment. It seems to be in the moments of distress that we reach for a familiar touch, a sense of kinship. Kindness is kinship felt and expressed, one senses that Jenny not only feels Dorothy's need, she prioritises her response. This is not always easy on a busy patient round—there are risks in lagging behind. Yet, she takes the few moments to respond and reassure. One wonders if this is not the first time that she has done this. 'Good care' seems to be more than listening and noticing, it results in action and an attempt to 'put things right'. Jenny's intervention is an example of 'leaping in', Heidegger's term for a fundamental way that 'care' is shown. Leaping in occurs when a person takes over in a 'troubling or concerning' situation (Glover & Philbin, 2017). Although leaping in can be disempowering, in this situation one senses that Dorothy is able to bounce back from her setback because of Jenny's immediate response. She is able to clutch on to some of the previously developed trust, and move on to the next part of the process.

Ron, the patient has been quietly watching on. He is quieter but observant and seems to take the lead from Dorothy. Her trust in the system, her speaking positively about trusting the staff seem to provide Ron with reassurance that all will be well. He tells of his experience in the ward after the hip replacement.

The nurse just said, well do you feel like you want to get up? And I said yeah I can get up and give it a test. She said well your leg's still your leg it will hold you up. You've just got to watch your balance. So I got up there and then, we went for a little walkie you know. I was good as gold and from then on I was allowed to walk with crutches, but oh I couldn't get used to the blimen things. My coordination's terrible. And anyway I put them wrong way round and sideways. (Ron)

Sometimes a direct approach is best. One can almost hear the confidence and trust in Ron's voice. He does not doubt the suggestion of the nurse; he trusts that what she is asking is possible. There seems to be almost a sense of surprise in his voice, she asked, he said yes, next thing there was action. Ron seems to implicitly trust the instruction, his trust leads to a kind of therapeutic alliance, his actions are aligned with the expectations of the nurse. He has no prior experience of getting up and walking after a hip has been replaced; yet, he seems to be prepared to just "give it a test". Dorothy continues with her description.

When I realised you just could not coordinate crutches, what a disaster that was. And knowing he was coming home, with crutches, even though we haven't got steps as such, I was really anxious about it. Because at that stage if he fell I could do nothing to help him. And so the nurse was very kind, I don't know how often they do it but she told us just to take a walker. One that wouldn't skid along the carpet too. (Dorothy)

Yeah, I was able to walk out because they got me that little thing and I could walk good as gold up and down the passage, it was good. It worked out. (Ron)

It can be difficult to talk about kindness, it is an ordinary quality. Maybe it seems so ordinary that it is easily overlooked. Kindness is not sentimental. Not clever. Not easy to audit. Yet when a person 'feels' kindness, they recognise it. Once again, in the unfamiliar, bewildering world of the hospital, kindness is felt. Heidegger described the average everyday activities of Being-in-the-world. Objects are there for a purpose; it seems that it is only when there is

a problem that they come into focus. For many people, getting up on crutches is the routine following a hip replacement. The crutches are an object that is ready-to-hand, for the purpose of walking. Yet they suddenly become obstructive—Ron is unable to make them work.

One can hear the reaction of Dorothy to this dilemma. There is a sense of anxiety in Dorothy's retelling of this situation. She seems to grow more anxious as she observes Ron's constant attempts at using the crutches. A growing fear of what might be ahead of her. There is almost a panic, the need to be supportive balanced with the worry of the consequences of a fall. This is not immediate, it grows over time, gnaws away at her, erodes her previous confidence in the system and the staff. She has choices to make and debates the options internally until finally, an alternative is offered. One can almost feel the relief of a problem solved, without a fight. The simple act of providing 'good care' by noticing, listening, hearing, responding on the part of the nurse melts the anxiety away.

Ron, however, has a different journey. He seems to be content to 'just be'. He tries what he is presented with—the crutches. He does not seem overly perturbed about his inability to use them effectively. The idea of falling does not seem to have entered his head. He seems surprised but not fearful about his skill with the crutches. He does though, seem to notice Dorothy's anxiety, however well-hidden she may think it is. In his retelling of the story, he seems determined to be up-beat, to keep on going, each step is a means to an end. He focuses on what he can control and does not let himself think further. One senses that he has an underlying sense of what is happening but does not let it surface. However, when a better plan emerges, he is grateful.

For the nurse, in the context of the post-operative journey there are guidelines to follow. Crutches are to be used, walkers are not just given out; there are assessments to be carried out and a process to get one. The nurse sweeps this away, she is attuned to their needs leaps ahead to what is best. Her kindness builds on the kinship and trust already developed. Her leaping to what will work best ensures a smooth path, a confident journey for Ron and for Dorothy. Perhaps 'good care' is listening, being attuned, and having the courage to break 'the rules' to leap ahead to what works.

Being Authentic

Perhaps kindness shown and felt comes from a place within. The way a person 'is' seems to be at the heart of the way their 'good care' is 'felt'. A person's words, intents, beliefs and values, stance, touch, physical presence, and actions are the components of comportment (Benner et al., 2008). Comportment is usually described in relation to a professional role; however, these attributes may be present regardless of the role a person holds. Margaret, the food service assistant, is employed to take meal orders, transport the food trolley from the kitchen, give out the meals, and to do regular refreshment rounds of the ward giving out cups of tea, coffee or water. Previously Margaret had worked in retail. She describes her interaction over a cup of tea with Jenny, a patient.

There was a lady who I went to get a cup of tea for and pulled back [the curtain] and she was just sobbing on the end of the bed and I just thought, you can't shut the curtain, because they need someone right there and then. I know I'm not medical but I just sat beside her and said are you okay love? And she said oh, she was panicking about going home, about the way she was feeling. And I just got her hand and I said to her, you know we have to take baby steps, just day by day, little bit by little bit. I said 'just like a surgeon he can't be a doctor tomorrow, he does all the work, all the years of study and then he's a surgeon. It's the same with you'. I said 'you have to get yourself right first so

when you're right here, then you go home, and it's just little baby steps. I said 'if you look at the big picture like you are, it just looks too big'. She said 'I know, I know'. So we had a chat, and then that afternoon she was sitting up, like this. When she left, she came and said 'thank you so much for what you said'. So it's very hard to be just the person who delivers a meal because often you're there, when the nurse can't be because they are so rushed, I just got that feeling that, that person really needs someone now. And I just feel, if that was me, I would really like someone at that point, to just sit with me, someone who cares. I'm kind of the neutral person. (Margaret)

Margaret talks about her feelings, the way she experiences her role. On the surface her role looks to be very transactional: take the meal order, deliver the food, take the drink order, deliver the drink. Looking more closely there is far more going on. Margaret brings her whole self to the ward, when she sees someone in distress she feels compelled to act. When faced with any situation there is always a choice—to act or not to act. Margaret is aware of the choice, she knows that she could quietly close the curtain and walk away. She has busy work to do after all, a whole ward to deliver food and drinks. While she is aware that she has a choice, she would not dream of walking away. Her values and belief that everyone deserves support from someone who cares are fully on display. Her actions are not about solving a problem, she recognises that to just 'be there' is important. She seems to know that sitting, listening, holding a hand, being present is a precious gift. As she sits quietly and listens, her humanity shines through and she offers what she can. Her words may or may not be correct, they are — step by step, little by little. Far more important is her calming presence, her feeling of care. One imagines that for the Jenny, the way Margaret talks is more important than what she says. Her calm reassuring presence, her tone, her stillness. It is easy to imagine the scene, the sobbing and the gradual calming. Margaret, on one hand, offers nothing special in terms of solutions. On the other hand, what she does offer gives

Jenny the space to calm, verbalise her fears, breathe, and consider her situation. Margaret knows that it is not really her job to sit, hold hands, calm, be present. She finds this expectation of her role difficult. She is unable to reduce herself to a functional role. Margaret's comportment, her very being requires her to do more. She is alert to her own feelings and the feelings of others. 'Good care' is the offering of what she has. Her wisdom, caring, and compassion are the things that compel her to act, to be present, to provide 'good care'.

Being Courageous

Not every patient is as grateful or accepting of help. Margaret goes on to describe her interaction with Nathan and his daughter.

I went into him all the time, 'oh, here she is'. Real disgruntled because I was coming to get the meal and he obviously wasn't feeling like eating. And his daughter would be in there and I'd read it out and she'd go 'ew yuck, ew yuck' and this went on for a week and on the Friday I said to her 'look, this place is a real blessing' and she said and the dad said, 'oh is it'? I said 'well where in the world can you come, walk in here, hopefully get fixed, you get fed, and you get your cups of tea, you get watered and you walk out of here without a half a million dollar bill'. And he went 'yeah. I suppose'. And I said to her, 'and you're not making it easy for me, when you say that every time that you're with your dad and I come in'. So after that I had no trouble with them. He just let me in and if she was there, she didn't say anything. (Margaret)

Margaret is not all about sitting and being present. Sometimes there is a line that she will not go beyond. Her interactions with Nathan and his daughter is one such time. One gets the feeling that Margaret is quite passionate about making sure patients eat and monitoring what is happening. When it comes to Nathan and his daughter she decides to push back. She may have tried all her other tricks, explaining about the contents of the menu, pleasant chatting,

projecting positivity. By Friday, after a week of being pleasant and accepting, she has had enough. She tries a different approach. There are many options open to Margaret in this situation. She could have spoken to the nurse or the charge nurse about the attitude she was being confronted with. She could have carried on for one more day; then, with her weekend break, this would become a problem for someone else. Instead she decides to handle it herself. One imagines that this is not her usual way of operating. However, she steels herself, plucks up courage, and has her say. She is not prepared to take it anymore. Even in this situation her wisdom, experience, and commitment to 'good care' is evident. She does not just 'tell them off'; she challenges them to think more deeply about what they are doing. She points them towards the 'good care' they are receiving and firmly suggests that they have their part to play. Over the week she has interacted with Nathan several times every day, and each day his daughter has been there at some point. She has observed their actions and attitudes, she feels their contempt. One imagines that her decision to act is not based solely on her own feelings of frustration and being unappreciated. Her commitment to 'good care' extends to Nathan and his daughter recognising the good care as well. In this conversation she also takes a risk, what if Nathan decides to make a complaint about her? What happens if he and his daughter react badly to her suggestions? This is, after all, an uncomfortable situation and sits well outside her official job description. Her success is as much about her personal qualities and how she delivers the message, as about the message itself. One wonders what it was that Nathan and his daughter felt in that moment. What tone did she use? What look was on her face? Where was she standing? Did she sit down? Confrontation is so much more than merely delivering a message, it is about the way the person receiving it feels. Maybe 'good care' is about the how of delivering a message, and sometimes it involves summoning your inner strength and being firm.

Manaakitanga

There are other situations when internal strength and one's personal values shine forth. Sandra, the healthcare assistant, often works in a part of the ward set aside for patients with delirium. Patients can be confused and act in unexpected ways. She tells the story of her experience looking after Bob.

I walked in yesterday and they said 'gosh he was horrible all night, he was kicking and hitting'. And I'm thinking, that can't be him. I said, 'why was he doing that'? No, they don't know. And then, because he started trying to get out of bed I went over, Paul [the nurse] said 'don't go near him Sandra', and I looked at Paul and said, 'well he wants to get out of bed'. 'Well he's already been to the toilet, don't worry about him'. I said 'no, no I will go', I ignored him, I ignore nurses when they say that. So I went and got him up and, held his hand, 'do you want to go to the toilet Bob'? 'Yes'. So away we went. And Paul shrugs his shoulders to the other nurse. What's she done? To me it's how they treat them during the afternoon and the night. If you treat patients good, they will be good for you. That's what I believe. Because they said you know 'we've had to have the doctor come up' and he said 'we'll give him a pill and he wouldn't take his medication'. He had a shower, waited for breakfast and breakfast came along. And the nurse put his pill down there, wanted him to take it, he wouldn't. And I was actually getting the other patients all dressed, all ready to have their meal. And she called out to me and I went over and I said 'what's the matter'? And she said 'he won't take his medication'. I said, 'oh well just leave it here, I will fix it'. So I whispered to him, I said 'Bob this medication is to help you, because you got Alzheimer's and you know what it's like, because your body goes all stiff'. And he goes 'yes'. 'So, are you going to take your medication for me Bob'? 'Yes'. Gave it to him, gave him the water with a straw, he drank it. That's all it is you know. You just have to have patience. It's interacting and talking, not down to them, you've got to talk on the same level. (Sandra)

Sandra is occupied with caring for the patients in the delirium room. One can feel her sensitivity towards Bob and his needs in the moment. She has strong views on the sanctity of the individual. Although in the official hierarchy of the ward she is not in charge, she has her own set of values. Sandra seems to worry about the welfare of the patients she cares for. Not in a, 'I am worried about them' way but more a care-as-worry way. This is similar to how a parent worries and is watchful of a child. Such worry leads to attentiveness. Sandra holds a concern for the well-being of the patients in her care. 'Good care' for Sandra seems to appear from a genuine sense of care-as-worry. According to Van Manen (2002a), when this motivation is present one cannot help but be pre-occupied with the other person's welfare. The kind of 'good care' that Sandra has as a base for her actions results in a caring encounter that is a human response to the patient who needs her care. Sandra seems to have built up a picture of what 'good care' is over time. Maybe she has found that the more she cares for others, the more she worries, the stronger her pull is to care. Sandra seems to move towards caring as a first instinct. Levinas describes the encounter with the other, when we look at the face of the other who is vulnerable, there is a command to responsibility (Van Manen, 2002a). We feel a caring responsibility even before making a commitment. This seems to be the way Sandra gives 'good care'. She sees the face of the other and moves towards it. She seems to strongly sense the vulnerability of the patient and cannot ignore it. She is drawn towards care automatically or, as Levinas says, "the presence of the other touches me" (Van Manen, 2002a, p. 276). Sandra seems very attuned and sensitive to the 'touch of the other'; she recognises when something is demanded of her and responds instinctively.

Sandra seems to have a deep respect for the humanity of the patients in her care that seems to give her a quiet, unassuming sense of confidence in her ability to know how to help these sometimes challenging patients. ‘Good care’ is given from a sense of deep seated calm and caring for the individuals. Her core way of being seems to call forward a kind of internal quality that projects itself into the room and alongside the patients she cares for. ‘Good care’ given by Sandra seems to be based on a sense of deep-seated respect for people which is difficult to define. Perhaps the concept of manaakitanga may provide a way to understand the ‘good care’ that Sandra’s patients experience. Manaakitanga is often translated as hospitality or to be hospitable; however, it has a broader meaning.

Manaakitanga derives from two words “mana” and “aki”. Mana is a condition that essentially holds every phenomenon in the highest regard. Aki means to uphold or support. By extending Manaakitanga, one is essentially holding up another in high regards, and to do so requires actions and attitudes that bestow upon them qualities like respect, humility, kindness and honesty. (Tupara, 2012, p. 48)

Sandra seems to have a deep regard for the patients for whom she cares. She is not concerned with their behaviour as such but seems to see more deeply their status of being-in-the-world. ‘Good care’ for Sandra seems to be about accepting people as they are, recognising the mana of each individual and doing what she can to ‘lift them up’. This commitment to manaakitanga seems to be part of Sandra’s very being, it is difficult to imagine her outside of this. The care she has for patients in her care seems to be a part of who she is. Her care seems to spring from her very being.

Conclusion

These experiences of ‘good care’ seem to be linked together by a common feeling. ‘Good care’ is felt. It is sometimes hard to capture in words, but participants readily told their

remembered stories. The attributes they experience are named as kindness, listening, and leading. At other times, the experience of 'good care' seems to come from the very essence of the person, something that is there but not explicitly named. Humanity shines through. 'Good care' is often experienced when the participants are just 'being' themselves. The intangibles that emerge from the stories seem to share a common sense of concern, connectedness, a respect and deep acknowledgement of the 'other'.

Heidegger teaches that there is always a choice to turn towards or to turn away from a need (Heidegger, 2008). Within these stories of 'good care', to look away from a need once noticed goes against the very being of these people who work in medical/surgical wards. It is almost a sense of 'call' that seems to lie beneath their presence with others. Freire (1970) described a kind of 'love' for fellow human beings:

As individuals or as peoples, by fighting for the restoration of [our] humanity [we] will be attempting the restoration of true generosity. And this fight, because of the purpose given it, will actually constitute an act of love. (p. 22)

It seems that the generosity of spirit referred to may give some insight into the very being of the experience of 'good care'. A deep-seated love for humanity seems to emanate from the participants, calling them towards a spontaneous way of being-with others that is neither forced nor put on. It is merely who they are.

Chapter Six: Being Me in the Moment

*O chestnut tree, great rooted blossomer,
Are you the leaf, the blossom or the bole?
O body swayed to music, O brightening glance,
How can we know the dancer from the dance?*

'Among School Children' (Yeats, 1935)

In the previous chapter I presented stories that highlighted the centrality of a person's 'being' to the provision of 'good care'. The concept of 'who' the person is comes through strongly, their values, their inner person, their attunement to patients in their care. In the opening lines of the poem above, we are asked how we can know "the dancer from the dance"? The following stories explore the essence of 'good care' more deeply. They focus perhaps more closely on the dance, in order to unpack the nuances of the dancer and the dance.

According to Heidegger, the past goes ahead of us, we are past, present, and future. When we are in the world, we are always doing something about it, maybe backing away, maybe indifferent but always attuned to being in the world that calls us. The to-and-fro-ness is what defines us (Heidegger, 2008). Put another way, we take up some possibilities and not others; these choices form our present and our future (Dall'Alba, 2009). This chapter seeks to illuminate the idea of possibilities that are 'chosen'.

Noticing

When caring for patients, in any capacity, there seems to be noticing. When we walk into a room, we notice things. Our past and the present shape the things that we notice, and the things that we do not notice. Some things will leap to our attention and some will fade into the background. We may notice a look, a mood, a posture, a pallor, a jug out of place,

something dropped on the floor. Who we are in the world influences what it is that grabs our attention. Other aspects go unnoticed or are seen subconsciously but not focused on specifically. We 'know' that for this moment that unnoticed thing is not to the fore or significant for this moment. Everything that has happened in our past is brought to this moment of noticing, our home life and our work life, things we have been taught deliberately such as during our professional training, things that we have learned as we experience life. Each person has a unique past and set of experiences that bring us to this moment of noticing when we walk into a room. What we notice more prominently are the things we have learned are important through our life thus far. Similarly, the things we do not notice, or choose to ignore, are also the result of what we bring to that moment.

For practitioners providing 'good care', the ability to notice a mood, to enable an action that will impact, is to take in an overall picture of a person. It is to hold many possibilities in our head as we seek to gauge the mood of the other person. We look for small clues, tension, where the eyes are looking, the facial expression, the tilt of a head, the willingness of the person to have eye contact, the covering of a sheet, the slump of the shoulders. There are many ways to judge a mood; our skill is built up over time, a collection of past experiences, always learning new feelings and ways of responding in the moment as we go.

When noticing occurs, there is then the possibility of responding to what has been noticed. Heidegger's (2008) "concept of 'facticity' "implies that an entity 'within-the-world' has Being-in-the world in such a way that it can understand itself as bound up in its 'destiny' with the Being of those entities which it encounters within its own world" (p. 82). Some people seem more sensitive to the meanings of moods than others.

Attunement

Jenny, a registered nurse, introduces us to Mrs D, a patient with a newly formed stoma who had transferred from the ICU several days early and was recovering from complications following her surgery.

Mrs D hadn't looked at her stoma and it was quite an ugly looking stoma, so to speak. The afternoon nurses handed over that she wasn't really that keen to participate in the care, that she was just a little bit put off by it. (Jenny)

When Jenny came on the night shift, she took over the care of Mrs D. She went to see Mrs D and had a conversation with her about the stoma. This was not just any conversation, for Jenny this was an opportunity to read her mood, to see where she was, to judge how to respond to the information passed on by the afternoon nurses.

