School of Nursing

Health to Health Promotion: Transforming Health Experience into Nursing Practice.

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ABSTRACT

In contemporary Western nursing, the notion of health is considered a basic concept in all nursing theory, yet the many nursing theorists have failed to express unanimity in their various descriptions of health. This situation exists even while the achievement of health is generally identified as the goal or purpose of nursing. In Australia, the requirement that nurses become health-promoting practitioners assumes that nurses understand health in positive ways, which can be translated into nursing practice. Given the myriad definitions of health, confusion among nurses about the nature of health as it is to be promoted appeared possible, even probable.

This phenomenological research aimed to illuminate the nature of nurses’ understandings of health and the ways such understandings are translated into nursing practice. The purpose of the study was to describe and interpret nurses’ experiences of health, and their experiences of giving health care to someone in their care, in order to illuminate the nature of health for nurses and in nursing.

The manner in which this research was carried out was informed by the human science approach to phenomenology described by van Manen, which is derived from the traditions of Husserl, Heidegger and Merleau-Ponty. Thus, the inquiry was grounded in the hermeneutic phenomenological philosophical perspective, which began with the work of Husserl who recognised the need to return to the grounding of truths in human experience. The thesis is informed by two views of phenomenology. The first involves the traditional approach to phenomenology advocated by the European phenomenological philosophers while the second approach is referred to by Silverman as arising from ‘American continental’ philosophy.

Data were generated from multiple audiotaped interviews with each of nine
participants, and from personal reflection and journalling undertaken by the researcher during the research process. The dual data analyses were guided by the phenomenological approach of van Manen and by that of various nursing scholars who have used phenomenological methodology as it has evolved from American continental philosophy. These analyses included several levels of reflection undertaken by the researcher and each of the participants in the study to illustrate the nature of health in nurses’ lives and in nursing.

The nature of health, as revealed through the original experience of the participants, was disclosed as manifest in the lives of the participants with most descriptions conveying a sense of contentment that showed as feelings of happiness, feeling alive, complete, energised and optimistic. Health also revealed itself as transient in nature, passing quickly and without notice into and out of the lives of most of the participants. Although obvious in some ways, health simultaneously eluded clear description and, even at the completion of the exploration with each participant, was characterised by an atmosphere of elusiveness. For all the participants, health was an embodied phenomenon with a common element of energy and a sense of wellbeing. These, together with a sense that life was manageable and achievable gave to it a distinctive spirit, even while the spirit simultaneously helped to make life manageable and achievable and thus contributed to health. For all of those who participated, health presented as having the ability to transform their emotional responses to daily life events in such a way that it made those events more acceptable and the tasks of life more achievable.

Although health showed as a physical, embodied state which was expressed as vitality and energy, it could not be separated from the mental / emotional state. As it was described, the following leitmotifs of health were lexically revealed: Health: A different encounter for each person, Health described as peace, Health described as feeling good about oneself, Health described as balance, Health as energy, Health as vitality and zest, Health described as happiness and / or
contentment, Health described as quality of life, The ‘picture of health’, Health described as dignity, and Health as the unknown or the inexpressible.

The nature of health-focused care in nursing showed as caring, rapport building and support, ever dependent on the social relationship that develops between each nurse-carer and the individual to whom they offer care. However, clear relationships between the meanings of health for the nurses in the study and the way they gave health care could not be elucidated. These relationships have not been identified because of the individualistic nature of health-focused care as these nurses have described it. For this reason, this research makes a strong plea for continued dialogue about the relationships between health and health-focused care in nursing.
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PREAMBLE

The idea of writing a preamble had never occurred to me until I realised that in some way, the journey through the methodological differences that has been the path of this thesis needed to be recorded in order that the position from which I speak could be fully explicated.

When I began this project three and a half years ago, I did not choose the phenomenological methodology; in a sense, it chose me. I began with a problem which was a recognition that something was hindering nurses from practising health promotion in the way in which it had been envisaged this would happen. Based on the notion that positive ideas of health are essential to the practice of health promotion (Nutbeam, 1986), I began to wonder about the nature of nurses’ ideas about health. Seeking ways to address this complex problem via traditional scientific methods proved unsuccessful when I realised that neither health itself, nor what was meant by ‘health’ in ‘health promotion’, could be identified narrowly enough to formulate an hypothesis. Thus, I was left to find a way of investigating nurses’ notions of health in a way that would also help me to understand, at least in part, what was happening between an understanding of health and the action of health promotion for nurses.

Subsequent to this realisation, I read a great deal of the phenomenological scholarship in nursing and developed an interest in phenomenology. I read van Manen’s text *Researching Lived Experience: Human Science for an Action Sensitive Pedagogy* (1990) and found it helpful in making less muddy the dense, seemingly impenetrable waters of phenomenological endeavour. It was only after I had enrolled and was writing the proposal for candidature that I endeavoured to read Husserl’s *Ideas: General Introduction to Pure Phenomenology* (1931), Heidegger’s *Being and Time* (1962), and Merleau-Ponty’s *Phenomenology of Perception* (1962). As anyone who has done so would know, a first or even a
second or third reading of these texts does not seem to lay before one with clarity the project of phenomenology.

However obscure the understanding may have been, I began this thesis with the idea that to undertake a ‘phenomenological’ study I would need to conduct interviews with a number of participants. Attempting to instigate descriptions of primordial experience (what I call ‘first-seeing’) of the phenomenon of health from the participants, I asked them to use concept mapping to record the results of their reflections. When this proved not to inspire insight into what that experience was like, I fell back on interviews alone, to elicit the data for this study. It is only now, however, when I reach the end of the journey of this thesis that I realise that silence and reflectiveness go out the door when one individual asks another individual to speak and describe an experience. For between the reality of ‘first-seeing’ and the description of ‘first-seeing’ of a phenomenon itself lies the unbridgeable gulf of language and meanings, which are individually constructed. So, despite my endeavours to reproduce the ‘first-seeings’ of the phenomenon, what I was left with was, for the most part, what Crotty (1996a) refers to as ‘pre-phenomenological’ data; not the ‘first-seeings’ that begin in silence as Spiegelberg (1975) describes.

More recently, I read the works of Crotty (1995, 1996a, 1996b, 1997b, 1997a) and came to understand that the process I had understood as phenomenological was open to question. Subsequently, searching for an American source that spoke with authority about American philosophy, I discovered the work of Silverman (1987) and began to recognise the implications of Crotty’s claim that European phenomenology and American phenomenology are somewhat different. More recently again, I read Paley’s (1997) insightful analysis of the phenomenological project of Husserl. I wondered whether such a project was possible for a person who speaks only English and who is removed in time, language and experience from the world of seeing and writing and being that was Husserl’s.
For all these reasons, what remains is, I think, as much a methodological journey through phenomenological endeavour as it is a phenomenological description of health in nursing. What was ‘seen’ anew of health was achieved glimpse by precious glimpse and, once named, became thought, became part of culture since it can only be interpreted in cultural terms. Once seen and interpreted, it slipped away from the grasp of understanding to become once more elusive and intangible. Nevertheless, what I lay before you here has not been negligible, even though its worth may be difficult to judge since still I am left with the question “What is health in nursing?”

Despite the limitations described, the nurses who participated in this study have been endlessly generous with their time and efforts. This study would not have been possible without their often arduous attempts to reach beyond their own cultural understandings and see the phenomenon of health, as it really is, in their lives. To them, I offer my sincere gratitude and thanks and hope that they see in this document a reflection of the honest searching and generosity of spirit that they gave to the study.
CHAPTER 1

ESTABLISHING THE GROUND FOR THE QUESTION

INTRODUCTION

The philosopher, Gadamer (1976) stated that deciding the question is the way to knowledge in a phenomenological study. However, the first real step to any discovery or creative act is to hit on the problem; to see the presence of that something which is hidden and which may not, therefore, be accessible (Polanyi, 1969). For that reason, the beginning of any thesis, which is to be expressed as an idea or statement and is to be discussed in a logical way, is to discover a specific problem or question deserving of exploration that can give direction to the work. To genuinely question something, however, indicates uncertainty about the thing. The act of questioning gives credence to the unknown or unsettled aspect of the phenomenon and acknowledges that it is a matter for discussion. In doing so, it fosters the search for opposites and similarities in order that the question may be fully understood and the answer clearly explained. Asking a question, then, opens up both possibilities of discovery as well as uncertainty because the examination may bring into dispute that which has previously been confidently held. Thus, while questioning gives direction to the work, it is of the first importance that one seeks to ask the most useful questions.

Personal encounters with health

Questions about health are not new in the annals of nursing or in the health care arena in general and questions about what is meant by health have occurred in my consciousness again and again. First was the idea of the importance of health as it
is presented to every English-speaking person in their daily lives, beginning with the daily greeting "How are you?" and extending to the many proverbs and sayings about health that abound in the English language. A deeper interest in health was kindled in nursing by the position maintained in the nursing literature that health plays such a strong part in nursing, while, in actuality, nursing appears to have little to do with health and all to do with illness and disease. Then again, when I became a community health nurse, my interest in health was restimulated by the notion of health promotion. What view of health were we to promote? Was it to be the obscure notion of health that appeared so tenuously in the everyday reality that was nursing? Or was it to be the type of health written about in nursing literature, or in medical literature perhaps? Maybe it was to be the notion of health that emerged through my own experiences of being healthy. I had pondered these questions as an individual wishing to be 'health-ful', as a nurse seeking answers in my day-to-day practice, as a mother desiring health for my children, as a researcher seeking for ways to ask practicable questions, and as a teaching-team leader seeking to find answers to the question of why we seemed not to be achieving our aims in health-teaching in nursing. Thus, I find myself deeply interested in health and being healthy. The questions 'What does it mean to be health-ful?' and 'What does it mean to give 'health' care?' recur constantly in my life.