So I said to her, 'oh you know I'm going to empty your stoma now', we often find that with women, it takes them longer to get their head around things but once they have, from a practical point of view they're often better with their hands because we do more fine motor skills as women than men often do. So I had a chat to her, about the way that the stoma looked and I said to her, that, whilst it was large and quite protrusive that would make it a lot easier to manage and personally, I would rather have a large protrusive stoma that is going to have a bag that adheres really well, than a small flat one that is more prone to leaking. (Jenny)

Jenny seems to understand the underlying issues around acceptance of a stoma. She is attuned to Mrs D's struggle to accept and manage her new stoma. Jenny takes a gentle but pragmatic approach discussing the stoma in a matter of fact, everyday kind of way. She offers practical advice to coach and encourage Mrs D to move along with her healing journey. Though this conversation is written as one dialogue, in real time it is likely there are pauses, looks, unspoken questions. Jenny senses the mood of Mrs D as she empties the stoma bag, as she

observes Mrs D's action or reaction as she does this. She senses the time to provide information from her own experience that makes the stoma seem every-day, average, not something to be afraid of or that is insurmountable. Jenny senses that Mrs D is ready to have a conversation; she is succinct about how she describes the stoma—large and obtrusive. Perhaps Mrs D has thought of it this way, perhaps she has not. All the time Jenny is talking, it seems she is also sensing where the mood is taking Mrs D, deciding whether to press on, or not.

Jenny aligns herself as a woman alongside Mrs D, by inserting the word 'we' into the conversation. This moves the conversation from being about someone out there, an unknown anonymous person, to 'us' the people in the room. The nurse and the patient, two women working on a problem together, united in finding a way forward. She talks about what she would want if she had a stoma. This is not something that most people may have thought about, but for Jenny it is natural to put herself in position of the other, to be-with (Heidegger, 2008). She talks about her own thoughts, imagining herself in the situation. Her tactful way of expressing gives an invitation for Mrs D to think about the stoma in a different way.

Dasein's facticity is such that its Being-in-the-world has always dispersed itself or even slit itself up into definite ways of Being-in. The multiplicity of these is indicated by the following examples: having to do with something, producing something, attending to something and looking after it, making use of something, giving something up and letting it go, undertaking, accomplishing, evincing, interrogating, considering, discussing, determining... All these ways of Being-in have *concern* as their kind of Being... Leaving undone, neglecting, renouncing, taking a rest – these too are ways of concern; but these are all *deficient* modes, in which the possibilities of concern are kept to a 'bare minimum'" (Heidegger, 2008, p. 83)

One can sense Jenny's concern for Mrs D. Faced with information about the stoma, Jenny observes the mood of Mrs D and feels enough concern that she undertakes to act on the information she has. She chooses to engage with Mrs D about her stoma and go beyond the mere task of emptying the stoma, to probe and discuss. This was not Jenny's first night on duty. She was able to build on her previous relationship with Mrs D to dive straight in, to go beyond surface chat, to the heart of the matter.

The feeling of concern is one thing; the decision to act by discussing a sensitive topic is another. To do that takes an ability to read or notice the subtleties of how Mrs D is, to see if she is in fact ready to even have a conversation at all, then to find a way to open the conversation, to invite Mrs D into the moment and to help. This concern and willingness to help, does not necessarily signal an ability to act in a way that is helpful. To do that takes more than recognition of the situation and the mood of Mrs D, it takes tact to find the right way to do it (Smythe et al., 2014).

Tact

Tact takes effort. It is being extra vigilant to see the subtle signs of the mood of the other. To use tact takes additional noticing, watching out for signs of response, being prepared to change course at any time with a subtle 'change in the air' (Smythe et al., 2014). How does one sense a mood to make the subtle, immediate, and swift changes of direction to ensure the response we are giving is acceptable to the other? It is in the words we use but also our own mood and subtle signals we send. A look too long, or too short, a hesitation perhaps. Tact is different from diplomacy. Tactful response is always couched in a desire for 'good' for the other (van Manen, 1995).

To respond with tact takes a ‘tentative confidence’, interpreting as one goes (Gadamer, 2004). When Jenny was working with Mrs D and her stoma, tact seems to have many faces. It appears in her confident handling of the stoma, a physical act. It is present in the eye contact and acceptance of the stoma as being everyday, ordinary, not something to be concerned about. Jenny chose the moment to dive right in, to empty the stoma and bring up the subject. She continues,

And I explained to her that some patients do name their stomas so that, if they are out and about they need to just go and deal with Fred, and sometimes it's helpful to name it after someone you really don't like. So we have a little bit of a laugh and giggle about that. So just trying to normalise it a little bit more. And so we talked about the fashions and how you can wear different clothing and tunics and those types of things and you actually, wouldn't know. (Jenny)

The idea of naming the stoma may not appeal to everyone but in this instance it is a way to inject some humour and lightness into the day; to progress onto more practical ways to manage. Jenny can see that the issue is not only one of practical ability. It is a matter of assisting Mrs D to ‘get her head around’ the huge change in terms of body image, and the enormity of getting on with a ‘normal’ life. Jenny alludes to her previous experience of caring for articulate women with stomata. This is not the first time that she has noticed the distress communicated in the non-verbal actions of ‘not looking’ or not engaging in learning how to care for a stoma. She recognises the adjustment needed and feels concern for Mrs D. Further to her concern, she feels a responsibility to help. Jenny’s concern, previous experience, internal motivation, and tact all come together. She facilitates meaningful conversation with Mrs D about the stoma and what may lie ahead. Use of the third person is far less challenging than a direct instruction.

After the discussion, Jenny talks about the other tools ‘in her pocket’ to help Mrs D. Once again, she has previous experience. She knows that seeing another person in the same situation is more helpful than the imaginary situation she has described:

Previously when I’ve had a patient like that, the lovely AB has come up as she also has a stoma and she’s got a sense of dress and no one would ever know and she’s so wonderfully humble to come forward and share those experiences with other people. And they think if you can be a professional doctor and look so well put together and have this, then maybe I can manage this in the community as well. (Jenny)

As Jenny talks with Mrs D about the stoma, she assesses, looks, wonders if now is the right time to bring someone in such as “the lovely AD”. Tact is not only about saying the right thing, sensitivity to the timing of the conversation or action is a critical factor (Smythe et al., 2014). To ask AD to come too early would not have the same effect as coming ‘at the right time’. Jenny knows that this needs to be at a time when Mrs D is ready to talk, ask questions, take in the personhood of AD.

Guidance

Sometimes to give ‘good care’ requires a deeper relationship. Walking alongside a patient over time can build a sense of connectedness, a swell of empathy and compassion. Andrew, a doctor, describes this journey of walking alongside Mary, a patient:

I remember looking after Mary. It was difficult for her because of the magnitude of the diagnosis and the sheer volume of medical teams giving her information. She had six different specialities all coming in from their own perspective. She was under my team under general medicine. She had the oncologist and the radiation therapist who had to review her case and let her know what they thought. There was the renal team then who had to look, try to explain to her glomerulonephritis from a cancer point of view which is

obviously a very rare complication and she also had the cardiologists involved because of her pericardial fusion. And then the surgeons were involved as well because they wanted to discuss future treatment for the pericardial fusion. Having one, two, three, four five, six different specialities all coming in from their own perspective was very overwhelming for her and her family. Each one was only willing to talk about their small aspect. Their stock answer for if she wanted to talk about something else that was outside their remit was to say, 'oh well cardiology will come back to that but from a renal point of view this is what I think we should be doing'. For me, it was difficult keeping a track of everyone's opinion. And I don't regret for a moment spending all that time with her and her family trying to collate all that information and explaining to them in an easy understandable way what was happening. That was probably one of my proudest moments, trying to guide her through this process. Eventually what she decided was that she didn't want any treatment. She actually stabilised for a couple of weeks and managed to go home but then was re admitted to hospital. When I heard she was in ED I went after clinic just to make sure she was being well treated. She came in with more complications unfortunately of the cancer and again went to hospice and then she passed away. Throughout the process, I think it was nice that I could be involved to help guide her through it and to also make sure that she understood what was going on, just because it was so complex. (Andrew)

The nature of health care is to divide the body into medical specialities. Mary, a woman with complex health problems, overlaid by a diagnosis of cancer, is struggling to put the puzzle of her situation together. Each expert is only prepared to discuss the issue under their speciality. Thus, she has the oncologist talking of her cancer at the same time as the surgeon is suggesting an operation. This is where Andrew stepped in. Even as a doctor, Andrew was becoming confused by the conflicting expert opinions. He recognised how important it was that she not only come to her own understanding of what was happening, but that he also find a way to help Mary understand enough to make her own decision about ongoing care.

Andrew saw himself as a guide. His role was not to tell Mary and her family what to do, but to help them find their way safely through all the possibilities. It was also to ensure they had enough time to do this in a way that enabled them to work through the issues. This action aligns well with Heidegger's (2008) notion of 'leaping ahead' which is always done to smooth the way for the other. There is a sense that Andrew admired Mary's choice to decline treatment and go home. It seems that there was a 'knowing' that the cancer would progress despite any other treatment.

When Andrew heard Mary had been readmitted, he made a point to going to see her, even though this was not his responsibility. In going 'above and beyond' as this additional checking may be described, there is a risk that this will not be welcomed. Other doctors are responsible at this stage. Andrew would be aware of the 'way things are' in hospitals, checking in on patients who are not your responsibility is not always welcomed. Andrew goes anyway, a kind of leaping in, based on his previous experience both looking after Mary and working in the hospital system. He takes the risk. One senses a bond of care. He needed to stand with Mary and her family as they faced the inevitable of what lay ahead. They had chosen this path with his guidance.

To guide is to take on responsibility that brings with it a duty of care. Care lingers. It does not switch off when the patient is discharged. It is still there when the patient returns to the hospital in a deteriorated condition. It is there in hearing the news of Mary's death. As Andrew tells this story sometime later, the care he had for Mary and her family lingers. He is proud of this care. He values the opportunity to 'help' and to somehow make a difference beyond the 'tasks' of the day. Care is at the heart of his practice.

Relationship

Sometimes, good care is the result of walking alongside a patient over a much longer period of time. One wonders if it is possible to give ‘good care’ in complex and long-term situations, without building the relationship over time. When that relationship is there, much is added to the care. When the relationship is not there, we are unaware of the possibilities continuity of relationship may have provided. The opportunities missed are unseen; but, when the opportunities are noticed, good care is the result.

Lisa, senior nurse, describes her relationship with Linda, a patient with highly complex needs whom she has cared for over a 10-year period:

She's had three significant strokes with us, she's only 47, she's got a rare genetic disorder which predisposes her to clotting. I've seen a decline in her overall health function, the continuity of my involvement in her care helps. This morning it was a medical team that didn't know her, she said 'oh it's Lisa' and that was great because I hadn't seen her for probably a year. That gave me information about her cognitive state. I knew what she was trying to say with her aphasia and she'd look to me to fill in the gaps. I stayed behind afterwards to just check, first of all she was really okay and that she understood the plan from a medical point of view. I was able to say, 'oh I notice you've changed your address', she's now living on a bus which made me think 'oh my goodness'. So, it's a mobile bus, with no handrails, no running water, so I escalated the OT [occupational therapist] to see her today. I thought actually this is an opportunity, they're going to be moving around with this bus, so I've just printed off her last few letters so that she can keep a file and she's got that continuity because potentially she'll visit other DHBs. (Lisa)

In her senior nursing role, Lisa meets with patients over and over again as they are readmitted. She journeys with them, is present when significant events happen, and builds a picture over

time of the impact of the health challenges on the person's life. Over the course of 10 years, she has come to know Linda on a deeper level. Each time Linda has a significant challenge to her health, another stroke or a complication, Lisa is there. She sees her ability to 'translate' or 'fill in the gaps' for the medical team as helpful. She seems happy to help. It is rewarding to be able to go beyond mere facts of Linda's condition. She is able to immediately 'see' problems up ahead, when she will not be there to assist. She knows about Linda's problems. They have spoken at length about them and she seems to be able to quickly move to planning ahead. This is a kind of leaping ahead while knowing that there is a lot to work through in the present. Lisa continues with her story:

She is tricky, I guess that she knows I know her, and she knows me, that helps. You know, those patients that you still think about even when she's gone. She's one, those occasional ones that just touch your heart, she's a medical miracle really. Looking back, she's had bad news broken to her and I've heard it as she's heard it. So there's an element of shock at the same time because her disorder is unpredictable, no one can say right you've got 8 months you've got 8 years. And she's not that much younger than me so I guess you look at your own mortality your own opportunities, your genetics. You think 'goodness I'm lucky'. I feel really privileged because we've had end of life conversations with her, that's how bad it's been. And then she's lived. And each time she has a stroke, it's almost like a small fire, that wasn't so bad, but then she had a really big fire in the sense of she lost all her language, her ability to walk. And then she's had a couple more strokes but I suppose incrementally in the bigger picture, one day she won't wake up and she knows that, so its huge. She has a partner, who has probably become her carer. There's definitely quite a lot of stress involved in that relationship. I guess for both of them, it's not great.
(Lisa)

Sometimes a particular patient or situation seems to resonate strongly. Lisa sees Linda, a person of a similar age to herself, as someone for whom she has a strong sense of compassion

and empathy. She reflects on the series of significant health events and accompanying ‘bad news’ events that Linda has had over time. As a senior nurse she has been there for all of them. One senses a kind of hopelessness at the insurmountable hurdles that are currently in Linda’s life and will continue to be into the future. Lisa manages to convey a sense of empathy and compassion while at the same time thinking ahead about the actions she can take to help Linda. The compassion that Lisa feels is not a ‘feeling sorry for’ type of sympathy; it seems to be something deeper. Over the 10 years Lisa has been with Linda on a number of occasions during sensitive and confronting conversations. She has felt the ups and downs as Linda’s health has fluctuated. She sees Linda as a person who has ‘touched her heart’. She brings her own self to the relationship, not removed from it but connected on a person-to-person level. Lisa seems to be fully present for conversations, watching and waiting, noticing. She has a quiet confidence about her. A depth of understanding has developed over the years that seems to enable Linda to leap ahead to what may be, in order to ‘see’ what will help. She holds many complex aspects together, the health issues, the living conditions, the relationship complexities. Her ability to see a bigger picture, while at the same time keeping an awareness of her own role, seems to allow her to immerse herself into the situation without being overwhelmed by it. It is her humanity that shines through, being who she is, with all the skills and insight that she has built up over the years. ‘Good care’ is often complex, heart wrenching, lingering and all about being fully there. Compassion, trust, empathy, and a sense of holding it all together are present. Compassionate, tactful action can seem so automatic that the wise thinking behind it is missed—this is where phronesis is important.

Phronesis/Practical Wisdom

Sometimes patients and their whānau do not appear appreciative of the care being provided. Some come to the experience without an underlying trust or expectation that care will be ‘good’. They do not expect that staff will have their best interests at heart or that professionals are experts and have special knowledge about their health. They may not find the system or the staff trustworthy. They may feel suspicious of the system or the staff, or perhaps they do not trust that what they are told or observe is true. Sam, the occupational therapist, describes Felicity whose mother has motor neurone disease (MND), a serious, debilitating, progressive disease.

At the moment we've got a client whose daughter is assertive to the point of aggressive, yells at people, from a challenging background. And life lessons are, the best form of defence is to attack. Her mum has got MND and is actively dying. So, trying to remind staff who can quickly get off the phone and go "that lady is so rude and so demanding" and say, if I had MND I could probably be quite demanding as well, we need to remember this lady is watching her mother demise. Absolutely she's angry and we need to remember that and she's only trying to advocate for her mum, with the skill-set that she's got. We see diagnoses like MND way too often. And you just get a bit blasé about it. I don't think we get it, we just see so many people come through and we just forget, but when it's one of our own staff, everyone goes isn't it sad, isn't it terrible? Well it's no more sad for our staff then it is for everybody that's come through, you kind of go hang on a minute! (Sam)

Sam tells the story of interactions with Felicity with passion and feeling. The conversation he overhears and the attitude he perceives strike a nerve. He is sensitive and alert to the underlying feelings that may be behind Felicity's approach. One gets the feeling that he has been here before. He is prepared to excuse her attitude and behaviour when he puts it into the context of her background. He considers her health literacy and the grief process he

imagines she is going through. Sam seems to leap ahead of her. He seems to be laying a foundation for a more understanding and welcoming reception for Felicity. He imagines himself in the position of Felicity, an unskilled communicator with genuine needs. It is as if he is preparing his colleagues for their next interaction with Felicity. He seems to be drawing on their humanity to tease out their attitudes, to hold up a mirror. The aim is to enable his colleagues to understand her situation. His invitation is to put themselves in Felicity's position. It is an invitation to connect with her feelings, to understand what they would hope for in her position. His leaping ahead and challenging staff attitudes is to prepare a more caring response next time she is encountered. 'Good care' is listening, looking for the undertone, understanding, and caring. One wonders how he feels in this situation. It seems uncomfortable. Sam seems able to step back from the abusive interactions with Felicity, to place them to the side and focus on Felicity's needs. He draws a distinction between the attitudes of staff when a patient with MND is someone they do not know, and their attitudes when the patient is 'one of their own'. Sam attempts to 'see' this patient and her family as 'one of his own'. He puts himself in their position and attempts to help his colleagues do the same. Sam is not content just to have his own attitudes and behaviour adjusted in this way. He uses his influence in the team to remind others to 'see' this family in a different way, as 'one of their own'. One wonders what experience he may have had to inform and reinforce his commitment to this viewpoint. Caring in this situation is 'putting oneself in another's shoes', to understand attitudes and behaviours that may present as aggressive and angry. Responses are softened by his understanding, his humanity, and guided by his philosophy of practice.

Sam seems to locate himself in a realm of seeking the good from a complex and challenging situation. This state of being lends itself to the concept of phronesis, a “state of grasping the truth, involving reason, concerned with action about what is good or bad for a human being” (Irwin, 1999, p. 154). One cannot possess phronesis without character virtues that point toward the ultimate good (Kristjánsson, 2015). It is the ability to weigh up competing virtues, courses, or action and emotions. To simultaneously take in to account ultimate good and unconditional ends, and focus on character traits that make up a virtuous person.

The idea of phronesis can be expanded to include a range of concepts such as being open-minded, curious, perceptive, and continuously re-examining ourselves and our actions (Jenkins et al., 2018). One gets the feeling that Sam has spent quite some time examining his own attitudes and actions. He has thought deeply about what really matters. His underlying concern for others shines through. For Sam, thinking through the experience of the ‘other’ is an essential component of ‘good care’ and something over which he is prepared to challenge his colleagues. For him, ‘good care’ is serious business.

Reflecting

Sam goes on to describe a personal story from his past.

When my mum went into care with dementia I got quite frustrated. People were talking about: this is what happens in this rest home, this is what the rules are, this is how we do this, this is how we do that. And very few people actually sat down and wanted to really get mum and dad’s story, what had taken them in there. So, every time dad would try and explain he would quickly get talked over with, well this is what happens here and this is what we do. And I was going, there’s 60 years of marriage here that you guys need to have a little bit of a closer ear to. And then they did the classic, we want Eileen’s storybook so that people can flick through that, and asked dad to put together her

storybook. But that wasn't really telling a story, he wanted to just be able to talk. Tell the story, where they'd come from, what they'd been, what her likes were, what her dislikes were, who she was as a younger woman. I was thinking, you just need to listen. (Sam)

Aside from his training and many years' experience as an occupational therapist, Sam recognises that events that have happened personally influence the way he offers care. He gives this one example, but one senses that he assimilates and takes forward events that happen to and around him. He is reflective. Sam ponders the meaning behind outward expressions. He applies wisdom gained from practice and from life. The stories Sam tells centre on the way it feels to give and to receive 'good care'. The experience that he observed, and no doubt was part of, when his dad was not listened to springs to mind when he is asked about 'good care'. He knows what it feels like when 'good care' is present, or not. He is clear on what should be done (listening), what the response should be (understanding) but the passion with which he tells the story indicates something deeper. Sam describes here his first-hand experience. One can imagine what it feels like when 'good care' is not on offer. Sam names the feeling as 'frustration'. He reveals his deep-seated feelings from his own experience. In the moment he re-lives his closeness and care for his dad, how hard it was to try to explain to the staff, and his care for his mother with the dementia. This knowing, born out of his experience, comes with him into his practice. Sam has developed a strong commitment to listen, to reflect, to act or not, in a way that adds to 'good care'. One can sense his desire to hear others, to put himself in their shoes, to be attuned to their feelings, and to influence and lead the provision of 'good care'. Heidegger (2008) asserted that our past always goes ahead of us, "in its factual Being, any Dasein is as it already was and is it 'what' it already was. It *is* its past" (p. 41). We can see that Sam's past experience, also goes

ahead of him to influence the future, or as Heidegger puts it, our past “is not something that *follows along after* Dasein, but something that already goes ahead of it” (p. 41).

Being a Tool

Sam’s commitment to listen and reflect can be seen in his description of another patient interaction. His commitment to this is not a long winded, feel good approach. He has a pragmatic side.