**Overview of the thesis**

To clarify for the reader the overriding question of this thesis, the contemporary situation with regard to health and health-focused care in nursing must be scrutinised and discussed since nursing does not exist in a vacuum but is, rather, engaged in and with the community. In this chapter, I explore the many ways health presents itself to nursing in order to expose the need for the question of this thesis that will be posed in Chapter Four. Then, in Chapter Two, I review the literature on health and health promotion in order to clarify the pre-eminent position of these concepts in the nursing literature. In Chapter Three, I present the approach used to study the question. These three chapters present the
underpinnings of the work of the subsequent chapters. Chapter Four is devoted to explicating my position with regard to both the question and the methodology since qualitative research rarely adopts a position of unbiased non-involvement with the question that drives the research. Subsequent chapters will discuss the data and analyses and in the final chapter a number of propositions or theses about the phenomenon will be offered in conclusion of this thesis.

THE SPHERE OF THE NURSE IN HEALTH CARE

While it is true that to work as a nurse today is to work in a time of constant change, nurses’ voices are being heard in the health care sector as they have never been heard before. It is not only that distinct ‘nursing’ knowledge is only now coming to be recognised, but also that nurses are willing to speak on a wider range of issues than ever before, and to address their discourse to a wider range of people. Issues of social justice such as those relating to homelessness, poverty, abuse and discrimination, to name just a few, are being taken up by nurses through their work in community health centres, child sexual abuse centres, indigenous health and multi-cultural health. Nurses hold positions in government, on hospital boards and in universities as well as having representation in myriad other places where they have access to decision-making and influence. The reason nurses are being heard is not because they are only now beginning to speak or because they did not previously have anything to say, but rather, because events have transpired that they are only now coming to be regarded as having anything of a public nature to say. This is due to the intersection of many factors, two of which are relevant to this discussion. Firstly, there is an emerging focus on Primary Health Care engendered by the Declaration of Alma Ata (World Health Organization, 1978), a blueprint document for the direction of health care which has resulted in a clearer recognition of nursing’s role in health care. Secondly, nursing has achieved a stronger voice through the movement of nursing education into the tertiary sector.
Nursing and primary health care

Attempts to provide brief definitions or descriptions of primary health care (PHC) frequently do not do justice to the full gamut of the intentions of the World Health Organization (WHO) (Wass, 1994). What is of relevance to this discussion is that PHC directed the attention of the health sector towards the inequities that existed (and still exist) in health services. The PHC directives toward health promotion and disease prevention to partly address these inequities have explicitly influenced the way it is required that nursing be practiced in Australia. As a result, these directives together with other factors have contributed to a strengthened role for nursing in health care services in Australia. Indeed, in 1988 the WHO commented that ‘without nursing leadership on the PHC team, we would have no team’ (1988: 57).

Among nurses and health writers generally there are those who think that the adoption of primary health care is the only viable way for nursing to proceed (Wass, 1994). Sensitive to the inequities within health care, some see the need for reduced use of technological and professional intervention in health (Charlesworth, 1993) while others accept the most sophisticated interventions without hesitation. There are those who appear to sanction any intervention which will keep individuals alive despite a massively diminished quality of life, while others maintain that without quality of life which accompanies health there is little point to many of the more aggressive interventions.

While there is no doubt that the escalating cost of health care is a matter of concern for governments and individuals alike, there is little consensus about what can be done to halt the erosion of universal access to needed care which has resulted from it (Leeder, 1996). Further improvements in the health status of Australians appear unlikely in the face of growing unemployment and fiscal cutbacks to the health care sector. Indeed, in the face of these odds, it is unlikely that Australia will be able to maintain its current high ranking health status among the international community unless a different way of viewing health and working
toward it is adopted (Charlesworth, 1993). Among those concerned with the health of Australians, nurses have perhaps as significant a responsibility in working toward health as any group in the health sector. Wass (1994) postulates that the only viable way for nursing to proceed in the face of these almost overwhelming odds is to take the path outlined by the primary health care agenda with its focus on health promotion.

The interest in health promotion which began with the WHO’s (1947) definition of health as ‘more than the absence of disease or infirmity’ found a voice in Australia in 1986 when the Better Health Commission identified health as Australia’s major resource. This Commission found that although the cost of ill-health care was increasing rapidly, it was bringing little improvement to the health of Australians. As part of the National Strategies for Better Health, the Better Health Commission (1986) recommended that the curriculum of each health-professional school be reoriented toward health promotion. Health promotion strategies are now included in all nursing curricula in Australia where they are seen as part of primary health care and as a fundamental component of nursing education (Australian Nursing Federation, 1994).

Health promotion incorporates both illness prevention and preventative health behaviours, but takes the promotion of health beyond merely fostering healthy lifestyles and into the realm of enabling people to increase control over and improve their health status, of advocating for and fostering wellbeing (Canadian Journal of Public Health, 1986: 426). Wass (1994) presents strong social and economic arguments in favour of nurses taking up the challenge of primary health care and health promotion. This argument gains force from the fact that nurses are the largest group of health professionals and work in a wide range of health care institutions and community settings (Task Force on Drug Abuse, 1995). By virtue of their numbers alone, nurses are at the forefront of the health professions in their contact with people and are ideally placed to promote health among the people with whom they interact (Wass, 1994) provided they embrace health
promotion and the philosophy of primary health care:

If the millions of nurses in a thousand different places articulate the same ideas and convictions about primary health care, and come together as one force, then they could act as a powerhouse for change (Mahler, 1987: 23).

With health promotion as part of primary health care and thus a strong factor in the health care agenda, nursing came to be recognised by government as having a strengthened role to play in health care:

Nursing’s stronger voice in health care

The second of the factors contributing to nurses being heard more now than previously can be attributed to nursing’s stronger voice. Although this has been fostered significantly by the recognition that nursing has a large and cost-effective role to play in primary health care, the main impetus toward nurses gaining a voice has been achieved through the transfer of nursing education from hospital-based programs to the tertiary sector.

While nurses were educated in hospital-based facilities, gaining registration via the achievement of a certificate or diploma, nursing was largely regarded as ‘technical nursing’ (Johnston, 1982). DeChow (1970) identified technical nursing roles as team member, participant in patient-care-conferences, staff nurse and care-giver (p. 374) although supervisory and administrative functions were assigned to some senior nurses when those nurses were educationally prepared at that level. However, professional nursing roles which are more clearly associated with baccalaureate level education for nurses have been identified as supervisor, team leader, primary care provider, teacher, patient advocate and change agent (Gabrielson, 1968). Significantly, the promotion and maintenance of health have been identified as professional nursing competencies.

The leadership, advocacy and change agent roles which are part of professional nursing practice have required that nurses learn to speak out about the problems
confronting them and those for whom they care. Influenced by the voices of feminism and postmodernism, nurses have also begun to speak, perhaps for the first time, of their work and their world as it really exists in the ambit of nursing. In doing so, while they may expand the boundaries of their domain, they also challenge the margins of acceptance of that domain. These things, combined with nursing’s strengthened role in health care have resulted in nurses gaining a stronger voice about health and nursing issues.

For all the reasons that nurses wish to speak and be heard, many wish to speak about their situation in the health care sector (Stein, 1968; Archer, 1984; Goldsworthy, Pickhaver and Young, 1984; Woods, 1987; Olsson and Gullberg, 1988; Chavasse, 1992) and the way they are positioned to work for the health of those for whom they care (Archer, 1984; Goldsworthy et al., 1984; Wass, 1994). Nursing concerns frequently revolve around the notion of health in health care delivery (Dixon, Dixon and Hickey, 1993; Jones and Meleis, 1993). Among nurses, there is scepticism about the relevance of traditional negative dimensions of health for nursing (Keller, 1981; Smith, 1981; Tripp-Reimer, 1984; Simmons, 1989; Kulbok and Baldwin, 1992) which Downie (1990) refers to as ‘ill-health’ and which constitute what is commonly referred to as the biomedical model of health (Ahmed, Kolker and Coelho, 1979). Doubt has arisen among nurses, and health care workers generally, about the best ways to promote health (Rifkin and Walt, 1985) and there has been recognition that the traditional health care system has let Australians down in achieving ‘health for all’ (Better Health Commission, 1986). While ‘theories do not spring fresh and new within a single discipline’ (Stainton Rogers, 1991: 8) nursing has evinced a prodigious academic interest in new and emerging ideas about health, an indication, perhaps, of profound dissatisfaction with the model of health under which nursing has operated traditionally.

When nurses speak about health they do so amidst a clamour of other voices: laypersons, community health workers, social workers, physiotherapists,
occupational therapists, medical doctors, sociologists, anthropologists and psychologists. What is it that distinguishes these nurses’ voices from the multiple voices around them? Perhaps it is that they seek a way of viewing health which they can apply in their practice or, instead of merely wishing to describe health, they wish to find a workable, functional way of re-constructing health with those for whom they care. Little doubt exists about the complexity of the idea of health and considerable attention has been given to elucidating the word ‘health’. Attempts have been made to describe health (Parse, Coyne and Smith, 1985a), to clarify what is meant by health (Salk, 1978; Keller, 1981; Greenberg, 1985), to conceptually define health (Keller, 1981; Greenberg, 1985; Laffrey, 1986; Simmons, 1989), to reconceptualise health (Tripp-Reimer, 1984), to develop an epidemiology of positive health (Kemm, 1993) and to philosophically inquire into the nature of health (Smith, 1981). While health promotion is, then, very clearly on the agenda of all health teaching institutions, there exists less clarity about the type of health that is to be promoted since there is little consensus about the meaning of the word ‘health’.

So then, when nurses talk about health and health care, about what do they speak? There are those who, by their actions and interests, appear to see health care in nursing as pertaining only to the traditional role of nurses in hospitals, caring for the sick and injured. In contrast with this view, there are those who by their actions and interests appear to see the nurse’s role as increasingly involved in the community. Health care in this guise incorporates the nursing care of the sick in their homes with the promotion of health, the prevention of illness and community development. For all of these nurses, whether or not their sphere of nursing empowers them to take up the task of health promotion, the meaning of health in health care is a challenge.

**Nursing and health promotion**

An extensive literature search failed to find research evidence that shows that non-community nurses practice health promotion in any but an elementary way.
Very little research that addresses the topic of nurses and their practice of health promotion could be found. Such research as is available addresses only the teaching aspect that is the most basic part of health promotion, and indicates that even this elementary aspect could be improved significantly. For example, in a study based on Kinnaird’s theoretical model ‘The Dynamic Model of Nurse Participation,’ Martin (1988) developed a questionnaire that examined the factors affecting the nurse’s assumption of the teaching role. Martin found that non-hospital nurses (community nurses) reported teaching for health maintenance, which is linked to positive health concepts (Kulbok and Baldwin, 1992), more frequently than did hospital nurses, although no clearer indication than ‘more frequently’ was given. Focusing only on health teaching as it related to injury prevention and control among paediatric nurses, Jones (1992) questioned 64 hospital-nurse members of an association of paediatric nurses and found that health teaching advice was given by less than 30% of those practitioners. In view of the fact that health promotion takes the advancement of health beyond merely teaching preventative health behaviours, Jones’ finding indicates that significant improvement in this area of nursing is required.

**Approaches to understanding health**

Despite the many approaches to understanding health that have been taken in recent years, this study focuses on the individual ways humans may experience health. This is not because it is not helpful to view health from family, community or global perspectives, but rather because this study explores the experience of individual nurses and their one-to-one practice with people in their care. It is acknowledged also that health as it is explored in this study relates only to health as it is viewed in the Western tradition and the discussion focuses on those who have sought to advance knowledge about health within that tradition.

Stainton Rogers (1991) presented a challenge to the dominance of biomedicine with regard to an understanding of health and illness through an exploration of the work of Foucault, Habermas, Berger and Luckmann among other social theorists.
and of the anthropological writers Young and Tussig. She argued that there has not been a deliberate conspiracy to dupe the public on the part of the medical profession as other writers have maintained, but that medical professionals ‘are themselves persuasively indoctrinated by the ‘reality’ of the world in which they work and have been educated’ (p. 19). Through this exploration, she illustrated clearly that the biomedical approach to health is coming to be seen as just one of many ways of explaining health and illness and directing medical treatment.

Within the clinical/medical model of health, physicians have traditionally defined health as a by-product of the biomedical definition of disease; that is, as the absence of the signs and symptoms of disease (Ahmed et al., 1979). Defining health from the perspective of absence means that it is expressed through negative concepts rather than by identifying the positive concepts that express it. The WHO, established in 1947, attempted to broaden the debate about health by describing it as ‘a complete state of physical, mental and social wellbeing and not merely the absence of disease or infirmity’ (World Health Organization, 1988: 2). Although this definition has been criticised as being unmeasurable (Sax, 1990), it nevertheless offered, for the first time, a much broader view of health than had the biomedical approach. By recognising health as a state of being with positive attributes in its own right, the WHO opened the way for the further development of ideas about health.

Downie (1990) identified positive health concepts as complex aspects of wellbeing, which may or may not be experienced by a person while simultaneously encountering some aspects of disease. While not identifying health with wellbeing, Nutbeam (1986) sees health as a resource for daily living and as a positive concept emphasising social and personal resources and physical capacities. Some positive concepts of health expressed in definitions of health are actualisation (Pender, 1987), acceptance, usefulness, optimism and clarity of life which result in psychological comfort (Dixon and Dixon, 1984), successful adaptation, integration (Roy, 1984), a feeling of wellbeing and a capacity to
perform to the best of one’s ability (Wu, 1973).

According to Nutbeam (1986), a positive concept of health is central to the idea of health promotion. This proposition posits that if nurses do not conceptualise health as a positive state, they would be unable to effectively practice health promotion. Only limited, non-Australian data are available about the type of health concepts held by nurses, and no data could be found about the way health concepts are reflected in nursing practice. The link between positive health concepts and health promotion constructed by Nutbeam (1986) has not been clearly addressed by other researchers, although Downie (1990: 25) discussed the lack of a clear-cut association between 'negative and positive health' as having implications for the goal of health promotion. However, since 'health promotion' refers to advancing some positive state of health, the term implies that promoters need to conceptualise health as a state which has definitive aspects that are achievable, towards which they can direct promotional strategies, before they could practice health promotion.

Despite developments that are directed towards fostering an understanding of health as a positive state, Curtin (1996) contends that, to all pragmatic purposes, nurses’ work is defined and controlled by the way funding is allotted. She argues that health is therefore still seen as the absence of illness, since this area receives almost 95% of available funds. For that reason, if health gains are to be achieved through nursing activity, it is necessary that nursing extend the scope of its thinking about health in order to bring new dimensions to health care.

THE SPHERE OF THE RESEARCHER IN THE STUDY

The phenomenon

The phenomenon of health central to this study presents itself in dual ways in nursing. The first part of this interrelated presentation is the experience of health of each nurse participating in the study. Exploring the way each nurse
experienced health showed how each person recognised and understood the phenomenon of health. The second part was composed of each nurse’s experience of health care, that is, how they experienced giving health-focused care to patients in their care. It was the intention of this part of the study to seek to discern how nurses employed their understandings of health in their nursing practice. The study intended to continue to explore this dual presentation from the perspective of each participant’s experience of congruity or incongruity inherent in the relationship between their understanding of health in their own lives and translating it into their practice. The beginning question of this thesis was then ‘How do nurses experience health in their own lives and in their practice?’ Through reflection and analyses of the subjective ways that these nurses encountered health in their lives and professional practice, the overriding aim of the study was to illuminate the nature of health as it exists contemporaneously with and in nursing.

The researcher's interest in the phenomenon

The idea of researching the phenomenon of nurses’ understandings of health and the way those understandings live in the nurses’ practice originated from my experience as part of a team, teaching both undergraduate and postgraduate nursing students about health and health promotion. Undergraduate nursing students appeared to be able to detect few opportunities for health promotion practice when on clinical practicum in hospitals. This was despite the fact that much time and effort had been expended on structuring pre-practicum courses that addressed theoretical health constructs and health promotion theories and strategies. As a result, a frequent complaint of the health-teaching team was that we were not 'getting the point across' to nursing students in such a way as to make the promotion of health seem to be straightforward or achievable. The need to explore the situation was reinforced during many discussions with nurses engaged in postgraduate studies when they stated that they rarely practiced health promotion. This lack of health promotion practice, although consistent with comments from undergraduates, was difficult to understand amongst recent
graduates, particularly when they related that notions of health, health promotion and primary health care strategies had been part of their undergraduate curriculum.

Based on Nutbeam's (1986) statement that positive concepts of health are central or pivotal to health promotion, it appeared possible that the problem might lie in the type of notions of health that graduates held. Informal data obtained from 240 year three nursing students in Melbourne between 1993-94 suggested that concepts of positive health, although included in curricula, were inadequately understood by these nursing students prior to registration. Added to this was the consistent plea from graduates that nursing educators needed to "understand what 'health' care and nursing practice was like". This plea introduced the problem of how to go about researching the way nurses understood health in such a manner that the link between understanding and practice could be explored. It seemed that merely finding out what nurses' understandings of health were like was not enough. The need was also to find out how those understandings were reflected in their nursing practice or, to put it another way, to know what 'health' care practice is like for these nurses.

The background to the study, therefore, included an interest in the phenomenon springing from my own teaching and experience and the thrust of nurses' comments to me that I needed to understand their experience and their world. Reflection on the question, 'What is it like?' led me to the conviction that, in seeking the meanings of health for nurses and the relationship of those meanings to health promotion, I needed to understand nurses' experiences of health and of health-focused care.

The purposes of the research

The study was proposed for the purposes of augmenting the effectiveness of nursing education in health and health promotion. It aimed to do this by seeking to understand the nature of the connection between the way health is experienced
by nurses and the practice of health-focused care in nursing and, in so doing, add to the knowledge which informs nursing. It was anticipated that a phenomenological exploration of nurses' experiences of health in their personal and professional lives would inform nursing by unravelling, in part, some of the manifold ways nurses comprehend health and the ways they integrate that comprehension to form their practice of health-focused care in nursing.