I think good care is about not getting caught up in the detail of people’s clinical presentation if it doesn’t matter to them and if it’s not going to transfer into the community. On the referral it says things like ‘doesn’t take insulin’, ‘doesn’t like needles’, ‘has some alternate beliefs around Māori health medicines’, ‘is a self-proclaimed drinker’, ‘doesn’t really believe that medicines really do a lot anyway’. Well there’s not much point in me going in and talking lots about the concerns of her blood pressure and how to manage blood pressure because she doesn’t buy that. So [I ask], what concerns have you got about how you’re managing at home? So then she went off down the tangent of her house being cold, despite the fact that her left upper limb doesn’t work very well at all. Housing New Zealand are poor landlords and they need to do it better, which is cool, that’s fine. ‘If you went back to home now how do you think you’d manage’? And ‘what have you done with Housing New Zealand to approach that’? She’s not a great historian but acknowledging that that’s important to her and that needs to be sorted at some point. But right here and now how are you managing with your upper limb function and bringing you back to the current problem but not dismissing the thing that keeps coming back to her as the concern. And equally, getting a picture of who’s in front of us more than just diagnosis. What makes this person tick, but equally we only often have three or four days of admission, so I’ve got the picture that might help me relate to them, but we still need to do A and B, because the rest is just kind of scene setting stuff. (Sam)

Sam is clear that his focus is on the things that are important to the patient and to working on whatever is going to transfer into their daily life. He is not interested in trying to change entrenched behaviours and is aware of the short timeframe that is available to him and to the patient to achieve meaningful results. When he gets a referral to see Trina, he leaps ahead to realise that trying to change too much is not going to work for her. You can hear in his description of this interaction that he understands quickly that Trina has a belief in Māori medicine and has no time for western medical methods. Sam's way of working is all about doing what is transferable, that will help Trina function when she gets home. While this is his focus, he understands that he is not likely to make progress without first getting to know her. He seems to be able to get to the heart of the matter quickly. He knows what to ask and when to push. He seems able to move past the factual information to what is important.

Sam starts the conversation as he usually would by asking what is worrying Trina the most about going home. It turns out that her main concern is heating in her house. Sam alludes to his feeling of surprise about this, when one would assume she would be concerned that her upper arm is not functioning. Sam listens to her concerns and briefly focuses on them. They are not dismissed. He also has in the back of his mind his goal of helping her to be able to function as independently as possible when she gets home. You get the feeling that he will ensure that the heating gets sorted but does not linger on that topic as he knows that taking more time to talk about it will not make a change to the heating. Focusing on the arm function and the activities of daily living has potential to make some real difference when she returns home. Sam seems to be able to weed out the things that are not going to help Trina. He makes a judgement about what he can help with and what he cannot. In leaping ahead to what he can do to help, he does not neglect the present.

His initial focus is on getting to know Trina, gaining understanding of her as a person. His approach is empathetic, with an undertone of acceptance of what 'is'. He seems to know not to go into changing her belief about the medical model. He accepts who she is and looks for the opening to help. Only then can he formulate an end goal. Perhaps Sam sees himself as a tool. There are some things he can use himself as 'a tool of improving arm function', perhaps as 'a tool for referring her on to a social worker for dealing with the heating issue'. The hermeneutic 'as' means we always see things 'as' being to something specific, but maybe we also see ourselves in the same way (Bradshaw, 2014). Perhaps this is where phronesis also appears. For Sam, 'good care' is accepting a person for who they are and choosing the next steps wisely and carefully. Sometimes this is to directly treat, sometimes it is to point the way to others. The wisdom to know which way to act in the best interests of the patients. Sam grasps the truth of the situation, reasons his way through it, and takes the course of action that is best for the patient. This is phronesis and for Sam the result is 'good care'.

Working as a Collective

Sometimes situations are complex and the way to 'good care' is not obvious, it may even be uncomfortable. Andrew, a doctor, describes the care provided for a very complex patient that challenges the whole team.

The trickiest patient I've had this week and she's been a tricky patient for the last few weeks, is a young girl with anorexia nervosa and she's had anorexia for a few years. She's been in hospital now for probably six weeks, initially under the psychiatrist on [the mental health ward] then up to general medicine and then back for I think two weeks and then back down to psychiatry for three weeks and then most recently is currently under general medicine again. And has been exceedingly tricky because for the full six weeks she had an

unwillingness to engage in treatment. Especially from a mental health side of things. And this week, over the weekend, she stopped engaging with physical treatment as well. She had been allowing NG feeding and IV fluids, but over the weekend she deteriorated and she pulled her NG tube out and refused to engage any further with any medical treatment. It's been particularly difficult given that we are lacking in eating disorders specialists here, and our nearest inpatient unit only takes informal admissions and of course with her being unwilling to engage, she doesn't fulfil criteria. And every day it's been difficult, to try and engage her from a medical perspective let alone a psychiatric perspective. I would like to think that I've had her best interests at heart, trying to talk to her without any jargon, and trying to appreciate things from her point of view. I guess the real big issue is that mismatch of what we think is best for her and what she wants. And, I think the psychiatry team have been very good at being present, on a medical ward when they've got other commitments as well, in trying to help us come up with a satisfactory solution for this lady. And the charge nurse from the mental health ward, this week has been very, very good at liaising with us and liaising with the patient as well as with her psychiatric team down in the ward to try and move forward with her treatment, because before the psychiatric team became more heavily involved, we were a bit stagnant with her treatment. I think that the best thing about her care is has been our attempted multidisciplinary approach and not one member of the team (general medical team, the dietician team and mental health team), has tried to throw our weight around with regards to what we think is best for her. We've had three complex case meetings this week to try and work out as a team what would be best for her, in what is a very challenging case. And that's probably been the best aspect of her care, rather than general medicine for example throwing their weight around saying we're not doing anything medically she should go, we're going to forward her back down to mental health or the psychiatrist saying she won't engage, we're not willing to do anything and therefore she is general medicine's. Although it's been unsatisfactory for, I think, the majority of us given the situation and that's probably the best of a bad situation unfortunately. (Andrew)

The work of the medical team is to ‘treat’ and to ‘cure’. This story illuminates the dilemma when what is considered ‘best’ for a patient, clashes with the wishes of the patient. The desire of Alison, the patient, to stop treatment by refusing all food and fluids confronts the treating teams on a number of levels. There is a sense that everyone is uncomfortable with the decision given the patient’s age and stage, and the very serious effects on her physical health of complying with her refusal of treatment. There is a struggle between respecting the wishes of the individual and the desire to ‘do something’ that will enable longer term life. Perhaps a feeling that she needs more time to make what could be seen as ‘good’ decisions for herself. Although the various treating teams, medical doctors, psychiatrists, dieticians, and nursing staff have tried their best to collaborate, and this is seen as a good thing, the effort is overwhelmed by the enormity of complying with the patient’s wishes for no treatment. Andrew sees his role as trying to persuade, educate, and guide Alison, and is troubled when this has not worked out to the solution that the treating teams see as best.

Andrew is left questioning his own motives around her treatment. Is his desire to treat based on her best interests, or is it based on his underlying respect for human life and desire to maximise it? There is a sense that he is involved in an internal ethical struggle about respect versus treatment. He is in a position where compulsory treatment would be possible. Although he is assisted in the decision making by his psychiatrist colleagues, the internal tension is palpable and unresolved. A plan unanimously agreed between the teams does not completely resolve the tension. The internal struggle further illustrates the concept of phronesis, an ability to weigh up competing virtues, courses of action and emotions. Phronesis assists in knowing how to act in the moral sphere. It involves the wisdom to take

a measured approach to knowing how to act and how to feel (Kristjánsson, 2015). This is evident in the way Andrew recognises that although the outcome of the plan of care is uncomfortable for all, it is “*probably the best of a bad situation*”.

‘Good care’ seems to be present when all members of the team are really committed to come together to solve this dilemma collectively. Each is contributing, playing their part, no-one is trying to make this tricky plan of care someone else’s responsibility. This collective effort is ‘good care’.

Conclusion

The underlying way of being towards a patient results in the impulse and the phronesis or practical wisdom to know when to leap in or leap ahead. The ‘decision’ about what to do, say, think, seems to be embodied at times but always based on an underlying attitude-towards a person. Much of the activity in the stories points towards teaching, coaching, wanting the best for the person. It is challenging to explain this being-towards, a kind of leaning in to the other, to consider and determine the best course of action. This determination seems to be towards a feeling of wanting the best, aiming for the best, doing whatever is needed to move in a positive direction, ultimately to ‘good care’.

Perhaps this leaning in, this underlying heart attitude that seems to enable ‘good care’ can be understood by another quote from Freire (2018): “It is impossible to teach without the courage to try a thousand times before giving up. In short, it is impossible to teach without a forged, invented, and well-thought-out capacity to love” (p. 3). It seems possible that the capacity to keep on going, even when situations are difficult or complex may be based on a basic but profound attitude towards others. Love for fellow human beings seems to combine

with the practical wisdom or phronesis to move in the direction of 'good care'. Motives are not in question. The action of 'good care' is born out of a leaning in, an attunement, a tool, perhaps a determination for good, a reflective attitude and a willingness to work collectively with others.

Chapter Seven: The Sacred Space

Te aroha
Te Whakapono
Me te rangimarie
Tātou, tātou e

Love,
Hope (or faith),
Peace,
For all of us

“Te aroha” is a Maori waiata (song) about love, hope/faith and peace (National Digital Forum, 2020).

In previous chapters, it has emerged that ‘good care’ seems to be about the essence, the very being of the person providing care. Further to ‘who’ the person is, ‘good care’ comes to the fore in ‘what’ occurs in the moment. It is an ability to read a mood, to be attuned to another. It is to show phronesis in how one reflects, feels, and responds. The nature of the experience of ‘good care’ is hard to define but readily known in experience. The waiata above is well known in Aotearoa New Zealand. It is often sung in marae (Māori meeting house) and powhiri (welcome ceremony) settings. The words point to concepts of love, hope, faith, and peace. I have included this waiata because the stories in the study seem to go further than ‘being’ and ‘doing’. There seems to be an awareness glimpsed of something more to ‘good care’ than the common practices of healthcare.

Mood/Karakia

According to Heidegger (2008), attunements “discover Dasein in its thrownness” (p. 175). An attunement makes it possible for things to “matter” to a person and can shape the possibilities of social interaction. Dasein is always already attuned; attunement is how one is pre-disposed to encounter the world. Attunements can shape the possibilities of social interaction; it is the way of our being there with another (Heidegger, 2008). Grace describes her approach to being-with patients as she goes about her work as a cleaner.

I've learned to know when to talk to people, but I always say good morning and when they say good morning and start talking to me, then I'll talk back to them and then the conversation just keeps going. When they see I'm busy, I'll keep talking to them and go around the room, and then, they either stop or I'll stop because one of the nurses, or something happens. And then the conversation just stops. And then another person will talk because once I start talking to one person then somebody else will come into the conversation from the other bed and then the other one will, then they all start talking. And then I just leave because they're all still talking. And the conversation just keeps going on to something else, and it's good leaving a room after being so quiet and no one's talking to no one! I'm just happy because I'm doing something really good for other people. It's like you give aroha away, it always comes back. And that's the same thing, I do things for people, and I get back. A lot of brightness will come into them, and I always have a prayer, I call it the karakia. I always say a prayer for people. (Grace)

Grace moves around the ward cleaning as she goes. Her role is quite clearly defined; she knows what she has to get done. However, Grace has a far broader view of her contribution to the 'good care' of the patients than mere cleanliness. She describes her joy when she manages to initiate a conversation, leave spaces for others to join, and leave a room of patients fully engaged in conversation amongst themselves. Grace is alert and attuned to the mood of the people in the room. She tentatively gives an opportunity for conversation, not being pushy or loud, just inviting. One can imagine her with her cleaner's trolley, quietly entering the room, testing the atmosphere, smiling as she goes.

Heidegger likens moods to atmospheres. They are already there; we exist *in* them. Most often we find ourselves in moods without realising it for they are not usually the focus of our attention (Elpidorou & Freeman, 2015; Heidegger, 2008). Moods, however, are important

‘in order for things in the world to matter to us’ (Elpidorou & Freeman, 2015). Grace, seems attuned to the moods of others. For her, moods are a focus. She senses moods to ‘see’ how others are in the world. This enables her to decide whether or not to interact further. The opportunity for conversation comes by her saying ‘good morning’. Then she leaves a space. She is attuned to the response and takes it in. Her senses are alert to the presence or absence of a verbal response. She listens for the tone; she sees the body language. She has a strong sense of wanting to bring “a lot of brightness” to those around her. Her joy shines through as she describes being able to leave a room that she entered with no-one talking and ending with everyone talking to each other. Being the centre of attention is not her aim. One wonders if the patients even notice her departure.

Grace does not achieve this for every room. There are patients who do not want to talk, and she is quick to ‘hear’ that. But when she discovers an individual patient or a group of patients who welcome conversation with her, she feels proud and happy. She describes giving aroha (love) away and getting it back. Grace mentions saying a karakia (Māori term for prayer). This is not a verbal utterance; rather, it is her internal conversation with God. She keeps her mind on helping, bringing joy, praying, anything to be-with and bring brightness. ‘Good care’ is seen in Grace’s approach to being-with the patients as she goes about her daily tasks. ‘Good care’ is giving aroha (love), bringing brightness, inviting interaction. Grace goes on to describe other ways that she supports ‘good care’ in the ward.

Me and Sandra, we usually come after someone’s passed and we actually do a blessing in the room. Sandra will always come to get me and I come with her and we have a blessing and we bless the room. For me it’s important. I’ve always done it in Māori and the pastor did an English version. So there’s a blessing for the room, and there’s ‘Our Father who art in heaven’. Most days I’m praying nearly all day! Because that’s the type of person I’ve been brought

up to be, thankful, always give thanks, and just give a smile to anyone that's around you. There are times you've got to know when to say things and know when not to say things. You've got to be witty about yourself and you've got to be able to read people. (Grace)

Grace continues to describe the things that are important to her. Along with the value she places on interaction with patients, she has a strong belief about what needs to happen after death. Heideggerian phenomenology assumes that we are already and always engaged in our world, interpreting, coping with practicalities, and caring about matters (Dreyfus, 1991). Being-in-the-world is revealed in various ways of Being-in; however, central to them all is 'concern' (Heidegger, 2008). Another way to describe this is the idea of being 'concernfully involved' in the world (Wilson, 2014). One could assume that Grace would be concerned for the world of her work as a cleaner. Here she talks about her concern for other parts of the world that are influenced by her culture and background which she brings into the present. She identifies that she is concerned with spiritual cleansing and blessing of rooms after a death. One assumes that there are others, perhaps nurses or chaplains, who are also concerned about this.

However, Grace, along with Sandra, the care assistant, has noticed that blessing of the room does not always occur. They have decided to ensure that blessing of rooms, the act of *karakia* (prayer/blessing) and prayer, always follow the passing of a patient. A system is in place. They each keep a look out and inform the other when a death has occurred. One imagines that they quietly and unobtrusively enter the room when the deceased person has gone. They quietly stand together for *karakia* and prayer. This act is not a secret kept from the rest of the ward, neither is it assigned to them as a role. It merely 'is'. When Grace talks about her work in the ward, she hardly refers to cleaning as an activity. This is so everyday and average

she does not think to mention it. Grace talks about ‘good care’ in terms of being attuned to the needs of the patients, her act of noticing, talking, inviting conversation, responding, and disappearing. She is content to initiate then leave the scene to play out. Likewise, her actions to ensure rooms are blessed following a death are carried out in an unobtrusive way. For Grace, ‘good care’ seems to be about facilitating and tidying up around the edges. She has no need for recognition. Her concern is called forth with issues such as blessings that are important to her in a deep and meaningful way. There is a sense that she is honouring her God in this humble and unobtrusive way.

A Deeper Knowing

The occurrence of a death on a ward carries with it possibilities for making deep connections. It can be a time when a focus on spirituality, belief systems, and thoughts of eternity come into focus. Heidegger wrote that ‘in every case’ Dasein exists for the sake of itself. ‘As long as it is’, right to the end, it comports itself towards its potentiality-for-Being. Even when it still exists but has nothing more ‘before it’ and has ‘settled its account’, its Being is still determined by the ‘ahead-of-itself’ (Heidegger, 2008). This lack of totality could be described as unfinished business that is never really finished until death. Somehow there is a feeling of something more to come, a whisper of an inner world that is fleetingly mentioned. It is an experience that is not necessarily in a formal religious sense, but a feeling of deep meaning for people. Maybe being able to sense the moment and respond to it is a component of ‘good care’. Jackie describes one such experience on a night shift.

There is one lady that passed away on my shift and, she wasn't with us long but what I did in that time, I feel I did everything I could for her and the family. And again this was a humungous whānau that came in, she was a very special lady. Her tangi was actually on the news and being Māori, when you look after Māori patients sometimes it's not that easy. Sometimes, I get the impression

they might be looking at me like I think I'm better than them, so it can be quite difficult to not be that person and just be me. I feel like I did it really well and it was a challenge because there were so many people, there were like 50. I just said, 'who am I talking to?' And it was the daughter and son, so two people. I knew it was really important to figure out who I'm talking to straight away. I involved them in her cares as much as they wanted to be, which they did want to be. I didn't realise, what a big lady she was. This 100 year old lady she's done amazing things, a very important lady and it was such an honour to look after her, do what I could for them. They had specific things they asked for. They didn't want me touching her body after she passed, they said that she had brought them up, taught them the old ways and no-one to touch her body apart from the family, just respecting those wishes, not doing the normal - better get the doctor up here. I felt like I did really well. I got the children paper and pens and got them sorted in the lounge, there were a lot of babies and kids, so I got them settled with colouring in stuff. It was an overwhelming time and it was a night shift, but I really felt like I was meant to be that person, because that night I got sent to another ward and then I got sent back and it was all a bit of a carry on. And then this lady came in and I was looking after her and I just feel like I was meant to be looking after her. (Jackie)

No-one loves a night shift and the added complication of being sent away to another ward makes it all seem harder. Jackie came on for her night shift, only to be sent away to help in another ward, then, after a period of time, was sent back to her ward. She described it as 'a bit of a carry on'. By the time she got back, a new patient was coming in. The patient was an elderly Māori woman, accompanied by 50 whānau (family). Jackie describes it as an overwhelming time. The ward where Jackie works is not set up for 50 whānau to be there; yet, Jackie 'knows' that it is important that all are there. She has experienced being a Māori nurse looking after a Māori patient in the past. Jackie immediately finds out who the right person in is to talk to in the whānau. She remembers the feeling when an undertone or emotion towards her is present, she has found this difficult in the past.

Jackie seems to ‘know’ that this is a spiritual family with values that are tightly held. When the whānau tell her they have been brought up in ‘the old ways’, she knows what that mean. One imagines that she is respectful and quiet, while all the time making a connection, keeping the whānau involved. She manages to produce ‘colouring-in’ for the children, getting paper and all the pens she can find. She seems to leap ahead to find a way to keep the children occupied, to maintain a sense of quiet and calm. She is alert to any clues about what is expected of her. Everything that is needed is responded to by her. She ‘knows’ that ‘doing the usual’ is not going to be the right thing. Long held beliefs about death and dying are at play. This is a sacred moment. As Jackie reflects on the night, she comments that she was ‘meant to be’ the one caring for this lady; her description has a spiritual feel to it. It is only later that Jackie finds out what an important person this woman is. She feels honoured to have cared for her. She is able to look back on the night and know that she did everything she could. She has a feeling of accomplishment; she has provided ‘good care’. Spirituality goes beyond religious affiliation. It conveys a sense of awe, reverence, meaning, and purpose.

The Sacred Space

Robyn, a chaplain describes her interaction with Rob, a patient, in a different way.

I happened to walk past a room and I caught his eye and I said ‘oh giddy’ and he said ‘giddy who are you?’ And I said ‘oh, I’m one of the chaplains’. ‘Chaplains’ he said. ‘What do I need one of them for?’ I said ‘oh you probably don’t.’ And so I’m still leaning on the door and he looked kind of interested and I said, ‘so what brings you here?’ And he said, ‘oh I’ve got cancer’. I said ‘oh, so what’s that like?’ And he looked at me, so I said ‘well can I come in and sit down’ and he said ‘oh yeah’. So I said, ‘what do you do when you’re

not here, taking up a bed like?’ And he laughed, because I could see that he was a guy who worked the land, he was a musterer and so he worked the high country with his dogs. I visited him probably every two days and mostly we talked about dogs and the importance of dogs in a person’s life. But eventually after conversations with the dogs, we got to what he did at the end of a day, and he went down to the stream that ran down below his house and he sat with his dog. What would he be doing that for? Because he got a sense of peace there. And we started to talk about the sense of disruption in his life from having cancer and what that meant to him. He eventually left hospital and would ring me every time he came back for treatment to see if he could catch up and talk. Well, people’s stories are about what’s right with them, even if there are problems within that. And by letting their story come out into that space, there is a healing around that because you’re treating it as important and you’re valuing that person and their story, and you’re letting them hold it, deal with it, you can ask questions about it, you can notice things about it, you can laugh with them, you can cry with them about it, but I see that as an individual’s sacred text. (Robyn)

Robyn begins her story with “*I happened to walk past a room and I caught his eye*”. It seems that any decision, such as which ward to visit, which direction to walk has the potential to make something ‘happen’. Catching his eye, led to a discussion that continued over time and eventually landed on exploring ‘finding peace’. Robyn describes a person’s story as their ‘sacred text’. Her approach is to ‘allow space’. The initial chatting about a common interest such as dogs, paved the way to a feeling of safety to share feelings more deeply. This was not immediate. Being able to examine deeply held feelings takes a relationship. Over a period of days, a place opened up where telling of inner feelings was possible. For Rob, the patient, this may or may not have been a new experience. He seemed to feel cared for enough to take a risk, to share his inner thoughts. Robyn aimed to ‘value’ the story and see it as important. Rob seemed to feel that, which led to a deeper discussion.

Robyn names the importance of people's stories. The progression to a deeper story seems to be an important element of the development of 'good care'. The offer to sit and to listen, to take time, to hear, seems to blur the distinction between outsider and insider. It enables a kind of one-ness to develop. This kind of conversation can feel vulnerable, but when it happens, the counterintuitive can happen. The one giving (listening, sitting, hearing) can unexpectedly gain from the exchange, becoming honoured and enhanced (Reynolds, 2010). Perhaps the 'love of one's neighbour', a concept at the core of many world religions is felt in the developing dialogue, where the 'stranger' becomes 'neighbour'. To be invited to share the 'sacred text' of another seems to be a privileged experience; perhaps that is what 'good care' feels like for each participant.

Openness

Others may have a different approach to spirituality. Margaret, the food service assistant, tells of an experience.

There was one gentleman in particular, we got on really well. He was doing really good, and then I came into the room and he was holding on to the bed, he was sweating, he was wet, absolutely different to how I left him the day before. And I went up to him and I said, 'are you okay?' He said, 'they've told me that I haven't got long to live', and I got quite a shock because he'd been doing so well. At that point I thought what do I do? Because I can't say 'oh no, you're going to be alright'. And I sort of put my hand on his back, he was just clinging on to the rails on the bed and the first thing I thought of was 'would you like me to pray for you?' And he said 'yes, I would.' So, I prayed with him. And, just prayed over him and just prayed with him because I thought what else can I offer him? And, he was just so worked up, so I did that for a while and I just stayed with him for a little bit, not too long. And he said 'thank you so much, thank you'. (Margaret)

Margaret's first response to seeing Mac the patient in distress was to offer to pray. This is risky: What if he is having a heart attack or some worsening of his condition? Her concern is for how he seems. She feels a sense of shock and helplessness to see him distressed. She wonders what she can do to help and offers physical reassurance and prayer. Perhaps they had conversed over the week about religious beliefs; maybe she just knew that he would appreciate prayer. Whatever it was, Margaret showed a commitment to honesty and was not willing to offer false reassurance. She felt the need to support, to care, to do something. When Mac told her of his recent news, she had choices about how to react. She could reinforce the horror of news by admitting her own shock. She instead chose to remain calm, put her hand on his back and offer prayer. One can imagine her low calm voice, her stillness as she does this. Her actions seemed to calm him, to help. Maybe 'good care' is seen when one is able to move beyond their own feelings to 'see' the right thing to do in the moment. To be able to do this, knowing oneself seems to be a key.

Insight/Self Knowledge

Knowing oneself is grounded in Being-with... it operates proximally in the world with the kind of being which is closest to us – Being-in-the-world as Being-with. Solicitous concern is understood in terms of what we are concerned with, along with our understanding of it. Thus, in concerned solicitude, the Other is proximally disclosed. (Heidegger, 2008, p. 161)

Dasein's Being is Being-with, its understanding of Being already implies an understanding of Others, not an acquaintance gained from knowledge about them. It is an existential type of knowing that makes knowledge and acquaintance possible. To authentically be-with another person, it seems necessary to know oneself and where we are in the world. A deeper understanding is able to develop when being-with another person is the focus of the

encounter. Marama describes one such conversation between Michael, the surgeon, and her mother.

For me watching them speak to mum, it was their manner about it, their opportunity that they gave mum to speak at any time, their reassurance that they gave her. The other one was that they were so determined to sit down and have a meeting within themselves, he literally sat there and picked his brain what could he do to make this situation a lot better for my mum. So he sat and he's like 'okay, so I could get the urologist, the social worker, the Māori nurses' and he got this whole little group together and literally sat there and figured out a plan for mum. Because we said to them 'mum's not leaving here without that plan. Otherwise we're going to make a plan of our own and you're just going to have to deal with it'. But he said, 'I take that on board and I will go back and think about that'. And when he did, he even went out of his way to ring and say look 'this is what we're thinking and this is what we're going to do, would you like to come in for a meeting', and I said 'yes'! Straightaway! They went out of their way to show us that she's not just a number, that was the biggest thing for me, my mum's not just a number. You do get treated like that, in hospitals. So, it was awesome. And they all sat there and listened to what mum had to say. Her feelings you know like they were asking her 'is there anyone you'd like to talk to', 'are you scared', 'is your anxiety okay'. They went out of their way to make sure she was covered all over, not just on one aspect, not just 'can I do an operation', and 'will it fix it'. That is why he said that it was better that we started planning things. And he spoke very nicely about it. Very gentle. (Marama)

Marama and her mother Ruby have had many hospital experiences in the past. This time it seems different. There is a deep feeling of being cared for, of concern from others, and of respect. Michael, the surgeon, seems to be grappling with the best treatment option for Ruby. He does not decide first and then tell Ruby what is going to happen. They have experienced this in the past, feeling 'like a number'. His approach is different. He sits and focuses on

being-with Ruby and Marama. He listens and probes, he lets them know his thoughts. They hear his musing about different options and what could happen. To Marama and Ruby, this feels like ‘good care’. They are listened to and part of the decision. For Michael, it seems important to get to ‘know’ Ruby and what is important to her. He feels his way through the conversation, moving slowly towards a decision. There is a risk with this approach. It is possible that sharing his thought processes could feel to Ruby like he is indecisive, like he does not really know what he is doing. However, Michael seems to know that the approach of ‘being-with’ is important. According to Heidegger, because being-in-the-world is essentially care (*Sorge*), ‘being-amidst the available’ could be taken as *concern*, and “being with the Dasein-with of others as we encounter it within-the-world” could be taken as *solicitude* (Heidegger, 2008, p. 237). Care lies within a person and is there before, during, and after an encounter.

Michael seems to offer ‘good care’ by being-with Ruby and Marama in the conversation. He is not ahead of them. He shows his genuine concern at the time. They seem to feel cared for through the way that Michael approaches them. He is intensely interested, making it clear to them that he will keep following up, keep involving others, keep connecting with them until the ‘right’ answer is found. ‘Good care’ seems to feel like walking alongside, being-with, and designing a path together. Ruby goes on to describe what ‘good care’ felt like for her.

They said they couldn't do the operation because if they cut me open, I could die straight away without it even going to the table. And then when they're talking to you, you'll see the tears in his eyes, he'd look at you and I'd smile at him. He gives you that reassurance like you're talking with your mate not your doctor. That's what it felt like.

And I didn't have to feel frightened, when you're told you're going to die, you get this fear of what's going to happen next. When is it going to happen? How is it going to happen? You get all those sorts of questions come into your head. And, I didn't have any of that because they were right there to tell me exactly and he even told me that if they did do the operation, this is only if they had to in an emergency, he said that I could end up in ICU and he said you could end up with brain damage, and he said you don't want that darling. And I said, 'no I don't, I'd rather go like I am now'. (Ruby)

This conversation is never an easy one to have. Ruby's recollection of the experience is all about how it felt. The way the discussion went had a feeling of being-with to her, feeling the surgeon's concern. She reflects on how she expected to feel with such terminal news, the fear of the unknown. Instead, she seems surprised by a kind of peace. She understands what could potentially happen and is not overtaken with fear. One can picture Michael sitting beside her, gently explaining her options. He explains in a way that makes the information accessible. Ruby is able to understand. His language is plain. Concern and care are evident in his eyes, and she feels settled in her desire to 'go on like she is now'. Something about his tone, his posture, his unhurried demeanour helps her to get there. 'Good care' seems to occur when there is a feeling of calm. Ruby seems able to take it all in and know what the 'right' thing is for her. To Ruby, the decision and the experience of the moment take on a sacred, special quality. She goes on to talk about the moment of realising that this current life will not be for long, she expresses a belief in the next life.

Just holding on to your hand and talking with you. Feeling what you could feel when you get told that you're in the next life. That you're not going to last and why they don't want to do surgery. (Ruby)

In this moment of realisation is found a tenderness and understanding between Michael, the surgeon, and Ruby. She feels deeply that is he also feeling with her. Michael shows concern

but seems to go beyond that to a compassion and empathy that is felt by Ruby. This seems intuitive. Having dealt with his own understandings it seems he is able to offer an attitude of being-with Ruby in the moment. It is almost as if he is holding his breath, feeling the tension as he waits to see her reaction. One anticipates that whatever her reaction, he is waiting with a compassionate, tender, and tactful response. It almost feels like a dance, moving slowly through the news, to the beginning of the next chapter of her life. A chapter that is anticipated to be short. The atmosphere he has set, paves the way for her to enter a new stage. She is going to need to make plans, work out what to do. The stage is set for a good beginning to this ending. ‘Good care’ is felt when difficult situations are attended to with care, dignity, and compassion.

The Infinite

After the initial conversation and realisation of the journey that may be ahead, Ruby talks about what would contribute to ‘good care’ for her. One senses that she is thinking deeply about what the surgeon has said. Her focus is on herself but also, she is concerned for her whānau alongside her as she goes along. She wonders aloud who could help.

When family are grieving, I believe that they need someone in there that's from a church because not everybody believes in God. But I believe that they need somebody just to talk to. It's like a relief. Not only in the Māori perspective of it but European as well, they might need someone to talk to as in, God, they might. They offered it to me and I said no, because at the time I didn't need it but then as time went on and we got into deeper things, my mind was changing all the time, this is why I'm saying that sometimes it might pay to have someone of the cloth. Doesn't matter who it is, Catholic, Church of England, whoever. But someone that they know that is pretty strong because some people are that way inclined and some aren't. And those that aren't are the ones that we usually look for. Yeah you see you need them, if you're dying. (Ruby)

Ruby mentions the needs of family when they are grieving. She sees ‘someone of the cloth’ as a good option. One can sense that Ruby has an awareness of some ‘other’, undefined but accessible. To her, talking with someone about this might help her process; she expresses this as an underlying need. Perhaps poetry may help describe this.

Who is the third who walks always beside you?
When I count, there are only you and I together
But when I look ahead up the white road
There is always another one walking beside you
Gliding wrapt in a brown mantle, hooded
I do not know whether a man or a woman
-But who is that on the other side of you?
(Eliot, 2013)

According to Descartes, ‘perception of the infinite is somehow prior in me to the perception of the finite, that is, my perception of God is prior to my perception of myself’. Buber takes this idea of *I and Thou* when he describes God as the ‘wholly other’; He is wholly the Same, wholly Present. In the beginning is relation—as category of being, readiness, grasping form, mould for the soul: it is the *a priori* of relation, *the inborn Thou* (Berman, 2013).

Heidegger (2008) described the temporality of Dasein, as not something that is clearly present. Time is understood in a threefold way where Dasein is outside itself swinging toward the past and the future simultaneously (Heidegger, 2008). Ruby seems to allude to something ahead, an anticipation of the grief to come. She is very aware that things have changed. Being in the surgical ward, with the expectation of surgery, she has turned a corner. A new direction is ahead. She seems disconcerted by her feelings, swinging between feeling self-sufficient to feeling the need to talk more deeply with someone. One can picture her working through the various ‘things to come’ that she imagines. She seems to have awareness that talking to someone more deeply would provide comfort not only for her, but

for her family. The chance to think through and talk through her thoughts with ‘someone of the cloth’ may enable her to connect her past, present, and future.

Ruby is clear that this desire to talk is not based on a particular religious viewpoint. Rather, she points to the possibility of comfort from the act of listening or more importantly being listened to. She seems to have an awareness of something bigger at play and does not elaborate on what exactly that is. She assigns a special character to talking with ‘someone of the cloth’ about her feelings. She describes that for someone not ‘inclined’ toward formal religion; to her a ‘person of the cloth’ seems an accessible and safe avenue. She seems to anticipate comfort, help, perhaps ‘good care’ from the conversation. Maybe she sees a strengthening of herself through the process. Perhaps being faced with the certainty of the end of life, renewed energy is directed to exploration of the future self. Perhaps ‘good care’ is watching out for times that a spiritual conversation may be needed. Ruby speaks of the transition from self-sufficiency to a felt need for spiritual input and conversation. ‘Good care’ may be about watching for and reacting to the changing needs of patients like Ruby. The journey through the ups and downs of their condition is not linear. People’s needs change.

Conclusion

There seems to be an extra dimension present in the experience of ‘good care’. This does not always present in a formal religious sense but can be glimpsed when a veil is lifted. When ‘good care’ is present, a deeper, unified ‘knowing’ of the other seems to develop. This extra dimension or sacred space is often hidden, sometimes only fleetingly grasped. In Te ao Māori (the Māori world), we walk backwards into the future, the past is always with us, and goes before us. The spiritual realm is largely embraced, both individually and collectively (Fraser,

2004). Tātaihono (a Māori term) is about ‘a binding together, a kind of spiritual binding that gives unity and strength’ (NiaNia et al., 2019). Heidegger (2008) described the past, present, and future being as simultaneously present. These concepts hint at another undescribed dimension, grounded in faith, belief, love, and an understanding of something beyond us.

To glimpse this something more, it seems to be necessary to be open, to approach the ‘other’ with compassion. As a psychological and spiritual motivator, compassion requires emotion and action. True compassion is based on love, vulnerability, and reciprocity (Sinclair et al., 2016). This love referred to is known as *agapē*, a love that seeks to give, irrespective of merit (Elwell, 2001). Within the Judaeo-Christian faith, *agapē* love is referred to in the sense of ‘love your neighbour as yourself’—Matthew 22:39 (Peterson, 2014). Similarly, Reynolds (2010) writes, “in Islam without love of the neighbor there is no true faith in God and no righteousness” (p. 177). Likewise, in Te ao Māori there is a strong emphasis on caring for others without expecting something in return (Fraser, 2004). Perhaps ‘good care; comes from a place of *agapē*, and an openness to the possibility of something more. Maybe this is a ‘generous love’ towards others (Quinn, 2012).

Perhaps this basis of love is actioned through ‘call’. Heidegger referred (2008) to the notion of ‘call’ and described it as:

...something which *we ourselves* have neither planned for nor prepared nor voluntarily performed, nor have we ever done so. ‘It’ calls against our expectations and even against our will. On the other hand, the call undoubtedly does not come from someone else who is with me in the world. The call comes from me and yet *from beyond me*. (p. 320)

‘Good care’ seems to be present when care is entered from a basis of unconditional love for humanity and based on a desire to ‘give’. ‘Good care’ seems to be present when a sense of ‘call’ is felt. If we conduct ourselves with integrity and openness, take all that is good and apply it to the dialogue between the complementary realms of knowing and being, then there may come ‘more light and sacred draughts’ (Stock, 2013). Perhaps ‘good care’ resides in the openness to deeper possibilities when a glimmer is felt. When one is attuned to the (often unspoken) needs of others and chooses to recognise and pursue this glimpse of the other, ‘good care’ results.

Chapter 8: Time

As I worked through the process of choosing a research topic, I discussed the subject of ‘good care’ in the hospital with a range of colleagues. The research question ‘what is the experience of good care in the general medical/surgical hospital setting?’, was born out of my observation that *some* people seem to consistently provide ‘good care’, regardless of the environment swirling around them. I articulated this to friends and colleagues as I worked on the proposal for this research. Without fail, every person I spoke to commented on ‘time’ as a factor in ‘good care’; with one person telling me ‘that’s easy, if there was more time the care would be good’.

I have an enduring belief about ‘time’ as a practitioner. As a registered nurse on a number of very busy and fast paced wards, I endeavoured to maintain a focus on managing my time without making my workload the patient’s problem. I remember talking to less experienced nurses about my belief that when a patient I am caring for says to me ‘I know you are busy but....’, that I have somehow failed them. As I read and reread the stories provided by participants, I have done so with an eye on the notion of ‘time’ and noticed comments about the impact of ‘time’ on ‘good care’.

The traditional view of time is the assumption that time exists in the context of eternity, with eternity as the starting point for understanding (Alweiss, 2002). When participants mentioned ‘time’ in their discussion, they appeared to be referring to management of time as related to time measured on a clock. On closer examination, there seems to be a deeper meaning that emerges in the relationship of ‘time’ to ‘good care’.

Heidegger challenged the understanding of time with eternity as a starting point. He suggested that ‘time’ for Da-sein finds its meaning in death. Time *is* only when there is awareness of one’s own mortality. Heidegger referred to death as a mode of being, not as an event (Alweiss, 2002). To further explain, in Heidegger’s thinking,

the primary question is not ‘what is time’? [but] Who is time?’ Namely, we first need to ask what kind of being other than the eternal, can understand the concept of time? We soon come to realize that time is intelligible only for a being that lives with an understanding of a limit. (Alweiss, 2002, p. 121)

This is an important concept as to Heidegger, understanding of the Being of beings is only possible by understanding the way Da-sein experiences time (Zimmerman, 1977). With this in mind, we will explore the comments that participants made about ‘time’ in the context of providing ‘good care’.

Appropriate Time

For Heidegger, time is a series of events where some aspects are visible and other aspects are shadowed by a concealed reality (Harman, 2007). We only see part of a picture which comes to the fore, and we can never fully see the whole. In the statement, “It is *time* for the day’s work”—interpreted time has, by its very nature, the existential and ontological structure of “appropriateness” and “inappropriateness”: the character of “time for...” (Scott, 2006, p. 195). Time as measured by the clock is referred to as ‘public time’. As the concept of time is unveiled, it is given meaning by the way Da-sein chooses to experience the time, by what is considered “appropriate” and “inappropriate”. Margaret, the food service assistant, describes her approach to requests for help.

Some people just ask, they say ‘oh have you got a minute’. And I’m thinking I haven’t really but you know, what would you like love, and they just ask could you just get my glasses or could you just cover up my feet I’ve had my bell on

for ages. It's just stuff and I really like people and it's just a moment of your time. I know sometimes a moment here, there, it takes up but then I work twice as hard to catch up but, there's just that need there. (Margaret)

Margaret has a view of the way her time 'should' be spent. She is 'supposed' to focus on meal orders and delivery of meals. But Margaret also seems to be attuned to other needs. When someone needs her help, she seems almost compelled to respond. To her, time seems to become a way to be of service to others. Although Margaret is very aware of what Heidegger would call 'public time', she seems to have a deep awareness of meaningful action. To Margaret, 'good care' seems to be about making what is "appropriate" (or even meaningful) her first response. The tasks of her role, getting through her list, seem to take second place to meaningful human interaction. Although Margaret knows the practical tasks that are required of her, they seem to fade into the background when she senses a human need that she can fulfil.

Time on the Clock?

In relation to 'time on a clock', some participants believe that there is lack of time for providing 'good care' in a perceived increasingly time-poor environment. The experience of 'good care' in this setting seems to focus on providing good care regardless of the workload and environment.

I'd like to think that I keep the same standard of care for everybody regardless of how much time I'm able to spend with them. I think getting family involved quite quickly, I'm always happy when I get the opportunity to do that because I feel like I'm really focusing on patient care in a multitude of different ways so what I can do physically but also what I can do for the patient and family members emotionally as well. (Eleanor)

Eleanor, a physiotherapist, seems to be able to put aside the concept of ‘time on the clock’ to focus on what it is that she provides for the patient and the family. Heidegger’s view of time as a process of revealing and shadow seems to be present in the way that Eleanor moves forward to include family in her care as part of the process that was already present in the beginning. She seems to ‘know’ how to pull together all the resources that she has available to her, including family, to achieve the provision of ‘good care’. Likewise Jenny, the nurse, seems to be aware of ‘time on the clock’ but chooses how she uses the time to experience ‘good care’.