A secondary purpose of the research was to begin the process of opening up for examination an area of nursing that appeared to be little understood. One of the benefits of qualitative research is that it can be used to explore situations about which little is known (Field and Morse, 1985). For this reason, it was expected that this study would pave the way for further research in both the quantitative and qualitative domains with regard to health and health promotion in nursing practice.

**The research inquiries**

The study used a hermeneutic phenomenological approach to explore the meaning of health in nurses' lives and to illuminate the nature of the way those meanings are expressed in their nursing practice. This was undertaken in order to enable the researcher to analyse the essential nature of health, as it is understood by nurses and in nursing, and to discover whether the meanings of health for nurses are significant to their nursing practice.

As a methodology for this research, phenomenology was not arbitrarily chosen in the way that Darbyshire (1997) indicated is becoming a worrying trend in some qualitative research. Rather, in a sense, it chose me. Prior to embarking on this research, I had been part of a team seeking to develop research hypotheses to investigate the problem described above. The intention of the team at that time was to research the problem via empirico-scientific means. However, given the multitude of definitions of health and the lack of clarity about the type of health which is to be incorporated into health promotion, the team recognised that not
enough was known about health or the way nurses view health to enable appropriate hypotheses to be developed. Phenomenology permits the exploration of the meaning of phenomena to individuals. For that reason, it appeared to be the most suitable method by which to pursue an understanding of the phenomenon of health to nurses and in nursing.

The study also explored the application of the strategy of concept mapping as expounded by Novak and Gowin (1984) to assist participants to organise and record their recall of their experience of health.

The initial notions of the framework for the research

The initial notions for a conceptual framework were indistinct due to the fact that little was known about the relationships within the phenomenon to be explored. There was also the expectation, and indeed intention, that phenomenology would take me ‘back to the things themselves’ and away from ‘prevailing understandings [which] are a seduction ... a blindfold’ (Wolff, 1989: 326) and which cover the truth of the phenomenon we seek to understand (Crotty, 1996b). I had some sense of the ways that nurses might encounter health and a sense also of its relationship to their nursing practice, but attempted at all times to foster the exploration of the phenomenon with open-mindedness and a willingness to be informed by what emerged from the quest.

My initial ideas for a literature search were collated from the two aspects of the phenomenon, health and health promotion, as separate entities. As the study progressed, the different manifestations of the phenomenon as discovered were explored.

In this beginning stage, the framework included my perception of the study falling into three natural phases of exploration with each participant. It was anticipated that the first stage would be an exploration of the participants’ lived experience of health. The second phase was to be an exploration of their lived experience of
giving health care to a patient in their care, while the third was to be an exploration of their experiences of congruity or incongruity between the first and second phases. In this way, I hoped to be able to explore the meanings of health in the lives of nurses and the way those meanings were transferred to their practice of nursing. Following the exploratory phases with each participant, it was anticipated that the study would involve intense reflection on the nature of health thus revealed. It was expected that such reflection would result in an understanding of the nature of health as it exists in nurses’ lives and in nursing.

The position from which I speak about the research

Explaining one’s position about any aspect of life with any sort of completeness is never an easy task and this was so for the task before me. This is partly because my position was not arrived at easily, nor is the task of explaining where I stand a simple matter of compiling all of the components of my thinking and committing them to paper. The task must be undertaken, however, to enable the reader to understand my inherent biases about humanity, health and nursing; and also to understand my beliefs and assumptions and the way those beliefs and assumptions were shaped (van Manen, 1990).

Phenomenological research is based on philosophical understandings of the world and what it means to be human, and thus demands that the position of the speaker be explained. Hermeneutic phenomenology in its existentialist form, which is employed in this study, emphasises the importance of human experience and aims to identify the encounters of human beings living in the world. Existentialism holds that human existence is distinctive in that it develops its own character and interprets the world (Hammond, Howarth and Keat, 1991). In addition, it holds that the person who poses the question ‘What is this thing?’ cannot begin from any other position but asking the question of themselves. This position makes it imperative that any person who employs such an approach explains to the reader the individual way they have interpreted the world. For these reasons, as well as
reviewing the literature and explicating the methodology, the following two chapters each include a section entitled 'The position from which I speak'. These sections attempt to explore the question of my being as a human among humans, as a nurse, and the way I understand health and phenomenology in order that the reader might clearly understand the notions which guided this research project.
CHAPTER 2

ON HEALTH AND HEALTH PROMOTION

INTRODUCTION

The achievement of human health has been referred to as ‘a fundamental human right’ in the Declaration of Alma-Ata (World Health Organization, 1978), as ‘valuable’ (Leeher, 1992) and as ‘a universal concern’ (Seedhouse, 1986). As a result, the achievement of health has occupied a prominent place on the political and social agendas in Australia in recent times. Without doubt, this prominence is motivated by political as well as financial considerations. These are in addition to multiple other reasons related to advances in scientific knowledge, the breaking down of authoritative systems of government and family and the resultant increased responsibility that is placed on the state, as well as issues of equity and justice. Whatever the causes, the prominence of health as a matter of concern has also permeated nursing and new nursing practice models based on health promotion are increasingly being recognised (Schroeder, 1993).

The need for study of the nature of health in nursing became obvious as the result of changes to nursing education. These changes arose from the Better Health Commission’s (BHC) (1986) identification of health as Australia's major resource as discussed in Chapter One. Among the resultant National Strategies for Better Health was a recommendation, discussed earlier, that the curriculum of each health professional school be reoriented toward health promotion. As a result of this and other developments, health promotion strategies were included in nursing education in order to direct nursing efforts toward health and health promotion. These new tasks are in addition to the care of those suffering from illness and disease that have been the traditional focus of nursing.
In order to be able to fulfil the new responsibility of health promotion, it became necessary that nurses learn something about the condition of health itself. With the exception of the various nursing theorists (Levine, 1973; Paterson and Zderad, 1976; Johnson, 1980; Orem, 1980; Roy, 1980; among others), health as a state in its own right was a condition that had previously received scant attention among nurses in general. Prior to the requirement of health promotion, health in nursing had been viewed generally from the biomedical perspective that equated it with the absence of signs and symptoms of illness or disease. Responsibility for implementing health promotion carried with it a need for nursing to understand the meaning of health; that is, it became incumbent on nurses to establish the precise nature of the state or condition of health that they were to promote. However, the search for an understanding of health has not been an easy one.

Attempts to understand health produced the notion of positive concepts of health that arose as a result of studies of the clinical/medical model of health. As described in Chapter One, physicians have traditionally defined health as a by-product of the biomedical definition of disease; that is, as the absence of the signs and symptoms of disease (Ahmed et al., 1979). If health is defined only from the perspective of absence, it is expressed through negative concepts, rather than by identifying the positive concepts which signify it. For example, if health is defined as the absence of the signs and symptoms of disease, the health promotion task of the nurse is concerned with teaching individuals how to avoid disease. However, if health is defined as a wellness state in which the person's potential for self-actualisation is emphasised, the task of the health promoter becomes a much broader one. In the latter case, the social, political and justice issues which impact on the person's life come under scrutiny and, where necessary, demand action on the part of the health promoter. Thus, the way health is defined has significant implications for the type of health that may be achieved. Pender (1990) expresses it thus:

... the dominant definition of health espoused by a society has profound
political and economic implications because the dimensions of that
definition and their associated measures often become major social
concerns (p. 116).

An attempt to discover whether Australian nurses conceptualise health as a
positive state exposed an absence of research in this area. A close scrutiny of
nursing and health literature was undertaken subsequently to identify the type of
health images to which nurses in Australia are exposed. This scrutiny revealed
that nurses are presented with a confused multiplicity of health images that no
single individual could hope to assimilate. Such a profusion of images leads one
to suspect that nurses encounter significant obstacles to a clear understanding of
the nature of health and that this lack of clarity may prevent them from becoming
health-promoting practitioners.

In contemporary Western nursing, the notion of health is considered a basic
concept in all nursing theory, yet the many nursing theorists have failed to express
unanimity in their various descriptions of health. This chapter explores the way
health has been viewed historically and examines 20th century attempts to clarify
the meaning of health. It investigates the differences between negative versus
positive notions of health and examines definitions of health in order to determine
how they might have application in nursing practice. Finally, it discusses some
phenomenological research studies of the experience of health to establish a basis
of comparison between what is already known of the nature of health and the
results of this study.

AN ETYMOLOGICAL EXAMINATION OF THE NOTION OF HEALTH

Etymological examination of the notion of health shows that the word ‘health’ did
not appear in writing until around the year 1000 AD (Dolfman, 1973). It derived
from an old English word ‘hoelth’ which was used to represent a state or
condition of being hal, that is safe or sound. The word ‘hal’ in the southern and
midland dialects of England was pronounced *hole*; thus, whole or sound came to be the meaning of *hoelth*. Although this meaning of health as a positive state appears to have been the dominant view in England at that time, historically, the duality inherent in the contemporary meaning of health had already shown itself. At least as far back as Heraclitus (540 - 480 BC), a tendency to describe what we now call 'health' from the perspective of absence of illness was demonstrated. Heraclitus pointed out that the world is distinguished by opposites and proposed that if we were never ill, we would not know what it was like to be well (Gaarder, 1994).