It takes a good 10-15 minutes to do your obs and antibiotics and check your wounds and check your skin areas. And it actually only takes probably 10% of that time to ask them the medical questions. So you want to ask them about their pain obviously and, and their mobility and their bowels and if they have any concerns about going home. And then the rest of that time, you make, small talk. You let them lead it. You start with a really open question and see where that goes and I think that if you’re open to chatting, then people will respond to that. (Jenny)

Jenny’s description of her approach to patients seems to ‘fit’ with Heidegger’s idea of revealing and shadowing. Although completion of tasks is one reason for entering a room, it is quickly dispensed with in her desire for a conversation of greater depth. She seems to ‘know’ that what matters is the person, development of a relationship is the underlying and perhaps unrecognised ‘work’ of the moment, the tasks are secondary. She lets her attunement guide her as she focuses on being present and connected. Jenny’s openness to being guided by the patient could be understood in Heidegger’s concept of nearer-bringing-nearness, described as ‘keeping open the arriving from the future’. It is the experience of uncertainty that determines her next action (Held, 2007). Jenny’s attunement seems to free her to let the relationship go where the patient wishes. It enables her to act in the moment as possibilities

become apparent. 'Good care' seems to be all about the developing relationship; the skills required for completion of tasks, although necessary, fade into the background and the possibilities of the future are kept open as opportunities (Held, 2007).

Andrew, the doctor, also has an approach where 'time on the clock' is pushed into the shadows so that other things can be revealed. He talks about his approach to spending time with patients.

In most cases it can be very difficult and sometimes having to ignore that pager for a few extra minutes or excusing yourself and going outside to talk to someone and say listen, but saying 'I'm here, I'm present but I'm going to give myself another few minutes before coming back to talk to you properly' usually helps. And you just have to prioritise that person in front of you and not allow yourself to be pulled in lots of different directions unnecessarily, but always keep in the back of your mind things you have to do. And writing them down helps as well obviously, there's only so much you can take in, so that's what I do. (Andrew)

This example of what it means to provide 'good care' seems to highlight the deliberate withdrawing from time as measured by the clock. Andrew is aware that 'time on the clock' is a factor but chooses to focus on the patient at hand. He makes a deliberate choice to 'be present'. His way of 'being' seems to align with Heidegger's view of the world as a 'space of possibilities'. Andrew recognises the act of 'being present' as so significant that he arranges his way of moving through the space to make sure he is available to the patient in front of him. This seems to draw together the past, present, and future as he provides 'good care' for a particular patient. Alongside this, he maintains awareness of others and, through this awareness, seems to be able to provide 'good care' to others and simultaneously maintain his focus on good care in the present. Being alongside is the Present, he seems to achieve a

“waiting-towards”, being “held in the future and having been” (Heidegger, 2008, p. 387). To state this in another way, it is important to understand the ‘present’ as a “‘dimension’ created by the interplay of two ways of absencing and thus withdrawn from possession” (Held, 2007, p. 243). Andrew seems to be on a continuous journey of bridging a distance (space) that includes the bringing nearer and the distancing of time, possession of the present is not possible (Held, 2007). How then are we to understand the location of the present?

Being Present

“The ‘now’ is a temporal phenomenon which belongs to time as within-time-ness: the ‘now’ ‘in which’ something arises passes away, or is present at hand” (Heidegger, 2008, p. 387). When time is experienced as a number of ‘things’ that present themselves in a flat or linear way, this is described by Heidegger as ‘inauthentic time’. In contrast, in ‘authentic time’ there is no ‘now’ moment, it is more a ‘waiting towards’ that gives the possibility of a ‘moment of vision’ (*Augenblick*) (Zimmerman, 1977). Robyn, the chaplain, describes her approach to spending time with a patient.

I will consciously still myself and walk slow, so that I enter a space slowly and I'll try and keep my movements slow and not throw my hands around because I can throw my hands around when I talk. And so I sit, I try and always sit but you don't have to always sit because nurses can't always sit, but it's entering, it's moving in a way that is in tune with a still sense of presence, if you rush in and somebody's an older person and they're frightened, it's only going to exacerbate that. (Robyn)

Time is seen by Heidegger as a movement through a world as a space of possibilities. The past can be described as ‘going back’ to the possibilities that have been in the moment of thrownness, and those possibilities being projected forward the ‘future’. This ‘going back’ and ‘projecting forward’ exist in the moment as “being with” others. Authentic temporality

is the unity of the future, past, and present (Korab-Karpowicz & Heidegger, 2009). Robyn seems to be very aware of possibilities when she meets with a patient. She has a deliberate focus on existing ‘in the moment’, without expectation of what will unfold, she seems open to the back and forth of past and future. Her emphasis is on ensuring that her approach does nothing to restrict or prevent the patient from being able to express themselves to her as they may wish. To Robyn, ‘good care’ encompasses a willingness and openness to move in any direction at any time. She takes care not to limit the possibilities.

The ‘Feeling’ of Time – Moods

Heidegger (2008) asserted that “the mood has already disclosed, in every case, being-in-the-world as a whole, and makes it possible first of all to direct oneself towards something” (p. 176). Mood is not in the sense of being in a certain mood; mood is responsible for the ‘*being-in*’ part of being-in-the-world. Mood is a condition for the potential of intentionality, not an intentional state in itself. The range of ways that things are able to matter to us and the range of possibilities open to us in the world have at their core the idea of ‘mood’ (Ratcliffe, 2013).

Debra, a patient, describes her expectation of the world of the doctor.

[He had a] different bedside manner, he gave the impression he knew what he was doing and it was quite good. He seemed to have a lot of time. Maybe that’s an old historic thing but I just expect the doctors on rounds, you always heard how busy they are and how they’re rushing to get from one place to the next. I was surprised how long they actually stayed and talked about what was going on. (Debra)

Debra’s description reveals her expectation about what she will experience because of the world the doctor inhabits, a world of being busy and not taking time with individuals. Her experience of ‘being-in’ this world, as a nurse herself, has resulted in an expectation that she will not really ‘matter’ and that this will show up as a lack of time spent with her. Against

this background, one can hear that what matters to her is the opportunity to talk, to express her questions and wonderings about what to expect. The doctor seems to have recognised this and Debra is left with a feeling of surprise and delight that she has received the gift of ‘time on the clock’, but also the gift of time as an act that seems to help her to feel like she ‘matters’ to the doctor. Mood was the revealing of her understanding of being-in the world and set the stage for what ‘matters to her. The attunement of the doctor seems to have enabled him to align what ‘matters’ to both of them.

Moods reveal our world as a whole, one’s attunement with it, or not (Large, 2008). Moods seem to be an important part of the way Lisa, the clinical nurse specialist, relates to patients. Her high level of attunement as she moves through the world seems to result in a level of trust that enables exposure of a patient’s deep mood revealing what ‘matters’. She explains one of her ‘unofficial roles’.

I spend a lot of time with patients crying in front of me and I see that as a very privileged part of the senior nurse role and kind of they joke with me but my doctor colleagues say to me how many patients have you made cry today? And they are joking but at the same time they know that it’s really important that somebody is facilitating that and it’s often me. And sometimes patients cry in front of me before their relatives come in and it’s almost like a safe opportunity and grown men crying, I don’t underestimate that and I try and enable them through that, tell them, you know, this is part of the stroke and the shock, and allow time for it. (Lisa)

As Lisa explains her experience of ‘being with’ patients during times of emotion, there seems to be a leaning towards the future within it. The understanding of Heidegger that the past, future, and present are all present, the authentic dimension of the future includes aspects of the past and present seems especially clear here. Lisa seems to have an understanding of what is necessary for a patient to move through the traumatic experience of having a stroke.

She is able to ‘be with’ the patient as they journey into the future with the new-found possibilities and limitations. According to Heidegger, “the future is the basis of Dasein’s existence (care moment) and its understanding (disclosedness moment)” (Zimmerman, 1977, p. 243). Lisa seems to be open to the possibilities of the future and her attunement and phronesis enable her to guide the patient toward understanding these possibilities as well. Lisa understands that the tears are more than just ‘sadness’, there are many layers. She goes on to reflect on ‘fear’ as part of the journey forward.

That fear and I can’t imagine what it’s like, but I do spend a lot of time with people who encounter that feeling so I try and help them through that. And perhaps experience has taught me that, when that’s happening it’s probably not the day to make long term decisions. (Lisa)

The emotion of fear is one that Lisa is familiar with. Fear seems to be a way that we are able to recognise what ‘matters’ in the world. Heidegger does not seem to distinguish between ‘mood’ and ‘emotion’; however, an emotion such as fear pre-supposes a mood-constituted way of revealing what matters (Ratcliffe, 2013). Because of her phronesis, Lisa seems able to accept the expression of fear and ‘hold’ the moment so that the patient is not afraid of the fear. One imagines her, sitting with a fearful patient, content to ‘be’, giving the patient permission for expression, or not. She seems to understand that this is not a time to be avoided, this ‘matters’, and she is attuned to enabling the fear to show itself and to gently receive it. Her understated acknowledgement that “*it’s probably not the day to make long term decisions*”, hints at a much deeper understanding of her role in ‘care’. For Lisa ‘good care’ seems to be about enabling, accepting, and being-with as the patient experiences their individual journey.

Understanding and Timeliness

Mood is not the only aspect of being-in-the-world. According to Heidegger, understanding and discourse are two other aspects that when combined with mood are the structure of care. Understanding is not meant in the sense of ‘understanding a plan’; it is more about our orientation towards future possibilities (Ratcliffe, 2013). Marama describes her experience of ‘good care’.

And every time she rung for something they were there straight away, you know how doctors can get very, very busy and get called away and be in surgery, but it just seemed every time mum needed them for something they were there. It was awesome. The last visit that my mum had, that was the happiest and the most understanding and relaxed I’ve seen her. So I give big ups to those doctors because they made mum feel really good about herself. (Marama)

Time is unable to be separated from its being lived through. It is not a separate entity given once and for all, time *is* timeliness. “Past, present and future ... acquire meaningfulness only because they are the means through which time extemporizes itself through the activity of Da-sein” (Scott, 2006, p. 185). Ruby, Marama’s mother, has had many admissions to hospital. In the above description given by Marama, she seems to be able to ‘feel’ the difference this time. She appreciates the prompt response to anything Ruby wants, but really what seems to be important to her is the way that it made Ruby ‘feel’. The ‘good care’ received by Ruby enabled them both to feel good in themselves. One can hear in her voice the relief of this; and, in turn, one imagines that this set the scene for Ruby to move forward on her journey. This admission was the one when the decision not to undertake surgery and to continue to a palliative pathway was made. The care given to Ruby seems to have enabled understanding towards the future to take place; it seemed to set the mood for going forward. ‘Good care’ was found in the sense of ‘being-in-the-world as mood or, to put it another way, allowed attunement toward the future to occur.

Time as Care

According to Heidegger, the three strands of mood, understanding, and discourse result in care (*sorge*). Discourse is not merely spoken language; it is the possibility for spoken language. In this way, mood and discourse are reliant on each other, discourse can be constrained or enabled by mood (Ratcliffe, 2013). Andrew, the doctor, explains the provision of ‘good care’ and the result of that for both himself and the patient.

And so what I tried to do with her and I don't regret for a moment spending all that time with her and her family. Trying to collate all that information for them in an easily digestible portion, and explaining to them in an easy understandable way what was happening. I think that was probably one of my proudest moments for her trying to guide her through this process. (Andrew)

Being present and giving time seems to provide the environment or maybe the mood for the experience of good care to unfold. Perhaps the feeling of giving ‘good care’, as described by Andrew, provides inspiration to follow through and give good care consistently. It seems that the provision of ‘good care’ and the feeling that ensues when one feels they have given ‘good care’ is circular and self-sustaining, to some extent. In this example, where multiple medical teams are involved and complex interplay is happening, Andrew is able to influence the mood, or possibility of seeing what matters. One can hear the pleasure he takes from doing this well, with the outcome of assisting a person to make her own decision on her future, with as good an understanding as possible of what may lay ahead. His care is not self-seeking or for any personal gain, aside from being the provider of ‘good care’.

It's Not Always Easy

Participants spoke about their management of time, and a commitment to focusing on the patient. This alludes to a turning away from ‘time on the clock’ or ‘public time’. It seems

that this commitment does come at a cost. Eleanor, the physiotherapist, talks about managing time in this context.

Sometimes when it does get busy, you really feel like you're not giving the patient the best that you could give them. Observing throughout the hospital you can see that each and every profession want to give their best which is lovely to see. And I think that's where I feel the majority of work stress comes out of, is when people feel like you just can't do as much as you'd like to be able to do for that patient. (Eleanor)

Time becomes significant when there is a perception that there is not enough 'time'. Heidegger's view is that 'public time' makes communication possible. It defines that is it time for work, time for sleep, time for any activity. He warned that once time has been defined on a clock, arriving at its original meaning is impossible. World time that belongs to everyday care allows the "fleeing from the 'all too human' future as it levels the ecstasies of time to an endless now-time occluding an infinite future into an irretrievable past" (Scott, 2006, p.196). One can almost hear the frustration in Eleanor's voice as she recounts the difficulty of providing 'good care' when 'time' is short. She seems to have an inner understanding of her desire to focus on the important aspects of 'good care'. She goes on to describe her approach:

Explaining, just really openly and honestly with the patient, that I would love to invest more time today, but unfortunately we just don't have the time and just basically prioritising what we need to get done, and then reassuring the patient that tomorrow you will be given a high priority for more time. (Eleanor)

Heidegger noted that "Dasein knows the feeling of time from the 'fleeing' knowledge of death" (Scott, 2006, p.194). Eleanor seems to have a deeper understanding of the passing of time. One can hear her almost resignation, to not having enough 'time'. There is a sense of time rushing by, a wish that things were different, that she could always be-with each patient

in an authentic way. She has developed skills to negotiate this feeling; however, one can see that she is left with an unsatisfied feeling when she is unable to provide 'good care' as she desires. Her 'throwness' into the situation is uncomfortable. As Heidegger infers, Da-sein can never escape the "past," its throwness, for as long as one exists, one is always "present" to oneself as already having been (Scott, 2006). Eleanor's distress that she cannot provide 'good care' today is projected forward to tomorrow in the hope that there a change may occur. She seems to live in a constant state of moving backwards and forwards between past, present, and future to give 'good care' where she can; or, as Heidegger would say, Da-sein can *be* authentically having-been only because it is futural. In a way, having-been arises from the future (Heidegger, 2008; Scott, 2006). In this way, care is able to be provided because of past experiences that also project into the future. 'Good care' emerges.

Time as Spirituality/Time as Love/Time as Care

Heidegger (2008), in *Being and Time*, provides a distinction between two possible courses of action by Da-seins positive solicitude (or care) for other Dasein. There is the possibility of 'leaping in' and taking care of things *for* the other. There is also the possibility of 'leaping ahead', not to take over, but to let the other 'be', to smooth the way for a choice (Carlson, 2012). Jenny gives an example of her view of 'time for caring'.

Sometimes I feel that with the acuity of our patients increasing, we're almost task based, medically managing people rather than delivering good nursing care. Some shifts it is like that, you just go from task to task to task. Every shift I need to feel like I have done something, so even if that means that I'm off 10 minutes late but I go home feeling like I've done a good job, then that's okay with me. That might be something like, taking someone's TEDs off and just massaging their feet for five minutes and putting them back on. And those things that aren't necessarily important in the health part of it, but it is important for their health because if you don't look after their spirituality and

their spiritual needs and their wairua, then it's really, really hard for them to have the strength to do the things that we're encouraging them to do well.
(Jenny)

Jenny seems to be very aware of 'time on the clock' and the need to accomplish tasks. As an experienced nurse, she is very skilled at managing the tasks needed. Yet, with all the pressure she feels, she seems to be able to 'go beyond' the obvious in front of her. She has a knowing that there is so much more than completion of tasks in the recovery journey. She is very able to manage the 'leaping in' to get the tasks completed; however, she has a much broader view of 'good care' than merely that. She is focused on the person; she seems able to put aside the demands on her time that pull at her all day long. She believes that the "*things that are not necessarily important*" are the most important of all. She appeals to the inner person in the choices she makes, she is able to 'see' the difference the 'extra things' make to the person. She goes so far as to describe physical tasks as having a spiritual meaning. For Jenny, 'good care' seems to be about knowing when to 'leap in' and when to 'leap ahead'. She acknowledges that the 'leaping ahead' is not always easy to achieve, but she has a commitment to managing some 'leaping ahead' to care every day.

Ruby, the patient, recognises 'good care' when she feels it. She comments about the 'good care' in the ward as she works through her diagnosis and plan for the future.

[They] sit next to the bed or sometimes on a bed and hold on to your hand and, oh they're just amazing. (Ruby)

In Ruby's voice one can hear the relief of feeling 'good care'. It is not about analysis of the care, it is purely the feeling of someone taking the time, being attuned, and placing importance on just 'being'. One can sense the feeling of peace, maybe a feeling of love, that

this brings to Ruby—it is ‘good care’ without words. Robyn, the chaplain, describes such a moment that she observed.

And there was a little old lady in that bed, and she was clearly suffering and I was standing there and it was like time stood still because a nurse came, she came out of nowhere and she was in that present moment. She went over to the bed, picked up this woman’s hand and she knelt beside the bed. And she kissed the woman on the cheek. Now she obviously knew this woman and knew what was going on, and I thought, ‘there’s a gap in the universe’. It was that kind of moment, and I thought, ‘wow’ and this woman’s face just lit up you know and she just kind of murmured to the nurse and the nurse put her hand down and, I can’t remember what she did, but she was there to provide some care. It was an act of appropriate love and appropriate touch in that moment.
(Robyn)

The relationship between the nurse and the patient in this scenario is almost too close to describe. The ‘knowing’ what is needed, described by Robyn as a ‘gap in the universe’, is experienced in a kind of fused together reality. Heidegger (2008) may allude to love when he suggests that “one Dasein can and must, within certain limits “be” another Dasein (p. 284). As Robyn describes it, there seems to be a sense of the nurse authentically *being with* the patient. Heidegger commented on anticipatory resoluteness

... ‘resoluteness, as being *authentic Being-one’s-Self*, does not detach Dasein from its world, nor does it isolate it so that it becomes a free-floating ‘I’. ...Resoluteness brings the Self right into its concernful Being-alongside what is ready-to-hand, and pushes it into solicitous Being with Others’ ...only by authentically Being-their-Selves in resoluteness can people authentically be with one another... (p. 344).

Carlson (2012) summed this up, “Thus, ‘resoluteness’ signifies letting oneself be summoned out of one’s lostness in the ‘they’ – and only in being so summoned can one care, as oneself, for the other as herself” (p. 28). In Robyn’s story, one can feel the focus on what is needed

by the patient; the nurse seems unconcerned that there are others present, she focuses on the moment, she seems to act instinctively and authentically with the patient. This tender moment seems to illustrate ‘good care’ in a deeper sense. It is a moment of tender love and care towards another.

Conclusion

Having examined comments and reflections on ‘time’ as an important notion in the provision of ‘good care’, are we any closer to understanding? The prayer of Saint Augustine (600 years ago) may describe where we find ourselves.

I confess to you, Lord, that I still do not know what time is. Yet I confess too that I do know that I am saying this in time, that I have been talking about time for a long time, and that this long time would not be a long time if it were not for the fact that time has been passing all the while. How can I know this, when I do not know what time is? Is it that I do know what time is, but do not even know what I do not know! (Alweiss, 2002, p. 128)

Regardless of our level of understanding, knowledge, or belief about time, for all participants, awareness of ‘time on the clock’ is a consideration in the ‘good care’ they provide. When ‘good care’ is provided, ‘time on the clock’ is often relegated to the shadows, leading to a focus on time as lived through the space. Although not articulated, a commitment to ‘good care’ with the notion of time, seems to be a commitment to keeping ‘time on the clock’ behind and allowing the needs of the patient to come into the space that is left unoccupied.

When ‘time on the clock’ or ‘public time’ pushes its way in, ‘good care’ seems more difficult to achieve. As more than one participant mentioned, care becomes ‘task based’. The essence of the person is lost as tasks take up the space. The aspects of ‘good care’ which are about the use of ‘time’ in a different way, take greater effort, are reduced, or lost altogether.

Underlying the desire to provide ‘good care’, we find ourselves once again recognising the importance of the person. In later life Heidegger wrote about love in a letter. He suggested that “the power to realize things derives not from possession, from what we have, but from our capability for giving” (Carlson, 2012, p. 29). Carlson (2012), in his analysis of Heidegger’s view of love, suggested that “Perhaps Dasein *can be*, then, thanks only to the gift of love. And what love gives – if we let it be - are none other than time and world” (p. 30). It seems possible that the study participants underlying regard, perhaps love, for their fellow human being is the basis for ‘good care’. Maybe love lays a foundation to ensure that ‘time’, whether managed ‘by the clock’ or in the space of possibilities, is used for the benefit of the patient. ‘Good care’ is taking care of the whole person in a deeply spiritual and loving way.

Chapter 9: Discussion

Beannacht

*On the day when...
... you stumble,...*

*...May a flock of colors...
...come to awaken in you
a meadow of delight*

*...And so may a slow
wind work these words
of love around you,
an invisible cloak
to mind your life.*

(O'Donohue, 2011)

Before any understanding of the experience of 'good care' can be articulated, an understanding of being-in-the-world is needed. As the above blessing, by John O'Donohue, suggests, all are immersed in this life, what we 'see' is only in part. Awareness happens; it is an awakening to something that matters, something that has been there all along. My research kept its focus on the experience of 'good care' from a broad range of individual perspectives including patients, family, whānau, professional and non-professional hospital staff members. The resounding common point is a way of 'being-in-the-world' that shines from each individual and the profound ability to 'be-with' another. At times, a deeper awareness of the sacred, of the fragility of humanity, is glimpsed. The 'love' for humanity that lies just beneath the surface comes through.

In this chapter, I point to the important notions that arose from my research. I articulate the thesis of the thesis. Recommendations are offered for practice, education, and further research. Limitations of the study are discussed. I return to my pre-understandings and

describe how my understanding of ‘good care’ has evolved over the course of this journey. I offer concluding comments to address my research question.

Love – An Overarching and Underlying Finding

*People say to me, ‘How do I know if a word is real?’
You know, anybody who’s read a children’s book knows that love makes things real.
Erin McKean, lexicographer (Dictionary of obscure sorrows, 2013)*

The notion of ‘love’ is illuminated and woven through the findings chapters of this thesis. Love, itself, is not explicitly mentioned; it reveals itself ‘between the lines’. A kind of ‘knowing’ that love is present appears. It seems to be present in the stories of ‘good care’ and missing in the stories where ‘good care’ is absent. Heidegger (2008) revealed some of his thinking about ‘love’ in letters to Hannah Arendt, written around the same time as *Being and Time* was penned.

Love is, indeed, qualified as the genuine space of a “we” and of a world that can be “ours”, and represents the genuine “taking care” of the other, since its formulation borrowed from Augustine, is *vol out sis*: “I want that you be what you are”. Thus love is a *mitglauben*, a shared faith in the “story of the other” and a *mitergreifen*, a shared grasp of the “potential of the other”. (Nancy, 2008, p. 14)

The Biblical notion of ‘love one’s neighbour’ (Matthew 22: 39) emerges as a deeply held underlying love for humanity. It resonates with Heidegger’s idea of a taking care of the other, with a commitment to the journey of the other. Freire (2001) wrote about the “*courage to love* (which far from being accommodation to an unjust world, is rather the transformation of that world in behalf of the increasing liberation of humankind; and *faith* in the people” (p. 176). Participants’ stories wherein they took a risk in order to address sensitive or difficult situation are illustrative of the need for having the ‘courage’ to love. Internal virtue and

character are present alongside wisdom and attunement to ‘press forward’ with a humble acceptance that ‘love’ will not guarantee that one will ‘get it right’. Yet this love for humankind seems to provide the motivation to try, to take a risk, to lean towards ‘good care’.

Manaakitanga – A Way of Being

The way a person ‘is’ comes from an inner place; it must be authentic. Being authentic is not about the role or title one holds; it is our way of being in the world, it is comportment. Who we are sits below the surface and transcends the prescribed role or title. It is to ‘just be’, knowing when or how to ‘leap-in’ or ‘leap-ahead’, recognising that this may mean non-action, a call to ‘just be’, to ‘breathe’, or to reach out to the other in the spirit of shared humanity.

To enable these attributes to emerge, alertness to one’s own feelings is needed. With strength of character that is focused on what is ‘right’, an underlying layer of care (*sorge*) and compassion is revealed. An ability to build a sense of kinship is evident in the way participants include themselves with others. This sense of kinship and *sorge* lies beneath an ability to not only cope, but to thrive in the ‘thrownness’ of being-in-the-world. The individual can ‘see’ the face of the ‘other’ and move towards them. A deep-seated calm and caring for the other is revealed and enables ‘good care’. The notion of manaakitanga, a state of ‘being’ that holds the other in high regard, is illuminated placing ‘good care’ in the Māori way of being within the New Zealand context. Perhaps the ‘new’ may be an ancient indigenous way (Ruka, 2017). It could lie outside the prescribed ‘way’ of providing ‘good care’, viewed as crossing personal/professional boundaries (Smythe et al., 2018). However, the findings of my thesis reveal that this underlying ‘essence’ of the person reveals a way of being-with that Māori have long known matters.

Thesis of the Thesis

At the heart of this thesis is the dual concepts of ‘who one is’ and ‘how one is’. A person’s comportment (*way of being*) has an aspect of being sensed and felt by others. It is illuminated in the way a person is able to be-with another (Heidegger, 2008). Heidegger referred to “(*sich*) *verhalten zu Seiendem*, that is, comportment towards beings, or relating oneself to beings” (Ma & Van Brakel, 2006, p. 521). Healthcare is always provided out of ‘who’ one is. ‘Good care’, as revealed by the participants in this study, cannot be reduced to a series of techniques or skills. ‘Good care’ is always provided from a person’s whole, sacred, and spiritual self. Comportment just ‘is’. When Margaret, the food service assistant, prayed with a patient, she was being her whole self. When a person is engaged in ‘good care’, they are not trying to project as ‘nurse’ or ‘doctor’ or ‘cleaner’. They appear to the other as ‘who’ they are as a person, as a ‘real’ person. When Jackie the nurse cared for an elderly Māori woman and her whānau, her way of caring for the children was saturated in her being-as a real person. Whatever one’s ‘mood’, how one ‘is’ projects the possibility of ‘good care’ into the situation. All that has gone before in one’s experience up to this ‘moment’ is hidden yet present at the same time. When Grace, the cleaner, took on the role of providing karakia and room blessings, she did this from a part of her ‘being’ that may not have been ‘seen’ by others. Participants seemed to just ‘know’ when to seize the moment and press on, and when to hold back for another time. This is not always easy, sometimes pressing on takes courage. When Andrew, the doctor, acted as a guide to a patient making difficult choices, he was both courageous and attuned to her needs. Sometimes holding back feels hard, one wants to be making progress. It takes attunement to move at the right pace, come alongside, listen and move together.

The notion of phronesis became important and is closely linked to one's comportment. It requires a sense of being alongside, of 'seeing' what is happening, weighing up the best plan of action (or inaction). This is where strength of character is illuminated. Sarah, the social worker, demonstrated this when she came alongside the mother of a young woman with anorexia. The ability to provide 'good care' seems to be founded on a deep knowledge of oneself in order to focus on 'good care' for others. This is not a glib, surface level desire for 'good care'. It is a deeply held commitment built up in layers over time. In caring for a patient with motor neurone disease, Sam, the occupational therapist, drew on his own experience as the son of elderly parents, and his experience with other similar patients. His 'knowing' built up over years enabled him to be confident to challenge the thinking of his colleagues. It is taking all that one has experienced into every experience because, as Heidegger (2008) stated, our past is already before us. Such awareness seems to enable listening and reflecting in a deeper way, to really 'hear' from the other and choose the best way forward from this 'knowing'. This is where 'leaping in' or 'leaping ahead' becomes important. It is phronesis that helps one be attuned to the moment and respond (or lead) in the direction of 'good care'. Lisa, the senior nurse, demonstrated this as she cared for a complex patient with a difficult diagnosis over a 10-year period. She was able to 'leap in' to enable others to understand the patient's situation. She was able to 'leap ahead' to plan ongoing care that would meet the patient's needs as she travelled around the country.

At times, comportment reveals itself in a spiritual way. There comes a sense of reverence, an awareness of the sacred, an openness to 'seeing' possibilities. Robyn, the chaplain, knew this when she passed by a patient's room and 'happened' to make contact towards forming a lasting and meaningful healing relationship. This sense is not necessarily revealed in an overt

way; rather, is often ‘felt’ and difficult to describe. It is Being-with in a special way. It is authentic. Debra, a patient, described this as feeling ‘loved’ when the nurses spent time beside her in her pain and distress. When there is a deep sense of ‘being-with’, ‘good care’ emerges from the shadows. Being-with, in this way, seems to nudge the ‘other’ towards a sense of peace. In talking about the delicate topic of care of a stoma, Jenny the nurse was able to walk alongside Mrs D towards acceptance. There was a sense of fellow traveller. A sense of being the neighbour loved. The mood of the sacred is present in many cultures. It is particularly recognised in Māori belief systems. Sandra, the health care assistant, demonstrated this in her caring, mana-enhancing ‘way’ of working with patients’ who had dementia. It is expressed in formal religious ways, in cultural ways, and privately within individuals. It is a sense of something beyond ourselves. Many participants either directly or indirectly mentioned this ‘something more’ that seems to be revealed when depth of understanding was needed. At these times, compassion shows itself where unconditional love is present and ‘good care’ happens.

A Note About ‘Time’

Reflection on the many perspectives about ‘time’ within the narratives illuminated further the place of ‘time’ in ‘good care’. Scott (2006) wrote, “Da-sein reads time off the face of the clock. The being of the clock is determined by the ‘how’ of Daseins’s existing: while, time *is* that only in ‘how’ it shows itself” (p. 193). As we orientate ourselves *towards* time, it is made public. Heidegger (2008) called this shifting “within-timeness”. Time is then available to everyone. Whilst ‘time on the clock’ is important, reflection on the narratives reveals that when more focus is placed on ‘time on the clock’, ‘good care’ can retreat to the shadows.

Links to Other Research

Studies that examine the concept of ‘good care’ from a range of perspectives including professional and non-professional staff, patients, and family or whānau are rare; however, there are some links to other research to explore. A literature review of good nursing care (Ghahramanian et al., 2020) concluded that the goal of good care is recovery and safety. Therefore, providing a standard, safe, and efficient care for all patients with the aim of improving their condition is considered as the outcome of good care. The results of my phenomenological study take another view, revealing the ‘how’ of good care which brings forth ‘felt’ experience. For example, in my study, ‘good care’ enabled a woman to choose to have no further treatment for her cancer. While other doctors were advising complex treatment scenarios, one doctor had paused to reach out to this woman in a human-to-human relationship. It was not about the outcome of care; rather, the building of trusted relationship. Describing the experience of ‘good care’ has helped me to illuminate aspects of ‘good care’ that lie beneath the surface. By examining participants’ description of ‘good care’, notions such as attunement, comportment, and phronesis emerged. Much of the experience of ‘good care’ is attributed to a feeling of care being different for each individual. Such notions are most often beyond ‘measure’ and thus stay hidden in more quantitatively methodological research.

A qualitative study in three hospitals in Sweden, by Jangland et al. (2017), sought to understand the challenges in everyday clinical practice for achieving ‘good care’ in a surgical ward setting. Ward leaders (either surgeons or nurses) reported a ‘gap’ between what is described in written documents and what can be performed in clinical practice to achieve ‘good care’ or ‘safe care’. The study cites moral distress, issues of competence, and lack of resources as barriers to delivery of ‘good care’. While some participants in my study

mentioned ‘busyness’ or the fast pace of the ward, focus seemed to rest on their ability to provide ‘good care’ within these challenges. A further study also set in the surgical ward identified themes that present obstacles and opportunities for ‘good care’ (Yngman-Uhlin et al., 2016). Shifting the focus away from the patients was seen as an obstacle and could be result from taking on or being given too many tasks. Helpful factors were placing emphasis on good communication and using the competence of the team, including collaborating between staff members and with the patient. My study findings, while having a different focus, would support the idea that including patients in decision making, along with good team relationships and collaboration, contribute to ‘good care’.

A final example is a study in the United Kingdom which sought to establish what it might mean to be a ‘good healthcare practitioner (Duncan & Stephenson, 2011). A sample of 13 practitioners from a range of professions and settings, including the acute hospital setting, participated. The idea of talking about ‘the good care practitioner’ was problematic and participants preferred to focus instead on ‘good practices’. They were unable to come up with a unified conception of a ‘good’ practitioner. The importance of understanding individual and social contexts that shape health care encounters was discussed. In a similar way, participants in my research may not have identified themselves as providers of ‘good care’, noting humility or perhaps advanced self-awareness. They were, however, able to identify factors that make up ‘good care’ as observed in others and found through reflection on their narratives.

Contribution to Knowledge

I have recently been involved as a leader of the care capacity demand programme (CCDM). This programme is largely based around nurse workload measurement and prediction for

‘safe staffing’ to ensure quality outcomes. The need for the correct staffing to ensure care can be delivered is important. A tension may arise when taking a predominantly quantitative approach to care. The findings of this research are a reminder of the importance of qualitative factors that are a cornerstone of ‘good care’. The notion of ‘time’ was part of the participants’ stories about ‘good care’. However, the phenomenological process of drawing out underlying perceptions resulted in a range of understandings about the meaning of ‘time’ in the workplace. Time on the clock can be important; however, when it takes over (even when time pressured), ‘good care’ seems to retreat to the shadows. The comportment of those engaged in ‘good care’ is important in finding ways to step outside of the specific circumstances to provide ‘good care’.

I was surprised at the prominence of the notions of spirituality and manaakitanga that emerged from this research. Although I personally would recognise spirituality as an important concept in my own practice, many participants also mentioned the sacred in some way. It has been a delight to uncover the generally unrecognised, but highly valuable ‘good care’ provided by non-professional staff in the hospital. In particular, stories of ‘good care’ provided by the cleaner, the food service assistant, and the health care assistant seem significant.

As this thesis developed, it became more and more apparent that the ‘being’ of each person is central to the phenomenon of ‘good care’. Hence, patient stories were explored person by person. This results in stories at times being grouped together from one individual at a time. It seems that ‘good care’ is built firstly on a foundation of ‘love for humanity’ and from this, all else seems to flow. My hope is that the findings of this study will inform ongoing care in

the hospital environment and thus continuously improve the experience of ‘good care’ in hospital settings.

‘Good Care’ in Practice

While much of my reflection on the narratives has illuminated ‘good care’ between staff members and patients/family/whānau, another aspect arose. The idea that attunement, phronesis, and, indeed, an underlying love for humanity is important in the way individuals work together. When staff participants were asked if they could give examples of good care as observed in the practice of colleagues, all were quick to recognise others in the team. There seems to be an appreciation of the ability of others to contribute to ‘good care’. I would be so bold as to say that the humanity of the other and the being-with that is observed extends to interactions with everyone in the medical/surgical setting. The participants in this study seemed able to just ‘be themselves’, in a way that ‘felt’ like good care to others. I am not suggesting perfection is attainable in all interactions; rather, that the ‘being’ of a person is an essential component in the experience of ‘good care’.

I am intrigued by the contribution of the food service assistant and the cleaner to ‘good care’ in the ward. Non-qualified staff, such as food service assistants (responsible for taking meal orders, delivering meals, refreshments), are often in the shadows rather than the foreground of ‘good care’. I discussed the possibility of including a food service assistant with the manager. I gave my rationale for inclusion by giving an example of ‘good care’ that had been observed. She asked what exactly the person was doing. In this instance, the food service assistant had provided ice wrapped in a cloth, as asked by a patient to relieve headache symptoms. On hearing this, the manager was surprised and stated that the food service assistant role is finely honed to 1 minute 20 seconds of focused conversation about meal

requirements per patient. Getting ice from the kitchen is not something that they ‘should’ be doing. This interaction brings to the surface unacknowledged, often unseen contributions to ‘good care’, which is courageously enacted beyond prescribed task-focused care activities. It brings to question the prescriptions of ‘good care’ that are articulated in job descriptions.

In a similar way, the contribution of the cleaner may be underappreciated. Cleaners, perhaps by the very nature of the role, are able to engage with patients as they go about their work. It seems that the ‘tasks’ occupy the shadows; they are able to be completed without absolute focus. This seems to allow for the cleaner to interact and provide ‘good care’ that is probably unseen by others but adds to the experience of ‘good care’ for patients and whānau. To some, cleaners may be invisible, working around the schedule of others. Maybe it is their very invisibility that is a potential contribution to ‘good care’. Perhaps ‘good care’ is knowing how to be visible and invisible, and when to do each? Maybe their lack of a ‘professional’ role enables their humanity to shine through in a more authentic manner.

In the ongoing work within the health care sector on values and their articulation, we must acknowledge the provisional, untidy, and necessarily incomplete character of our understanding of the breadth of ‘good care’. All aspects of health within the broader context of society need to be examined to find new relationships and ways of working within the complex and fast paced environment of health generally, and specifically within the general medical/surgical hospital setting. In times of challenge, such as the current complex, resource limited environment it is tempting for leaders to ask organisations to work harder, put in longer hours, or cut budgets. We owe more than this to our patients and communities. We owe them innovative ways to take advantage of the social gains in the sciences of

medicine and nursing, in new technologies, and in new partnerships between families and providers. Changing the way healthcare is perceived and provided could offer a pathway to better care and lower costs—perhaps this could be ‘good care’ in the current context.

Recommendations for Practice

- ***Practice environments.*** Participants in this study seemed to be able to provide ‘good care’ within a changing and challenging environment. The ‘being’ of those providing ‘good care’ may have contributed to the environment, decreasing emphasis on ‘time’ or ‘tasks’ and increasing the focus on ‘good care’ in the moment. Efforts to ensure practice environments are conducive to provision of ‘good care’ should focus on increasing understanding of the shared humanity of staff and patients.
- ***Use of stories.*** The notions revealed in this study such as being, attunement, phronesis, love, spirituality, are not generally present on position descriptions. The inclusion of stories about ‘good care’ would strengthen recruitment practices to move individuals and teams towards the provision of ‘good care’ in practice. Interviews for new staff could include an invitation for people to tell a story of when they provided or received ‘good care’ revealing their understanding of ‘what matters’.
- ***Teamwork.*** This research underscores the importance of all members of the team in providing ‘good care’ and brings further recognition that the ‘being’ of a person is not tied to their ‘title’ or ‘occupation’. Emphasis on drawing out individual comportment through the use of stories may be a positive step in promoting individuals who will contribute positively to the provision of ‘good care’ within a team.

- ***Staff appraisal.*** There are likely to be staff in any work situation who are known NOT to provide the kind of ‘good’ care articulated in this thesis. It is imperative that a process is introduced to draw that person’s awareness to how they could improve their comportment, and to take measures to exit staff who continue to distress patients and colleagues.

Recommendations for Education

- ***The place of stories.*** Engaging in difference and otherness is critical to deep understanding of something (Gadamer, 2001). In recognising something as strange, one first needs to be acquainted with the familiar (Smythe & Spence 2012). Inclusion and emphasis on stories of ‘good care’ should be present in education for those preparing to work in a healthcare setting. This includes registered and unregistered staff. While ‘good care’ is elusive, hard to define, and challenging to teach, it is absolutely known by its absence.
- ***Focus on increasing understanding.*** ‘Good care’ is revealed as found in the human response to another human. It shows itself in a myriad of ways. Measurement is challenging; however, measurement is also ‘what counts’ in educational preparation for healthcare. One study showed an increase in ethical comportment in pre and post testing of nursing students. Intervention included theoretical teaching and the experience of following individual patient’s on their healthcare journey (Asfour et al., 2016). Perhaps analysis of case studies to assess understanding of human-to-human comportment may be helpful. It is important that ways to measure and discern potential for ‘good care’ to lean further towards consistent provision of ‘good care’ in practice are discovered. Attaining regular feedback from the patients they care for (in a way that is non-

threatening for the patient) may be one way to gain an authentic picture of the comportment of a student.