Almost contemporaneously with the view proposed by Heraclitus, other ancient Greeks understood health as pertaining to the integrated whole of a person's life (Ahmed et al., 1979), now called a 'holistic' way of understanding health. There are two etymologically distinct words translatable as 'health' in ancient Greek, *hygeia* and *euxia* (Kass, 1981). Hygeia, the source of the English word hygiene, appears to mean 'living well' while euxia means 'well-habitedness' meaning a good habit of body (Kass, 1981: 15). Kass pointed out that in both the English and Greek languages, the words relating to health are totally unrelated to the words signifying disease, illness and sickness. However, it is only in Greek that the words for health are likewise unrelated to the words for healing. Reflecting on these differences, Kass (1981) noted that while the English emphasis on wholeness or completeness is relatively static and structural, the Greek emphasis is on functioning and activity of the whole and relates not only to its working but also to its working well.

Hippocrates (400 BC) viewed human wellbeing as 'influenced by the totality of environmental factors', incorporating living habits, climate, quality of air, water and food (Ahmed et al., 1979: 8). In Hippocrates' view, health or wellbeing was thought to result from equilibrium between the body's four 'humours': blood, phlegm, black bile and yellow bile; and 'from harmony between the body, the environment, and the person's living habits' (p. 8) while illness resulted from
disruption of this balance. According to contemporary sources (Engel, 1977; Ahmed et al., 1979) this holistic view of health represented the majority view of health until the Cartesian revolution in the 17th century and persists today in the folk traditions of many cultures. The first negative quality allocated in writing to the word health appears in the work of George Herbert in 1633 when he referred to ‘sickly healths’ (Dolfman, 1973). However, among Christians in the early centuries AD, a view of illness as a demonological manifestation indicated that health or wellness was seen at least by the Church as an indication of goodliness, rather than as something which resulted from tangible sources such as environment and living habits. Even today, with healing seen as an integral part of many Christian faiths, the view of health that guides such healing is not clear.

With the work of Descartes (1596-1650 AD) who became the founding force behind both rationalism and, later, empiricism, came the notion that the workings of the body and mind were separate. Descartes proposed the idea of the duality of the mind and body which sees action as based on beliefs and desires and humans as subjects who represent objects to themselves (Haldane and Ross, 1955; Scruton, 1984). This Cartesian revolution in thought led to the functionings of the body coming to be seen as those of a machine. With the body viewed as machine, illness and disease came to be viewed as the breakdown of the machine, and health, by default, came to be viewed as that which was not illness; that is, health was seen as the absence of illness or disease. This understanding of health was challenged when the World Health Organization (1947) first introduced the definition of health as ‘a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity’ (p. 1). Prior to that time, it was generally accepted that health equated with a disease-free state (Dolfman, 1973).

LINKING HEALTH CONSTRUCTS TO HEALTH PROMOTION

Any discussion about health promotion needs to make clear precisely what is
intended by the term ‘health promotion’ and how it differs from disease prevention. Health promotion, as previously explained, incorporates both illness prevention and preventative health behaviours. However, it takes the advancement of health beyond such beginning measures and into the quasi-political sphere of enabling people to increase control over and improve their health status and foster their wellbeing (Canadian Journal of Public Health, 1986). Because health promotion refers to advancing an unequivocal state of health, it indicates that practitioners need to understand health unequivocally in order to be able to direct their promotional strategies. Pender (1987: 7) describes prevention as ‘avoidance’ behaviour in which we engage in order to keep disease or illness from occurring while health promotion is ‘approach’ behaviour engaged in to help or encourage health to exist or flourish. Health promotion is not specific to disease or health problems while prevention relates only to these.

With the exceptions of Labonte (1993) and Downie (1990), the link between positive health concepts and health promotion constructed by Nutbeam (1986) has not been explicated by other researchers. Labonte points out that public health has long been based on the positive first half of the World Health Organization’s definition of health (i.e., ‘a complete state of physical, mental and social wellbeing’). Meanwhile, health practice remains focused on the second, negative half of the definition (i.e., ‘the absence of disease or infirmity’).

**20TH CENTURY ATTEMPTS TO CLARIFY THE NOTION OF HEALTH**

Recognition of health as a positive state different from the absence of illness did not come easily. An overall review of the literature since the World Health Organization’s (1947) statement about health shows definite trends in the way health has been viewed since that time. This section attempts to put these trends into a perspective not previously elucidated by examining the progression of thought about health since the WHO statement. This recapitulation begins with the WHO statement about health and progresses to discussion of behavioural
views of health which were subsequently found to expose many definitions of health to charges of victim blaming. It explores the social view of health which acknowledges that both functional and structural determinants of health need to be taken into account and concludes with notions of health as a positive concept in its own right.

Beginning with the World Health Organization’s (1947) indication that health was more than the absence of disease or infirmity, a considerable amount of research was directed toward unravelling the differences between this new view of health and the prevailing negative view of health. The early attempts to redefine health from a positive perspective were many and diverse. For example, Parsons (1958) introduced a view of health and illness as culturally determined by the ability to perform social roles, while Oberteuffer (1960) visualised health as a state or condition that allows people to function adequately. Later, Dubos (1965) proposed a view of health as a state or condition that enables the individual to adapt adequately to their environment. Meanwhile, there were those who assigned health to the metaphysical mould such as Williams and Bauer (cited by Dolfman, 1973). Although all the above attempts to re-vision health took the discussion away from the view of health as the absence of illness, to all practical purposes, perplexity resulted because there was no longer a dominant view of health but rather many views.

Efforts to clarify meaning out of the turmoil of definitions of and discussions about health as a positive state continued unabated. The discussion about positive versus negative concepts of health did not proceed auspiciously, however. In 1965, Dubos espoused the position that 'the concept of ... positive health is a Utopian creation of the human mind' (p. 346). Dubos adopted this position because, in his view, positive health could not become a reality as ‘man’ (Dubos’ term) could never adapt so perfectly to the environment that life would not involve struggle, suffering and failure. In spite of this somewhat daunting pronouncement, scholars in nursing and the health fields have endeavoured to
enlighten the discussion about the meaning of health as a positive state (Downie, 1990; Pender, 1987; Nutbeam, 1986; Dixon and Dixon, 1984; Roy, 1984; Wu, 1973).

Continuing the discussion about negative versus positive images of health, many writers and researchers have contributed to attempts to change the way health is viewed by the health care system (Salk, 1978; Ahmed et al., 1979; Keller, 1981). Ahmed et al. (1979) called attention to the fact that the concepts of 'disease' and 'health' could no longer be adequately defined in the purely medical terms of the presence or absence of symptoms. Continuing this line of thought, Kemm (1993) undertook an examination of the ways in which operational definitions of negative health have been derived with the intention of producing definitions of positive health, but found that only tentative conclusions were possible on the nature of positive health. Exploring the conceptualisation of health via a self-assessment instrument, Dixon, Dixon and Hickey (1993) found, however, that a person's energy level emerged as central in health. They concluded that self-assessment of energy level is a key to an integrated view of a person's health status.

**Behavioural views of health**

The eminent virologist Jonas Salk (1978) attempted to convey a sense of the term 'health' as 'not merely a passive state of freedom from disease, but as an active condition of being, in growth, development, and evolution' (p. 14). While the proposal that people begin to view health differently was a positive move in the discussion about health, Salk's further proposal, that we should begin to consider health as not only an individual matter but as a matter of group concern, contributed to the behavioural view of health. This view of health later came under severe criticism because it frequently led to 'victim blaming'. Victim blaming occurs when the structural or societal causes of ill health fail to be recognised and the focus is directed toward the behaviour of the individual who is affected by the problem (Crawford, 1977).
It is recognised that individual behaviours may have a significant impact on health. Recognition of the key role that behaviours have in health needs to occur, however, within a climate of acknowledgment of two factors: the social contexts of people’s lives, and the constraints that impact on the choices they are able to make (Wass, 1994). If this does not occur, encouraging people to take responsibility for their own health may quickly degenerate into blame for those who are unable or unwilling to do so. A considerable volume of health literature from the 1970s onward focused on encouraging people to take responsibility for their own health; that is, it focused on the functional aspects of health (Donatelle, Davis and Hoover, 1988; Anspaugh, Hamrick and Rosato, 1994). During this period, many of what came to be known as the structural determinants of health were largely unknown or ignored. As the relationships between individual behaviours and illness became known, it became popular to call for individuals to take control of and change their behaviours in order to avoid the ‘lifestyle’ diseases which ensued from some of those behaviours (Wass, 1994). This type of behavioural approach to the achievement of health is used in some health promotion programs that address the functional determinants of health and is known, in many cases, to be effective. In others, where the causes of ill health are multi-dimensional and include structural aspects of peoples’ lives that they are powerless to change, failure of the program may be blamed on the participants.

As well as accentuating the differences between functional and structural causes of ill health, the recognition of victim blaming had important implications for the ongoing discussion of health, both in nursing and in the discussion about health generally. Prior to recognition that the determinants of health fell into different categories and that failure to address both could lead to victim blaming, both nursing and health theorists had offered definitions of health for consideration. Many, if not all of these definitions of health proved on later analysis to contain elements which were open to misconstruction and could result in victim blaming activities or attitudes. For example, Levine (1973) defined health as a state distinguished by balance between input and output of energy in which exists
structural, personal, and social integrity. It can be seen that a definition of health focused on energy output may readily define those with low energy output as lazy or incompetent in some regard. Less directly, Orem (1980) defined health as a state characterised by wholeness or soundness related to human structures, body and mental functions. Although this latter definition is more obscure, the link between soundness of mental functions and the potential for judgement of the appropriateness of a person's emotional behaviour is obvious. Examination of these and other definitions of health shows that if these definitions were used in the context of health promotion, there is a danger that recipients of care might be judged or labelled as the result of such application. Wass (1994) asserts that the concept of labelling is related to the notion of victim blaming.