Recommendations for Research

- ***Research of ‘poor care’.*** Courage and support is required by the health professions, separately and collectively, to research ‘poor care’. The initial spark for this study came from stories of what seemed like ‘poor care’. My experience and reading about philosophical approaches tells me that ‘things’ are not always as they seem. In the current healthcare environment, with a concentrated focus on improvement, it seemed that to research ‘poor care’ may not be well received, or even be given approval. Nevertheless until the extent of ‘poor care’ is revealed there may not be a commitment to address the staff whose comportment consistently leads to poor care.
- ***Longitudinal study.*** Three patients and three family members as participants is not representative of all patients/family/whānau, nor is one participant from a discipline. An alternative would be to follow participants over a period of time; for example, three months, and interview regularly to discover how many stories they have of ‘good care’ versus ‘poor care’.
- ***Spirituality.*** Although not the focus of this study, the notion of spirituality revealed itself. Further study about spirituality in every day practice would build on this beginning.
- ***Love.*** The notion of ‘love’ was illuminated as I reflected on the stories both individually and as a whole. This was not explicitly named by participants but was an interpretation ‘between the lines’. It would be interesting to research this notion with a more explicit notion on the nature of ‘love’ between a health professional or ancillary staff and patients.

- ***Other settings.*** There is room for further research into the ontological nature of ‘how’ ‘good care’ is provided in a variety of healthcare settings. This study would be enhanced and extended by completing this same approach in other settings, for example in primary care.
- ***Other patient groups.*** Due to the setting that I chose to conduct this research, there was a tendency to interview adults only. Medical/surgical wards primarily care for adult patients, and occasionally adolescents. There were no adolescents in this study.

Limitations of this Research

- I am a health professional and at the time of this study was in a senior nursing position. This may have introduced bias as I have ‘inside’ knowledge of the way things work. There is also potential that my position could influence my ability to recruit participants. Yet I had no trouble recruiting participants for this study.
- My aim was to interview staff recommended by others. By making this choice I may have uncovered particularly outstanding examples of ‘good care’ which may not be the everyday reality for other staff. My hope is that the insights and examples of practice shared with me would become more and more ‘every day’ for all those involved in ‘care’ in this setting. If I had chosen a random sample of participants or asked for staff who saw themselves as consistently providing ‘good care’ the findings may have been different. When I revealed to participants that they had been given the opportunity to participate because they were recommended by others as consistently providing ‘good care’, many were humble in their response. Perhaps there is something in this response that points to the ‘good care’ uncovered in this research.

- Due to external factors inclusive of a large workload, I did not commence analysis as I interviewed. Had I done so, the quality of later interviews may have changed.

Returning to Pre-Understandings

As I journeyed with the ‘data’, looking within the narratives I became more aware of some of my pre-understandings or prejudices which I had not been conscious of before. One example would be that while I personally find spirituality to be an important factor in overall healthcare, I was surprised by the frequency that this topic arose, and the depth of feeling of participants who talked about aspects of the divine either directly or indirectly. I now recognise that the sacred component of ‘good care’ is revealed in a variety of ways. Each individual has their own perspective and experience, being alert to the emergence of an individual’s spirituality is an important contributor to ‘good care’.

I was also struck by the minimal mention of technical skill in the experience of ‘good care’. Is that because technical skill is assumed or is there some ‘way’ or ‘knowing’ that people have of expertise underpinning their actions and attitudes that result in a feeling of ‘good care’?

Inclusion of five Māori participants in this study has brought a richness that I had wondered about but not understood. My exploration of my own Māori whakapapa (family line) has been tentative and is ongoing. My understanding of Māori culture is growing and expanding. The rich and deep stories gifted to me by participants sent me in search of Māori meanings and notions that bring depth and warmth to experiences of ‘good care’.

Final Reflections

*Kia hora te marino
Kia whakapapa pounamu te moana
Hei huarahi mā tatou I te rangi nei
Aroha atu, aroha mai
Tātou i a tatou i ngā wā katoa
Hui e tāiki e*

May peace be widespread
May the sea be smooth like greenstone
A pathway for us all this day
Give love, receive love
Let us show respect for each other

The experience of ‘good care’ in the fast-paced world of the medical or surgical ward is complex. With the current emphasis on efficiency and getting patients through the system, we need to reclaim the place of ‘love’ and ‘manaakitanga’. While individuals have different ‘roles’ to perform, it is ‘*how they are*’ as they go about their day that is recognised and felt by others as ‘good care’. As this blessing infers, while not always easy, it is possible for peace to be widespread, for love to show, for respect (as seen in manaakitanga) to be apparent and ‘good care’ to flourish in the current healthcare environment. A final word from Heidegger (2000):

To embrace a ‘thing’ or a ‘person’ in its essence
means to love it, to favor it’
and such favoring can let something
essentially unfold in its provenance,
that is, let it be.

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Glossary

All definitions from the “*Raupō Dictionary of Modern Māori*” (Ryan, 2012), unless otherwise indicated.

| Māori Term | Meaning |
|----------------------|--|
| Awa | river, channel |
| Iwi | tribe, people, nation |
| Karakia | prayers |
| Korowai | cloak of protection |
| Mana | integrity, charisma, prestige, formal, status, jurisdiction, power, control |
| Manaakitanga | hospitality |
| Marae | meeting area of whānau or iwi, focal point of settlement, central area of village and its buildings, courtyard |
| Maunga | mountain, act of carrying |
| Me te rangimarie | peace |
| Mihimihi | greetings |
| Ngāi Tahu | title of tribe |
| Powhiri | welcome ceremony |
| Taha hinekaro | emotion |
| Taha tinana | physical |
| Taha wairua | spiritual |
| Taha whānau | social |
| Tangata Whenua | local people, aborigine, native |
| Te ao Māori | traditional Māori society (Rochford, 2004) |
| Te aroha | love |
| Te reo | Māori language (Rochford, 2004) |
| Te Tiriti o Waitangi | Treaty of Waitangi |
| Te Whakapono | hope (or faith) |
| Tikanga Māori | Māori customs |
| Toku ingoa | my name, title |

| | |
|----------------|--|
| Tātou, tātou e | for all of us |
| Waiata | song |
| Waka | canoe, vehicle, container, descendants of historic canoe, confederate tribes of one canoe |
| Whakapapa | genealogical table |
| Whakataukī | Māori proverb |
| Whānau | extended family (Lambert, 2007) |
| Whare Tapa Wha | a holistic model of health (four cornerstones of health) (Rochford, 2004) |

Appendices

Appendix A: AUTECH Approval



Auckland University of Technology Ethics Committee (AUTECH)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

11 October 2018

Liz Smythe
Faculty of Health and Environmental Sciences

Dear Liz

Re Ethics Application: **18/337 The meaning of 'good care' in the medical/surgical hospital experience**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTECH).

Your ethics application has been approved for three years until 11 October 2021.

Standard Conditions of Approval

1. A progress report is due annually on the anniversary of the approval date, using form EA2, which is available online through <http://www.aut.ac.nz/research/researchethics>.
2. A final report is due at the expiration of the approval period, or, upon completion of project, using form EA3, which is available online through <http://www.aut.ac.nz/research/researchethics>.
3. Any amendments to the project must be approved by AUTECH prior to being implemented. Amendments can be requested using the EA2 form: <http://www.aut.ac.nz/research/researchethics>.
4. Any serious or unexpected adverse events must be reported to AUTECH Secretariat as a matter of priority.
5. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTECH Secretariat as a matter of priority.

Please quote the application number and title on all future correspondence related to this project.

AUTECH grants ethical approval only. If you require management approval for access for your research from another institution or organisation, then you are responsible for obtaining it. You are reminded that it is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard.

For any enquiries, please contact ethics@aut.ac.nz

Yours sincerely,

Kate O'Connor
Executive Manager
Auckland University of Technology Ethics Committee

Cc: janette.dewar@gmail.com; Deb Spence

Appendix B: Māori Ethics Committee Support Letter



**Te Whare Rapuora/Pae Ora
Māori Health Directorate**
PO Box 2056, Palmerston North
Phone (06) 350 8210
Fax (06) 350 8158

29 June 2018

To whom it may concern
Auckland University of Technology Ethics Committee (AUTEC)
AUT
Auckland

Tēnā koe,

Re: The meaning of 'good care' in the medical/surgical hospital experience

I write to you as a member of the Māori Research Review Group, MidCentral District Health Board to indicate my support for the above mentioned study.

The proposed research has been outlined to me by Jan Dewar and we have discussed aspects of the study that may be particularly relevant for Māori participants (staff, patients and whānau) who have had experiences with medical/surgical services at Palmerston North Hospital.

I confirm that the Māori Research Review Group will provide Jan with any necessary advice and support to enhance the cultural responsiveness of her research to Māori and to fulfil the obligations of Te Tiriti o Waitangi.

*Whaowhia te kete mātauranga
Fill the basket of knowledge.*

Heoi ano

On behalf of the Māori Research Review Group

Dr Janine Stevens
Public Health Physician, Pae Ora Māori Health Directorate
MidCentral District Health Board
M: 027 40 60 595
E: janine.stevens@midcentraldhsb.govt.nz

Appendix C: DHB Ethics Approval



MID CENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Rūhine o Tairāroa

CentralPHO
Working together, towards healthy
and flourishing communities



Doc. Code:

Policy for Health Research

MDHB APPROVAL FORM FOR LOW RISK RESEARCH ACTIVITY

| |
|---|
| Use this form if your application is for; |
| <ul style="list-style-type: none"> A cost-neutral study (no budget required at MDHB) AND EITHER An audit or minimal risk study that does not qualify for review by a Health and Disability Ethics Committee OR A low risk observational study reviewed by a Health and Disability Ethics Committee via the expedited pathway, except when any participants will receive non-standard care as part of the research OR A low risk study by a non-MDHB researcher reviewed by an institutional ethics committee |

Research ID (RSO to complete)

2018.10.002

| Section 1: General | | | |
|---|--|-------------|-----------------------------------|
| Full Project Title | The meaning of 'good care' in the medical/surgical hospital experience | | |
| Principle Investigator | Jan Dewar | | |
| MDHB Service Area | Medical/surgical wards | Designation | If relevant |
| Address | 31a Puriri Terrace | | |
| Phone | 0275454635 | | |
| Email | jan.dewar@midcentraldhb.govt.nz | | |
| For non-MDHB employees, please provide name of MDHB contact person. | | | |
| MDHB Contact Name | Signature | | |
| Job Title | Phone No. | | |
| Service | Email | | |
| For student projects (e.g. summer, masters and doctoral), please provide name of MDHB clinical supervisor, if different to the contact person (above). | | | |
| MDHB Clinical Supervisor Name | Celina Eves | Signature | |
| Job Title | EDONM | Phone No. | 06 350 8908 |
| Service | Nursing | Email | Celina.eves@midcentraldhb.govt.nz |
| Other Contact Name | | Phone No. | |
| | | Email | |
| Student Led? | Yes/No | | |
| Clinical supervisor: In relation to this student and this project I take the responsibility to ensure: The student investigator is appropriately advised on clinical safety and correct processes in the interests of the patients involved in this research, and in the interests of MDHB | | | |
| Yes/No | | | |

| Section 2: Proposal |
|---|
| Indicate the study type: e.g. Outcome analysis, Registry, Low risk interventional study For definitions, please refer to: Standard Operating Procedures for Health and Disability Ethics Committees, version 1.0 2012 http://ethics.health.govt.nz/operating-procedures |
| Student let research <input checked="" type="checkbox"/> |
| Briefly, what is the principal study question (hypothesis) that your study will examine? What does it mean to give and receive good care in the medical/surgical hospital experience? |

Appendix D: Patient Participant Recruitment Notice



Invitation to patients who have experienced 'good care' in a medical or surgical ward

Have you:

- Been a patient in a medical or surgical ward for more than 3 days in the past year

AND

- Experienced 'good care' during your hospital stay

If this is you then please read on....

My name is Jan Dewar, I am a Registered Nurse and currently a student at AUT carrying out research into 'good care' as part of my Doctor of Health Science qualification.

I am really interested in discovering more about the experience of 'good care' in the medical or surgical wards so that I can help build on that knowledge to make sure that 'good care' happens more often for patients and family/whanau.

My aim is to bring together this range of ideas to understand how 'good care' is experienced both by those receiving care and those providing it.

Are you interested in finding out more or taking part in this research?

If you think that you would be interested in participating in this research, please contact the researcher directly using the contact details below for a full information sheet.

Researcher Contact Details:

Jan Dewar - jan.dewar@midcentraldhb.govt.nz or +64 27 5454 635

Date Recruitment Sheet Produced: 29 September 2018

Appendix E: Participant Information Sheet



Information Sheet for patients and family / whānau

This information sheet is provided for patients and family/whānau of patients who may be able to assist in this research about 'good care'.

Date Information Sheet Produced: 1 July 2018

Project Title: *The meaning of 'good care' in the medical/surgical hospital experience*

An Invitation

My name is Jan Dewar, I am a Registered Nurse and currently a student at AUT carrying out research into 'good care' as part of my Doctor of Health Science qualification.

I am really interested in discovering more about the experience of 'good care' in the medical or surgical wards so that I can help build on that knowledge to make sure that 'good care' happens more often for patients and family/whānau.

I plan to interview patients and family members/whānau about their experience of 'good care'. As well I will be talking to a wide range of hospital staff including nurses, doctors, physios, cleaners, care assistants to understand from many perspectives what 'good care' is like.

My aim is to bring together this range of ideas to help us all understand how 'good care' is experienced both by those receiving care and those providing it.

I would like to invite you to help with this study by telling me your story about receiving care you thought was 'good'. Whether or not you decide to take part will not have any influence on future care that you may need, you are completely free to join the study or not take part, it is up to you.

What is the purpose of this research?

The reason that I am doing this research is to better understand the experience of 'good care' in the medical or surgical hospital experience. When this research is finished I hope it will help inform the way care is provided and experienced in medical/surgical settings in New Zealand hospitals. Once I have finished the study I hope to publish a thesis and also to provide information about the experience of good care to journals and at conferences. I would also like to make a short video clip that showcases the experience of good care as a teaching tool for hospital staff and patients alike to better understand good care, and therefore influence how care is provided and experienced. Some participants may be invited to re-tell some of their stories later in the study. This would involve a separate consent process. It is fine to say 'No' to the video part of the project. I am carrying out this study as part of my Doctor of Health Science qualification.

How was I identified and why am I being invited to participate in this research?

You have been given this information about the study because you have identified that you have experienced good care in hospital either through verbal feedback to staff, through responding to a notice or through indicating this to someone who knows me (the researcher) and has recommended that you might be interested in being included in this study. To be part of the study you will need to have spent at least 2 nights in hospital.

How do I agree to participate in this research?

When you have read this information sheet, please feel free to contact me either by email at jan.dewar@midcentralthb.govt.nz or text/phone me on 027 5454 635 if you have any questions, or would like to participate, leave me your details and I will be in contact with you.

If you decide to be part of this study, there is a consent form that you will need to complete which I will send to you. Once we have made contact with each other, we can decide together how this would work best for you. My contact details are in the questions above.

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

What will happen in this research?

Taking part in this research will mean talking to me about your experience of good care in a medical/surgical setting. I will invite you to tell me your story and will tape this conversation so that I can remember the details later on. We

will meet somewhere that is convenient to you for the conversation, I could come to your home or somewhere that you would prefer, or we could meet at the hospital in a meeting room. This could take up to 1 ½ hours of your time. The tape will be typed up and you will be given a copy of your story or stories so that you can be sure that they are as you meant to tell them. Once this is done, I will work on reading in depth the various stories that I have and work hard to describe the experience of 'good care' from a variety of perspectives.

Once I have finished looking at all the stories, I might come back to you to ask if you would be happy to read or retell your story on video, or have someone else read the story for you. This is because I want to make a short video that highlights what 'good care' is like so that staff and patients can watch it to improve understanding of how to achieve 'good care' in our hospitals in the future. As previously stated, you have the right to say 'No' to the video phase of the project.

I will also be writing a thesis (large document) that will describe the entire study and what has been learned by pulling together the stories from a range of patients, family, whanau and staff. This will be used to write articles for journals and also to present at conferences on how people experience 'good care' in hospital.

What are the discomforts and risks?

I am hoping that you will really enjoy telling me your story of your experience of 'good care' in hospital, however in the retelling of your story, there may be some aspects of care that are not good. In our conversation we will try to focus on what would have made these things good, and not to name individual staff. However, if there are things that need further discussion you may wish to discuss those aspects further.

How will these discomforts and risks be alleviated?

If you feel any distress or wish to discuss anything that comes up from telling me your story, there is support available. If anything about poor care or other issues come up in your interview, I may advise you to contact your general practice team (doctor or nurse) in the first instance to discuss options.

Your general practice is able to refer you for up to three free counselling provided through the YOSS service or another suitable service if required.

How will my privacy be protected?

All information that you provide will be kept confidential so that you cannot be recognised in any publications or presentations about the experience of 'good care'.

If you agree to participate in reading or retelling your story for the short video, then you may be recognisable to those who know you. We would agree on a first name that you may want to use in the retelling of your story, your last name will not be used. This video clip may become available to the public via the internet.

What are the costs of participating in this research?

I estimate that telling me your story may take up to 1 ½ hours. Also when I return your story or stories to you, it may take approximately half an hour to read and confirm these. There should be no other financial costs involved in taking part in the study.

What opportunity do I have to consider this invitation?

If you would like to be part of this study, please let me know within the next 2 weeks either by email at jan.dewar@midcentraldhb.govt.nz or by text at 027 5454 635 and I will make contact with you.

Will I receive feedback on the results of this research?

When the study is finished, the thesis will be available in the MidCentral DHB library. I will provide you with a short summary of the main findings of the study for your information.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Liz Smythe who can be contacted at liz.smythe@aut.ac.nz or by phone on +64 21 351 005

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTC, Kate O'Connor, ethics@aut.ac.nz, 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please contact the researcher for further details - jan.dewar@midcentraldhb.govt.nz or +64 27 5454 635

Please keep this Information Sheet and a copy of the Consent Form for your future reference.

Researcher Contact Details: Jan Dewar - jan.dewar@midcentraldhb.govt.nz or +64 27 5454 635

Project Supervisor Contact Details: Liz Smythe - liz.smythe@aut.ac.nz or by phone on +64 21 351 005
Approved by the Auckland University of Technology Ethics Committee on 11/10/2018, AUTC Reference number 18/337



Participant Information Sheet for staff

This information sheet is provided for staff who may be able to assist in this research about 'good care'.
Date Information Sheet Produced: 2 July 2018

Project Title

The meaning of 'good care' in the medical/surgical hospital experience

An Invitation

My name is Jan Dewar, I am a Nurse Director and currently a student at AUT carrying out research into 'good care' as part of my Doctor of Health Science qualification.

My research is aimed at revealing the experience of 'good care' in the medical or surgical wards, to build on the knowledge we already have, to find ways that a team can ensure that 'good care' happens consistently for patients and family/whanau.

I plan to interview patients and family members/whanau about their experience of 'good care'. As well I will be talking to a wide range of hospital staff including nurses, doctors, physios, cleaners, care assistants to understand from many perspectives what 'good care' is like.

My aim is to bring together this range of ideas to understand how 'good care' is experienced both by those receiving care and those providing it.

I would like to invite you to participate in this study by telling me your story about delivering or being involved in patient care that you thought was 'good'. Whether or not you decide to take part will not have any influence on your current position. You are completely free to join the study or not take part, it is up to you.

What is the purpose of this research?

The reason that I am doing this research is to better understand the experience of 'good care' in the medical or surgical hospital experience. When this research is finished I hope it will help inform the way care is provided and experienced in medical/surgical settings in New Zealand hospitals. My results will be published as a thesis, in journal articles and presented at conferences. I would also like to make a short video clip that showcases the experience of good care as a teaching tool for hospital staff and patients alike to better understand good care, and therefore influence how care is provided and experienced. I am carrying out this study as part of my Doctor of Health Science qualification.

How was I identified and why am I being invited to participate in this research?

You have been given this information about the study because you provide 'good care' in a medical or surgical ward and have indicated an interest in this research study. A range of staff are included in this study with the aim of bringing together the views of a range of staff involved in care provision such as nurses, doctors, allied health staff members, auxiliary staff and other staff who interact with patients in the medical/surgical area, along with the experience of patients and family/whanau. Your experience as a care provider will add to the information that is collated to give depth and richness to the study by inclusion of a range of perspectives.

How do I agree to participate in this research?

When you have read this information sheet, please feel free to contact me either by email at jan.dewar@midcentraldhb.govt.nz or text/phone me on 027 5454 635 if you have any questions, or would like to participate, leave me your details and I will be in contact with you.