The social view of health
Sociologists have long viewed health as a social construction, not only defined by culture but structured also by the social conditions in which people live. The socio-ecological approach to health was the outcome of recognition that ill health resulted from poor social conditions. This socio-ecological approach was specifically targeted in the Ottawa Charter for Health Promotion (World Health Organization, 1986) which recognised that health is inextricably intertwined with other social goals and conditions. In adopting a social view of health, the South Australian Health Commission (1988) provided a comprehensive overview of the role of government in the achievement of health. This document recognised that intervention to change aspects of the environment that promote ill health was an essential component of the fight to achieve health. Rather than continuing to deal with illness after it appears or continuing to exhort people to change attitudes or lifestyle when there is little support for such change, it advocated social and political interventions for health. Since the release of these documents, however, social policy has become one of the victims of the severe fiscal cutbacks in Australia in the 1990s and relatively few of the proposed improvements for health have been achieved.
Charging nursing with conservatively maintaining a 'think small perspective', Dreher (1982: 504) asserted that focusing attention on one-to-one relationships in health promotion results in a confined scope of intervention possibilities for the nurse. Dreher's aim was to ensure that nursing education did not only focus on one-to-one relationships in nursing and that it extend the scope of nursing education to encompass health promotion from a social perspective. This proposition fails to recognise, however, that by far the largest number of nursing interactions only relate to one-to-one situations. In terms of health promotion, much of what students are taught in the tertiary setting relates primarily to large-group health promotion and fails to address strategies for the one-to-one situation.

Continuing the focus on the social view of health, Milio (1976) pointed out that deficits in health frequently result from a lack of equilibrium between a society's health needs and the health-sustaining resources available to them. This indicates that although people may be aware of the health-promoting ways they could act, the options available do not reflect the choices they might wish to make. Butterfield (1990) also discussed the scope of health-promoting or health-damaging selections accessible to individuals. She asserted that these selections are affected by such things as the availability of environmental protection, adequate housing and the ways people are rewarded or penalised by society for failing to select given options, as well as by the individual's personal and societal resources. Personal resources include awareness, knowledge, beliefs, money, time and the urgency of other priorities, while societal resources include the availability and costs of health services.

In relation to health and illness, sociologists are especially interested in exploring how different societal groups explain these phenomena and seek to know how differences are moulded by social forces, particularly power relationships (Stainton Rogers, 1991). However, Seedhouse (1986) discusses the fact that while social research is vital to enable us to redress injustices which cause ill-health, too little attention has been paid to the meanings of health and the scope of
the various theories of health. He charges sociologists with viewing health as a continuum, a notion that inevitably sees health as the opposite of disease and therefore as the absence of illness or disease. Thus, while a social view of health is a necessary part of the push for improved health for individuals and societies, it is but one of the ways of viewing health that nurses must integrate into their armoury if they are to become health-promoting practitioners. Discussing the capacity to initiate meaningful action or ‘agency’, Liaschenko (1994) notes that ‘protecting and fostering patient agency ... are fundamental features of the moral work of nursing practice’ (p. 17). Therefore, if nurses are to initiate meaningful action in health promotion, they must understand all the diverse aspects and moderators of health for the individuals and groups with whom they work.

Attempts to understand the meaning of health

Although not discussed explicitly, what became evident, following recognition that many of the contemporary descriptions of health were open to misinterpretation which could lead to victim blaming, was avoidance of such descriptions. A review of the literature over the last ten years shows that fewer definitions of health have been offered but a considerable amount of analytical work ensued, including attempts to more fully understand health. Herzlich (1973), the first to conduct research to establish the nature of health in France, approached the problem by trying to determine popular lay conceptions of health and illness. She pointed out that there is often a discrepancy between the reality of health as perceived by laypersons and medical definitions of health. In discussing health and illness, Herzlich maintained that health is a long way from being unequivocally defined by its opposition to illness. She proposed that ‘the various forms of health have different characteristics and functions and entail a variety of relations among them, and between them and illness’ (p. 63) and summarised her findings about health under three headings: ‘health-in-a-vacuum’ (or the absence of illness), ‘reserve of health’ and ‘equilibrium’. While Herzlich’s work was pivotal to the ongoing discussion about the differences between health and illness states, it did not clearly lead to an understanding of positive notions of
health.

Herzlich (1973) asserted that its opposition to illness could not define health. This is supported also by Balog (1982), who, through a philosophical analysis of the concept of disease, challenged the assumption that disease is an objective phenomenon that can be used to objectively define health. He concluded that ‘the notion of health cannot really be known’ (p. 12) because health is not an empirical fact or an objective phenomenon but is, rather, a state of functioning on a biological and personal level.

A philosophical inquiry into the nature of health (Smith, 1981) was conducted via a literature search for fundamental concepts of the nature of health. Four models of health were identified from this study, namely the clinical, role-performance, adaptive and eudaimonistic models. In the clinical model, health is perceived as the absence of the signs or symptoms of disease or disability. In the role-performance model, the performance of social roles with maximum expected output is seen to be commensurate with health. Within the adaptive model, the healthy person maintains flexible adaptation with the environment and interacts with it to maximum advantage, while the eudaimonistic model describes health as exuberant wellbeing (Smith, 1981).

Seeking a consistent or agreed upon conception of health, Laffrey (1986) developed the Laffrey Health Conception Scale to measure individual perceptions of the meaning of health. This scale was developed to measure four dimensions of health conception in accord with the four contemporary models of health that were explored further by Smith (1983). Were it the practitioner’s aim to determine patients’ beliefs and/or attitudes about health, an essential pre-requisite of health promotion action, this scale would be particularly helpful. While the report begins the task of explicating meanings of health, the intention of developing a measurement tool occluded full description of those meanings.
Keller (1981) pursued research directed toward determining commonly held beliefs about health. This took the form of a conceptual analysis of 42 definitions / descriptions of health derived from a variety of sources and identified 22 subconcepts of health that vary considerably in 'comprehensiveness, abstractness, clarity and detail' (p. 48). Seven nurses (Woods, Laffrey, Duffy et al., 1988) undertook a content analysis of taped telephone interviews obtained from a multi-ethnic group of 528 women aged between 18 and 45 years to describe the meaning of health for a population of women in the Pacific Northwest of the USA. This study was one component of a larger study about perimenstrual symptoms and was intended to assess the consistency of the dimensions of health identified with the four models of health proposed by Smith (1981). A rich variety of health images were reported with a strong emphasis on health as exuberant wellbeing, the most definitively positive of the four contemporary models of health.

d'Houtaud and Field (1984) offered a class differentiated analysis of concepts of health derived from a French sample who were asked an open-ended question on what health meant to them. The results offered two polar conceptions of health between which individuals and sub-groups oscillated but which indicated clearly that the higher the socio-economic class of the individual, the more likely they were to espouse positive concepts of health. In contrast to the above, Calnan and Johnson (1985), performing a similar study in Britain, found that there was little difference in the meaning given to health between social classes and that most exhibited a preponderance of negative concepts of health. The emphasis on negative concepts rather than positive ones was also reported by McKie, Wood and Gregory (1993), who asked a group of largely working class women from the North East of England the question ‘What is meant by the word health?’ This question elicited a clear link between food, diet and health for these women. While these findings may be related to the UK Government's 1991 focus on reducing death and illness related to fat consumption, the 78 women interviewees talked mainly about preventative measures for health rather than identifying any
positive concepts of health. However, since little cross-cultural analysis of health has been attempted, it would be merely conjecture to imply from the differences between the French and English studies the existence of cultural differences in understandings of health.

Coutts and Hardy (1985) sought to answer the question ‘What does health mean?’ via a synthesis of etymological sources and modern 20th century definitions. They proposed that health is dynamic and that being healthy ‘has something to do with achieving potential’ (p. 2). Defining health in terms of a person’s ability to function effectively, productively and happily, Hamrick, Anspaugh and Ezell (1986) concluded that the eradication of disease would not necessarily equate with health. Labonte (1993) undertook an exploration of health in order to discover how health was conceptualised. It resulted in identification of a list of concepts associated with health. These were: energised, being loved, loving, being in control, fit, fitting in, doing, stress-free, outdoors, nature, friends, family; giving, receiving, sharing, belonging, meaning in life, able to do things I enjoy, peak physical shape, happiness, creativity, spiritual contentment, wholeness and playfulness (p. 15). Asking the question ‘What does being healthy mean to you?’ of older women aged 70 to 91 years, Perry and Woods (1995) replicated a study of younger women and showed that women retain an impressively large number of positive images of health as they age. At the conclusion of the study the participants proposed jointly the following conceptually positive definition of health for older women: ‘Health involves an appreciation of life, experiencing joy and happiness. To be free from sickness does not guarantee health’ (Perry and Woods, 1995: 55). Labonte (1993) also emphasised the key nature of positive concepts to health and stated that ‘peoples’ experiences of health are more about their experiences of capacity and connectedness than about their experiences of disease or disability’ (p. 15).

The esteemed philosopher and ‘grand old man’ of 20th century German philosophy, Hans-Georg Gadamer explored hermeneutically the nature of health
over a period of time ranging from 1963 to 1996 (Gadamer, 1996). Yet Gadamer referred to health as 'an enigma' and as something that somehow escapes the objectifying scientific method. He alludes to the nature of health as sustaining its own proper and natural balance and states that the reason health cannot be measured is because it is a condition of inner accord and of harmony with oneself that cannot be overridden by external forms of control (p. 108).

Health and nursing

As nursing education transferred from hospital-based training into the tertiary sector, nursing researchers increasingly sought ways to define nursing practice so that the domain of nursing might be more clearly identified. Health is included in most conceptual analyses of nursing as one of the four domain concepts (i.e., nursing, person, health and environment) of nursing scholarship (Fitzpatrick and Whall, 1989). On the basis that health plays a central role in nursing, many nurse researchers attempted to explore the nature of health. The achievement of health is generally identified as the goal or purpose of nursing (Chinn and Kramer, 1991) although the way health is understood in the various nursing models and theories differs greatly.

Chinn (in Chinn and Kramer, 1991: 46) analysed the terms related to health used by a variety of nursing theorists to demonstrate that nursing still followed Nightingale's (1969) original conceptualisation of nursing. An examination of some of these terms shows the multitudinous ways health has been described in nursing. It has been linked to independent function (Henderson, 1964), self-actualisation and self-love (Hall, 1966), maintaining holism and conservation (Levine, 1967), authentic awareness (Paterson and Zderad, 1976), self-care agency (Orem, 1980), continual adaptation (Roy, 1980) and expanding consciousness (Newman, 1986). From these few examples, it can be seen that the terms imply that a profusion of images of health co-exist in nursing with little clarity emerging to give direction to the health-promoting practitioner.
In 1985, Greenberg enlightened the discussion somewhat by differentiating between health and wellness via an analysis of a health continuum and showed that such a straight-line analysis does not do justice to health. He concluded that while health is comprised of social, mental, emotional, spiritual and physical components, wellness is the integration of these components and high-level wellness is the balance of the components. In a further effort to promote theoretical clarity for nursing science, Simmons (1989) undertook a concept analysis of health that was directed toward an explication of the theoretical work of Smith (1983) and the four contemporary models of health. Although Simmons found the concept of health difficult to define, she concluded that ‘viable strategies for moving the health care system from a disease perspective to a health focus can only come from an understanding of health itself’ (p 160). The need for researchers to pursue multidisciplinary collaboration to understand the concept of health in all its complexity was also proposed by Duffy and Pender (1987). Pender (1990) affirms the position that a new view of health is needed, one that is ‘positive, comprehensive, unifying and humanistic’ (p. 122).

Attempting to reconceptualise the construct of health, Tripp-Reimer (1984) reviewed the emic-etic distinction between the concepts of disease and illness and presented a new model of health for consideration - the Emic-Etic Health Grid. This tool incorporates both the emic (i.e., meaning of health to the individual) and the etic (i.e., objective observation without input from those observed) perspectives. It offers a way to synthesise a description of the person’s so-called ‘health’ state from the perspective of both the provider of care and the recipient. The grid is helpful for specifying the areas of congruence between client and practitioner perspectives on the client’s state of, or attitudes to, illness or health-as-feelings-of-wellness. Although relevant, by itself it does little to advance an understanding of health as a positive state. Indeed, within this model, health as wellness is viewed as the opposite end of a continuum from illness. Such placing puts health again in the equivocal position from which it may only be viewed as a negative construct; that is, it implies that health is the absence of illness.
Health concepts as the basis of health promotion

The first and major implication of health promotion is that the way health is conceptualised should be clearly understood (Labonte, 1993). For this reason, since the introduction of notions and strategies associated with health promotion, the discourse about positive notions of health has accelerated. However, while definitions of health abound in the nursing and health literature, the images of health evoked by these definitions are frequently vague and do not provide a clear picture for the practitioner wishing to understand health or practice health promotion.

Examination of some of the attempts to clarify the concept of health in nursing provides illumination to the discussion about the ways health has previously been conceptualised and defined. Such examination reveals the multiform ways health has been described, or has failed to be described, in nursing and the health fields generally and, thus, makes explicit why confusion on this issue may be common to practicing nurses. Recently, Dines and Cribb (1993), discussing the meaning of health, began from the perspective that there was great difficulty in trying to capture and define so complex a concept. Proceeding from the relative and dynamic nature of health, they concluded that 'the uncertainty surrounding the meaning of health makes the work of the health promoter a difficult task' (p. 18). In pursuit of this discussion, they failed almost entirely to identify the prevailing positive concepts that distinguish health. This indicates that the discussion of health concepts in nursing is perhaps becoming a circular one, which serves to warn that unless progression is made, little that is of practical use to nursing may be achieved.

An examination of the multiplicity of definitions and descriptions of health in nursing is revealing. For example, in one nursing textbook alone, 28 different definitions of health are given (Murray and Zentner, 1993: 637-638). If confusion about the meaning of health exists among nurses, it may be explained when one
looks at the differences among these definitions. For example, Johnson (1988) defined health as balance and stability among behavioural systems. Health in Neuman’s (1989) terms is described as a state of energy saturation in which the person is free of disruptive needs, forces or noxious stressors. Roy (1984) described health as a state or process of successful adaptation through modes that promote being and becoming and Smith (1981) described health as characterised by the four contemporary models referred to earlier.

Some definitions or explanations of health are so complex as to be little but perplexing to the nurse engaged in everyday practice. One such example of this is Carboni’s (1995) discussion of ‘Enfolding Health-as-Wholeness-and-Harmony’ derived from the science of unitary human beings. Carboni cites the work of Bohm (1980) as offering clarity to the discussion of homeodynamics and the nature of change in her discussion of the work of Martha Rogers. The concepts that emerge from this ‘clarity’ are, however, both indirect and extremely complex.

Credit for some of the emerging clarity that has resulted from the examination of health as a positive state is owed to the work of Pender (1987). In writing about health promotion, Pender undertook an historical review of the meaning of health as well as exploring the notion of health as an evolving concept through the work of various theorists. She explored health through definitions focusing on stability, actualisation, and on both stability and actualisation, ending with an evolved definition of health as a positive state described as:

... the actualisation of inherent and acquired human potential through goal-directed behaviour, knowledgeable and competent self-care, constructive amelioration of barriers to growth, and satisfying interpersonal relationships while adjustments are made to maintain structural integrity, harmony with environment, and positive change over time (Pender, 1987:27).

In response, perhaps, to health researchers and nurse scholars’ persistent
expressions of the need for clear concepts of health to be identified (Salk, 1978; Smith, 1981; Keller, 1981; Tripp-Reimer, 1984; Greenberg, 1985) many researchers have contributed to the discussion about health. Although the discussion continues with some force, advances in understanding health have been made (Parse et al., 1985a; Labonte, 1993). Seedhouse (1996: 25) states, however, that if health promotion is to succeed ‘it must develop a theory of purpose - in other words it must work out a philosophy of health’. Philosophy may be interpreted as the creation of theories (Collins Dictionary, 1987), but theories do not arise within a single discipline (Stainton Rogers, 1991); they arise within an historical context and are products of the general intellectual, moral and cultural climate of an era. For that reason, nurses' and health researchers' contributions to inquiry into the nature of health add to the knowledge out of which a philosophy of health and an understanding of the positive nature of health will eventually be constructed. In pursuit of this latter aim, Pender (1990) developed a classification system for expressions of health that clarifies the roles in health of affect, attitudes, activity, aspirations and accomplishments. Jones and Meleis (1993) stressed the urgency of the task of understanding health when they stated that:

As long as diverse, underserved and disenfranchised groups face overwhelming obstacles to achieving their health potential, nursing cannot afford [to spend] too long on attempts to develop definitions of health (p. 3).

Currently, a negative view of health may still be seen to drive the so-called 'health-care' system. The WHO (1947 until the present), as well as many other national and international health organizations, have made a concerted effort to promote a view of health as a positive state of wellbeing that is perceptible in its own right and is, to some extent, independent of any illness state. To all practical purposes, however, the definition of health according to which nurses must work is defined by the way funding is distributed (Curtin, 1996); that is, as the absence of disease, since ill-health consumes between 85% and 95% of health resources. Curtin describes the WHO definition of health as a political statement that is
largely ignored in any effective sense. She observes that, if the basis of practice is
grounded in the absence of disease, what style of health people want or need
becomes irrelevant to the achievement of the type of health recognised by the
health-care sector. Consequently, if real health gains are to be achieved, the
paradigm of health needs to be shifted into a new dimension. The argument
presented by Curtin is not a new one. For example, as early as 1979, Ahmed,
Kolker and Coelho stated that:

For several decades, social scientists as well as health planners and
practitioners have perceived the need to return to the premodern
conception of disease as a sociocultural phenomenon, and of health as a
multidimensional ‘process’ involving the wellbeing of the whole person in
the context of his (sic) environment (p. 9).

Given that the need for change has now been recognised for almost five decades
one might well ask why the confusion about the meaning of health has not yet
been resolved. One of the major hindrances to attempts to move the health care
system toward a new and enlightened view of holistic health is that ‘the concept
of health, in principle, is of little concern to the doctor; from a practical point of
view only illness counts’ (Herzlich, 1973: 55). Although this statement by
Herzlich was made 25 years ago, it is clear that it still has force, since the
treatment and care of ill health continues to consume most of the total expenditure
on health care. With a large and powerful medical group within the health care
system, which, in the main, still appears to be divorced through disinterest from
the discourse about the meaning of health, the ‘absence of disease’ model of
health continues to receive significant recognition. Thus, confusion exists about
what is meant when health is discussed.