If you decide to be part of this study, there is a consent form that you will need to complete which I will send to you. Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

What will happen in this research?

Taking part in this research will mean talking to me about your experience of delivering 'good' care in a medical/surgical setting. I will invite you to tell me your story and will tape this conversation, a transcript of the stories you tell me will be provided to you for checking. We will meet at the hospital in a meeting room and I anticipate that the interview could take up to 1 ½ hours of your time. Once the transcript has been checked by you,

the information that you give me will be used to describe the experience of 'good care' from a variety of perspectives.

Once I have assimilated all the information from a range of interviews with staff and patients, family/whanau, I might come back to you to ask if you would be happy to read or retell your story on video, or have someone else read the story for you. This is because I want to make a short video that highlights what 'good care' is like so that staff and patients can watch it to improve understanding of how to achieve 'good care' in our hospitals in the future.

What are the discomforts and risks?

I am hoping that you will really enjoy telling me your story of your experience of delivering 'good care' in hospital, however in telling me your experiences, some aspects of care that is not good may arise. In our conversation we will try to focus on what would have made these things good, and not to name individual staff. However, if there are things that need further discussion you may wish to discuss those aspects further.

How will these discomforts and risks be alleviated?

If you feel any distress or wish to discuss anything that comes up from telling me your story, there is support available. If anything about poor care or other issues come up in your interview you are able to contact the Employee Assistance Programme. This is a free and confidential service funded by the DHB offering up to 6 counselling sessions.

How will my privacy be protected?

All information that you provide will be kept confidential so that you cannot be recognised in any publications or presentations about the experience of 'good care'.

If you agree to participate in reading or retelling your story for the short video, then you may be recognisable to those who know you. We would agree on a first name that you may want to use in the retelling of your story, your last name will not be used. This video clip may become available to the public via the internet, a separate consent form will be offered to you should you agree to this aspect of the research.

What are the costs of participating in this research?

I estimate that telling me your story may take up to 1 ½ hours. Also when I return your story or stories to you, it may take approximately half an hour to read and confirm these. There should be no other financial costs involved in taking part in the study. This study has the support of the DHB so time for the interview can be negotiated with your manager, I am happy to assist you with gaining permission to arrange this.

What opportunity do I have to consider this invitation?

If you would like to be part of this study, please let me know within the next 2 weeks either by email at jan.dewar@midcentraldhb.govt.nz or by text at 027 5454 635 and I will make contact with you.

Will I receive feedback on the results of this research?

When the study is finished, the thesis will be available in the MidCentral DHB library, and online via the AUT library. I will provide you with a short summary of the main findings of the study for your information.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Liz Smythe who can be contacted at liz.smythe@aut.ac.nz or by phone on +64 21 351 005

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEK, Kate O'Connor, ethics@aut.ac.nz, 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the researcher as follows: Jan Dewar – jan.dewar@midcentraldhb.govt.nz or +64 27 5454 635

Researcher Contact Details:

Jan Dewar - jan.dewar@midcentraldhb.govt.nz or +64 27 5454 635

Project Supervisor Contact Details:

Liz Smythe – liz.smythe@aut.ac.nz or by phone on +64 21 351 005

Appendix F: Participant Consent Form



Consent Form

Project title: The meaning of 'good care' in the medical/surgical hospital experience

Project Supervisor: Liz Smythe

Researcher: Jan Dewar

- ☐ I have read and understood the information provided about this research project in the Information Sheet dated 01 July 2018.
- ☐ I have had an opportunity to ask questions and to have them answered.
- ☐ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- ☐ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- ☐ I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- ☐ I agree to take part in this research.
- ☐ I wish to receive a summary of the research findings (please tick one): Yes ☐ No ☐

Participant's signature:

Participant's name:

Participant's Contact Details (if appropriate):

.....
.....
.....
.....

Date:

Approved by the Auckland University of Technology Ethics Committee on 18 October 2018 AUTEK Reference number 18/337

Note: The Participant should retain a copy of this form.

Appendix G: Interview Questions



Indicative Questions for patients/whanau and staff

This information sheet is provided for patients and family/whanau of patients who may be able to assist in this research about 'good care'.
Date Produced: 1 July 2018

Project Title: *The meaning of 'good care' in the medical/surgical hospital experience*

What is the purpose of this research?

The reason that I am doing this research is to better understand the experience of 'good care' in the medical or surgical hospital experience. When this research is finished I hope it will help inform the way care is provided and experienced in medical/surgical settings in New Zealand hospitals. Once I have finished the study I hope to publish a thesis and also to provide information about the experience of good care to journals and at conferences. I would also like to make a short video clip that showcases the experience of good care as a teaching tool for hospital staff and patients alike to better understand good care, and therefore influence how care is provided and experienced. I am carrying out this study as part of my Doctor of Health Science qualification.

What indicative questions will be asked?

Data will be collected in a face-to-face interview. An open interviewing style will be used where listening is essential and achieved by guiding the conversation to the topic of interest, inviting the participant to recount a story of an episode (or episodes) of good care. There will be questions that are a guide only, used to orientate the participant back to the intent of the research where the story has digressed to another topic that has more detail than required (Van Manen, 2007b). Participants will be encouraged to tell the story as they wish to tell it; too much direction runs a risk of missing hidden meanings as the story unfolds. The purpose of the interview is to both gather and reflect on lived experience material, with the participant being a collaborator of the study (Van Manen, 2007b).

Examples for ex-clients:

Open question: tell me about a time when you received 'good care' in hospital?

Examples of orientating questions:

- Tell me about the circumstances of your admission to hospital?
- Tell me about the situation around you at the time?
- Tell me your story of what made you feel that you were receiving good care?
- Tell me who the people were who gave you care and what they did?
- Tell me about the things that happened that helped you decide that your care was good?

Examples for health professionals

Open question: Tell me about providing 'good care' in hospital

Examples of orientating questions:

- Tell me about a recent client you cared for where you had a sense of the care being very an example of 'good'
- Tell me about yesterday, how was your care 'good'?
- Tell me a story that stays in your mind as being about care that was outstandingly 'good'

Examples for those not directly involved in care

- Tell me about something you have worked on recently that you believe has impacted on the provision of 'good care'
- Have you a story of how some 'directive' you were involved with improved care?

The interviews will be digitally recorded and then transcribed. The transcript will then be crafted into stories using the words of the participants. This method removes grammatical errors and lapses and seeks to coherently crystallise meaning (E. Smythe, 2011). Stories will then be returned to participants to provide an opportunity for participants to ensure that the meaning of their story has been captured, and to provide an opportunity for changes or clarifications to be suggested.

Researcher Contact Details: Jan Dewar - jan.dewar@midcentraldhb.govt.nz or +64 27 5454 635

Project Supervisor Contact Details: Liz Smythe – liz.smythe@aut.ac.nz or by phone on +64 21 351 005

Approved by the Auckland University of Technology Ethics Committee on 11/10/2018, AUTEK Reference number 18/337.

Appendix H: Transcriber Confidentiality Agreement



Confidentiality Agreement

Project title: The meaning of 'good care' in the medical/surgical hospital experience

Project Supervisor: **Liz Smythe**

Researcher: **Jan Dewar**

- ☐ I understand that all the material I will be asked to transcribe is confidential.
- ☐ I understand that the contents of the tapes or recordings can only be discussed with the researchers.
- ☐ I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature:

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Approved by the Auckland University of Technology Ethics Committee on 11 October 2018 AUTC Reference number 18/337

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Appendix I: Working with the Story

First draft of working with a story

Well Mrs D hadn't looked at her stoma and it was quite an ugly looking stoma, so to speak. The afternoon nurses handed over that she wasn't really that keen to participate in the care that she was just a little bit put off by it I suppose. So I said to her, oh you know I'm going to empty your stoma now, we often find that with women, it takes them longer to get their head around things but once they have, from a practical point of view they're often better with their hands because we do more fine motor skills as women than men often do. So I had a chat to her, about the way that the stoma looked and I said to her, that, whilst it was large and quite protrusive that would make it a lot easier to manage and personally, I would rather have a large protrusive stoma that is going to have a bag that adheres really well, than a small flat one that is more prone to leaking. And I explained to her that some patients do name their stomas so that, if they are out and about they need to just go and deal with Fred, and sometimes it's helpful to name it after someone you really don't like. So we have a little bit of a laugh and giggle about that. So just trying to normalise it a little bit more. And so we talked about the fashions and how you can wear different clothing and tunics and those types of things and you actually, wouldn't know. Previously when I've had a patient like that, the lovely AD has come up as she also has a stoma and she's got a sense of dress and no one would ever know and she's so wonderfully humble to come forward and share those experiences with other people. And they think if you can be a professional doctor and look so well put together and have this, then maybe I can manage this in the community as well. So sort of seeking out other resources, who can empathise as much as sympathise with and give practical solutions as well.

Jenny the nurse seems to have an understanding of the underlying issues around acceptance of a stoma, she is attuned to Mrs D's struggle to accept and manage her new stoma. Jenny takes a gentle but pragmatic approach using both humour and practical advice to coach and encourage Mrs D to move along with her healing journey. The idea of naming the stoma may not appeal to everyone but in this instance was a perfect way to inject some humour and lightness into the day, and to progress onto more practical ways to manage. Jenny can see that the issue is not only one of practical ability, but a matter of assisting Mrs D to 'get her head around' the huge change in terms of body image and the enormity of going on generally with a 'normal' life. She is aware that too much too soon is not good but is also committed to moving Mrs D along towards acceptance and ability to manage positively in the end. Her idea of identifying someone who manages very well with a stoma in a similarly professional setting is aimed at giving a sense of hope that it is possible to carry on. Caring is about attending to the emotional and intellectual needs of Mrs D as well as the physical needs. Maintaining a sense of dignity seems to be a driver for Jenny, she has

listened to her colleagues assessment and undertakes to approach Mrs D with respect but also an underlying commitment to her progress and eventual ability to cope with her new circumstances.

Final draft working with a story

Jenny, a registered nurse introduces us to Mrs D, a patient with a newly formed stoma who had transferred from the intensive care unit several days early and was recovering from complications following her surgery.

Mrs D hadn't looked at her stoma and it was quite an ugly looking stoma, so to speak. The afternoon nurses handed over that she wasn't really that keen to participate in the care, that she was just a little bit put off by it. (Jenny)

When Jenny, the nurse came on the night shift she took over the care of Mrs D. She went to see Mrs D and had a conversation with her about the stoma. This was not just any conversation, for Jenny this was an opportunity to read her mood, to see where she was at, to judge how to respond to the information passed on by the afternoon nurses.

So I said to her, 'oh you know I'm going to empty your stoma now', we often find that with women, it takes them longer to get their head around things but once they have, from a practical point of view they're often better with their hands because we do more fine motor skills as women than men often do. So I had a chat to her, about the way that the stoma looked and I said to her, that, whilst it was large and quite protrusive that would make it a lot easier to manage and personally, I would rather have a large protrusive stoma that is going to have a bag that adheres really well, than a small flat one that is more prone to leaking. (Jenny)

Jenny seems to understand the underlying issues around acceptance of a stoma. She is attuned to Mrs D's struggle to accept and manage her new stoma. Jenny takes a gentle but pragmatic approach discussing the stoma in a matter of fact, everyday kind of way. She offers practical advice to coach and encourage Mrs D to move along with her healing journey. Though this conversation is written as one dialogue, in real time it is likely there are pauses, looks, unspoken questions. Jenny senses the mood of Mrs D as she empties the stoma bag, as she observes Mrs D's action or reaction as she does this. She senses the time to provide information from her own experience that makes the stoma seem every-day, average, not something to be afraid of or that is insurmountable. Jenny senses that Mrs D is ready to have a conversation, she is succinct about how she describes the stoma – large and obtrusive.

Perhaps Mrs D has thought of it this way, perhaps she hasn't. All the time Jenny is talking, it seems she is also sensing where the mood is taking Mrs D, deciding whether to press on, or not.

Jenny aligns herself as a woman alongside Mrs D, by inserting the word 'we' into the conversation. This moves the conversation from being about someone out there, an unknown anonymous person, to 'us' the people in the room. The nurse and the patient, two women working on a problem together, united in finding a way forward. She talks about what she would want if she had a stoma. This is not something that most people may have thought about, but for Jenny it is natural to put herself in position of the other, to be-with ((Heidegger, 2008). She talks about her own thoughts, imagining herself in the situation. Her tactful way of expressing this gives an invitation for Mrs D to think about the stoma in a different way.

"Dasein's facticity is such that its Being-in-the-world has always dispersed itself or even slit itself up into definite ways of Being-in. The multiplicity of these is indicated by the following examples: having to do with something, producing something, attending to something and looking after it, making use of something, giving something up and letting it go, undertaking, accomplishing, evincing, interrogating, considering, discussing, determining All these ways of Being-in have *concern* as their kind of Being.... Leaving undone, neglecting, renouncing, taking a rest – these too are ways of concern; but these are all *deficient* modes, in which the possibilities of concern are kept to a 'bare minimum'" (Heidegger, 2008, p. (83)[57]). One can sense Jenny's concern for Mrs D. Faced with information about the stoma, Jenny observes the mood of Mrs D and feels enough concern that she undertakes to act on the information she has. She chooses to engage with Mrs D about her stoma and go beyond the mere task of emptying the stoma, to probe and discuss. This was not Jenny's first night on duty. She was able to build on her previous relationship with Mrs D to dive straight in, to go beyond surface chat, to the heart of the matter.

The feeling of concern is one thing, the decision to act by discussing a sensitive topic is another. To do that takes an ability to read or notice the subtleties of how Mrs D is, to see if she is in fact ready to even have a conversation at all. Then to find a way to open the conversation, to invite Mrs D into the moment and to help. This concern and willingness to

help, does not necessarily signal an ability to act in a way that is helpful. To do that takes more than a recognition of the situation and the mood of Mrs D, it takes tact to find the right way to do it (Smythe et al., 2014).

Tact

Tact takes effort. It is being extra vigilant to see the subtle signs of the mood of the other. To use tact takes additional noticing, watching out for signs of response, being prepared to change course at any time with a subtle ‘change in the air’(Smythe et al., 2014). How does one sense a mood to make the subtle, immediate and swift changes of direction to ensure the response we are giving is acceptable to the other? It is in the words we use but also our own mood and subtle signals we send. A look too long, or too short, a hesitation perhaps. Tact is different from diplomacy, tactful response is always couched in a desire for ‘good’ for the other (van Manen, 1995).

To respond with tact takes a ‘tentative confidence’, interpreting as one goes (Gadamer, 2004). When Jenny was working with Mrs D and her stoma, tact seems to have many faces. It appears in her confident handling of the stoma, a physical act. It is present in the eye contact and acceptance of the stoma as being everyday, ordinary, not something to be concerned about. Jenny chose the moment to dive right in, to empty the stoma and bring up the subject. She continues...

And I explained to her that some patients do name their stomas so that, if they are out and about they need to just go and deal with Fred, and sometimes it's helpful to name it after someone you really don't like. So we have a little bit of a laugh and giggle about that. So just trying to normalise it a little bit more. And so we talked about the fashions and how you can wear different clothing and tunics and those types of things and you actually, wouldn't know. (Jenny)

The idea of naming the stoma may not appeal to everyone but in this instance it is a way to inject some humour and lightness into the day. To progress onto more practical ways to manage. Jenny can see that the issue is not only one of practical ability. It is a matter of assisting Mrs D to ‘get her head around’ the huge change in terms of body image, and the enormity of getting on with a ‘normal’ life. Jenny alludes to her previous experience of caring for articulate women with stomata. This is not the first time that she has noticed the distress communicated in the non-verbal actions of ‘not looking’ or not engaging in learning how to care for a stoma. She recognises the adjustment needed and feels concern for Mrs D.

Further to her concern, she feels a responsibility to help. Jenny's concern, previous experience, internal motivation and tact all come together. She facilitates meaningful conversation with Mrs D about the stoma and what may lie ahead. Use of the third person is far less challenging than a direct instruction.

After the discussion, Jenny talks about the other tools 'in her pocket' to help Mrs D. Once again, she has previous experience. She knows that seeing another person in the same situation is more helpful than the imaginary situation she has described:

Previously when I've had a patient like that, the lovely AB has come up as she also has a stoma and she's got a sense of dress and no one would ever know and she's so wonderfully humble to come forward and share those experiences with other people. And they think if you can be a professional doctor and look so well put together and have this, then maybe I can manage this in the community as well. (Jenny)

As Jenny talks with Mrs D about the stoma, she assesses, looks, wonders if now is the right time to bring someone in such as "the lovely AD". Tact is not only about saying the right thing, sensitivity to the timing of the conversation or action is a critical factor (Smythe et al., 2014). To ask AD to come too early would not have the same effect as coming 'at the right time'. Jenny knows that this needs to be at a time when Mrs D is ready to talk, ask questions, take in the personhood of AD.

Appendix J: Clustered Stories

| Number | Person | Topic | Done | To do | Leave ?? |
|--------|--------|---|------|-------|----------|
| 1 | Dr | Complex cancer | ✓ | | |
| 2 | Dr | Girl with anorexia | | ✓? | |
| 3 | RN | Complex pain | | ✓ | |
| 4 | RN | Elderly Māori lady – respect, tact, phronesis | | ✓ | |
| 5 | RN | Woman with stoma | ✓ | | |
| 6 | RN | Māori man with pain and diabetes | | ✓ | |
| 7 | RN | Lady with a schnauzer | | | ✓ |
| 8 | RN | Running and pumpkin soup | | | ✓ |
| 9 | RN | The Friday walkaround | | | ✓ |
| 10 | RN | Night shift nasogastric change | | ✓? | ✓? |
| 11 | RN | The PR bleed on nights | | | ✓? |
| 12 | HCA | Managing challenging behaviour | | | ✓ |
| 13 | HCA | The Fiddles | | ✓ | |
| 14 | Physio | Pt learning to pick things up | | | ✓ |
| 15 | Physio | Man learning to walk | | | ✓? |
| 16 | Physio | Pt regaining movement in back | ✓ | | |
| 17 | Pt 1 | Timing | | | ✓? |
| 18 | Pt 1 | Getting a walker | ✓ | | |
| 19 | Pt 1 | The lovely booking clerk and the lovely nurse | ✓ | | |
| 20 | Snr Ns | Lady with stroke | ✓ | | |
| 21 | Snr Ns | Lady with large bleed in ED | | | ✓ |
| 22 | Snr Ns | Great stroke pathway | | | ✓ |
| 23 | Snr Ns | Man crying with a stroke | | ✓ | |
| 24 | OT | Demanding daughter | ✓ | | |
| 25 | OT | Māori lady non functioning limb | ✓ | | |
| 26 | OT | Personal story – parents dementia | ✓ | | |
| 27 | OT | Large Māori family | | | ✓Herm ch |
| 28 | OT | Being practical not oversharing | | | ✓ |
| 29 | OT | Stroke assessment and plan | | | ✓ |
| 30 | SCC | Man with cancer | ✓ | | |
| 31 | Pt 2 | Husband little things | ✓ | | |
| 33 | Pt 2 | Removal of ring | ✓ | | |
| 34 | Pt 2 | Working in partnership | ✓ | | |
| 35 | Pt 2 | Kindness – putting in the effort | ✓ | | |

| 36 | RN Māori | Lady with dementia | | | ✓ |
|--------|----------|---------------------------------------|------|-------|----------|
| Number | Person | Topic | Done | To do | Leave ?? |
| 37 | RN Māori | Challenging frequent attender | ✓ | | |
| 38 | RN Māori | Cultural connections | ✓ | | |
| 39 | FSA | Sitting and praying | ✓ | | |
| 40 | FSA | Getting to know and peeling an orange | ✓ | | |
| 41 | FSA | The HCA and the clothes | ✓ | | |
| 42 | FSA | Small acts of kindness | ✓ | | |
| 43 | Pt 3 | Nurse wairua | ✓ | | |
| 44 | Pt 3 | Unreal doctors | ✓ | | |
| 45 | Pt 3 | Mahi Tahi and the social worker | | | ✓ |
| 46 | Pt 3 | The Chinese cleaner | | | ✓ |
| 47 | Cleaner | Starting a conversation | ✓ | | |
| 48 | Cleaner | Mopping the floor | | | ✓ H&S |
| 49 | FSA | Learning to care from my mother | | | ✓? |
| 50 | Cleaner | The karakia | ✓ | | |
| 51 | SW | Young Māori woman with complex needs | | | ✓ |
| 52 | SW | Samoan woman going into care | | ✓? | |