This confusion about the meaning of health and how it might be achieved in
nursing was noted as early as the 1980s by Winstead-Fry (1980) who observed
that because nursing had a strong commitment to health, it was necessary for
nurses to clarify what it meant in nursing. Smith (1981) reinforced this position
and identified the urgent need to clarify meaning from the confusion about health because the notion of health plays a central role in every phase of nursing. Given that these pleas were mounted over fifteen years ago, the recent failure of Dines and Cribb (1993) to clearly identify notions of health by which health promotion is to be guided is not encouraging.

It can be demonstrated that when people talk about health they speak of something far wider and more inclusive than the mere absence of illness or disease. Inevitably then, one is led to ask why the positive meanings of health appear to be obscured in the public arena and why such obscurity continues. The answer to this would appear to lie in the fact that no public consensus has been reached about the meanings of health. It is only in relatively recent times, however, that the status quo of the meaning of health has been challenged. Because change does not generally come quickly to structures as large as the health care system, it is only through repeated and multifaceted research in health that change may be able to be achieved. Labonte (1993) also discussed the problem presented by the fact that relational experiences of 'being healthy' are not easily rendered into simple, quantifiable measurements.

Despite the ongoing attempts to clarify what is meant by health or to appropriately describe health as a positive state, there remains little evidence that illustrates precisely how nurses actually perceive health or how they see the concept of health interacting with their practice. Indeed, illustrations of confusion in the health discourse continue, as evidenced by the title of an oration by Leeder (1992) "Valuable health: what do we want, and how do we get it?" In this paper, delivered to both nurses and doctors, Leeder discusses ideas of health as 'something deeply and irrationally held' and states that 'there is much unresolved ambiguity in our thinking' about making health promotion a priority (p. 7).

Holmes (in Gray and Pratt, 1991) asserts that postmodern knowledge construction avoids traditional dichotomies as that between health and illness and, instead,
gives way to alternatives which see both merely as 'ways of being'. Holmes contends that 'illness and health are outmoded categories which do not adequately represent the experiences of real people, and unnecessarily constrain the relationships between people' (p 361). However, Holmes' statements about health are couched in a defence of postmodernism that takes as its basis the rejection of all metatheories of knowledge. He recognises that in so doing, postmodernism itself engages in the very metatheorising that it decries when it explicitly rejects all totalising thought. In its rejection of metanarratives it creates the very metanarrative it seeks to displace by stating that 'all' are to be rejected.

McIntyre (1996), citing Liaschenko, argued that we have talked too long about health and should instead ask people what makes their lives worth living and work toward achieving those things. Given, however, the difficulties that have been encountered in merely attempting to refocus the health-care system toward a more positive view of health, it is hard to see how such a complete redirection of that system could be achieved. Nor is it clear at this relatively early stage in discussions about health-as-a-positive-state precisely what will be involved in a change to a positive view of health and, thus, it seems too early to abandon the pursuit of that goal. This is not to argue that the value of such research is less than any other approach. Indeed, it is only through the use of a multiplicity of approaches to discovering what gives meaning to people's lives that we can truly approach understanding about what is at issue when we talk about health.

From where, then, do nurses gain the positive health images that are to guide their health promotion practice? To whom do they look? Do they look to the 'Health for All' slogan which speaks of 'equity' and 'fairness' as the key elements in health policy and which emphasises a positive sense of health without describing what that means? Do they look to Pender (1987), who attempted to make sense for nursing of the many definitions and descriptions of health by discussing health as 'an evolving concept' encompassing many definitions which variously focus on such positive images as 'stability', or on 'actualisation,' or on putting both
Wherever nurses may look for an understanding of health for nursing, confusion is generated by the persistence of negative images of health. Recently, Lawson (1991), a director of a centre for public health and once a consultant for the WHO, writing of public health in Australia, stated that public health is essentially concerned with the prevention of disease and injury. One might reasonably assume that he had not even heard of the 'new' public health movement that arose from the Ottawa Charter for Health Promotion (World Health Organization, 1986) since he fails so singularly to address it. The Ottawa Charter adopted a five-way focus for health, which was directed towards the building of healthy public policy, the creation of supportive environments, the strengthening of community action, developing skills of individuals and the reorientation of the health system toward health promotion. Indeed, nowhere in Lawson's text does the Ottawa Charter even rate a mention! When considering the possible reasons for confusion about the meaning of health in health promotion, influences such as this need to be included in the analysis.

The position from which I speak about health

Although traditional phenomenology requires that the person engaging in the inquiry attempt to free themselves from their presuppositions and preconceptions about the phenomenon, this is not always possible in any comprehensive way. For that reason, when I speak about health, it is appropriate that the reader is able understand the position from which I speak. I am a community health nurse and my work has for many years been conducted within an atmosphere of discussion and debate about notions of health, health promotion and ways of fostering and promoting health and community development. It would be fair to say that my professional engagement has been almost entirely with health and the notions of autonomy in health care that are enmeshed with the idea of health. Ideas about health were formed also by talking with, observing and reflecting upon the lives of people with whom I have worked. Exploration and examination of the
phömenon of health in my own life is therefore part of the analysis of this thesis.

Initially, my understanding of health was that it was present when disease and/or sickness were absent. When people were admitted to hospital for care, and treatment was successful, I perceived them to be more ‘healthy’ upon discharge than previously. One of the most formative moments in my understanding of health occurred, however, when, as a very young nurse, I cared for a man who had suffered a myocardial infarction. Before his discharge from hospital he told me in confidence that his son was estranged from him, his marriage lacking, and that he had married outside of his fundamentalist faith and was therefore not at peace with his God. I began to recognise that ‘treatment’ for his ‘heart attack’ meant little to him in the form in which it was offered, although he readily adopted the recommended diet and exercise regime. It was clear, however, that health could only be achieved for him through addressing the relationship and spirituality problems in his life. Thus, I began to view health as relating to the whole of a person’s life – a position now known as a ‘holistic’ view of health. This burgeoning understanding of health was somewhat reinforced when the man was readmitted to hospital some months later and died of a massive infarction, despite a ‘good prognosis’ and having meticulously followed instructions since his first admission.

Later I came to realise that what was known as the ‘health care system’ is not ‘health’ care at all but only illness care. For example, doctors are not educated or hospitals equipped to help people stay healthy – mostly they service the ill or suffering. Thus, health in this usage refers to the very opposite of health. Similarly, understanding of the word ‘health’ also appears to be generally in the negative dimension. This is encapsulated, for example, in the Australian response of ‘Not bad thanks!’ to inquiries about one’s health, indicating that if one is ‘not bad’ one is healthy.
In my own life, recognition of the nature of health came first as a series of comparisons. I noted that during less than healthy times, common tasks seemed overwhelming and the normal impedimenta of life in the 20th century sometimes appeared insurmountable. Conversely, when I was healthy I felt at peace with myself and the common tasks of my life seemed manageable and achievable. I came to realise that at such times I felt joy in living and both accepting of and accepted by the important people in my life. I also realised that I felt more relaxed and therefore rested well at such times, giving me more energy and enthusiasm for life. I came then to understand health as incorporating all the aspects of my life – bodily functioning, energy and enthusiasm, peace of mind and tranquillity as well as joy and harmony.

In order to explore the health experience of others in nursing, I have engaged in conversations with nurses wherever I could over a period of time spanning more than five years. These conversations have taken two forms, the one-time conversation and the in-depth series of conversations during interviews for this research. With each person, I spoke of my interest in health; that is, why I wished to explore the nature of health in nursing. With some nurses, the conversations investigated specific aspects of health or sought their reflections about health. With some, I sought only their response to specific questions about the nature of health as I moved through the research process. Through these discussions, the notions of health that I had developed were refined and clarified.

Together with the understandings of health that have emerged from this process has come awareness that the achievement of this kind of health does not come only from the management and prevention of illness and disease. By reason, then, of exploration, education, inclination and possibly indoctrination, I am committed to the idea of health promotion as the most viable direction for health care of the future.

During the period of this study, however, I have tried to free myself from my own
notions of health and ‘see’ health as the participants in this study have seen it. This required that I constantly question whether health really is what I conceived it to be. It required that I refrain from discussion about my views of health with the participants, or indeed from any discussion that might influence the way they were able to access their lived experience of health, at least until after the interview series had been completed with each of them. It involved trying to identify, clearly and exactly, what my reactions and responses were to the descriptions offered by the participants and why I responded in the ways that I did, in order that I might recognise previously undiscerned preconceptions about health. Seeking to free myself of my presuppositions about health also required that I constantly ask myself the question ‘Is this what health is really like?’ Other questions about my own notions of health arose as the research proceeded, and these are to be found in the discussions of health and health care in Chapters Five and Seven.

PHENOMENOLOGICAL EXAMINATIONS OF HEALTH

Several contemporary studies in the phenomenological genre have addressed the feeling of health although not necessarily in the way this thesis has approached the subject. Using van Kaam’s (1969) six operations of scientific explication of phenomenological analysis, three nurses (Parse et al., 1985a) generated a complex listing of almost exclusively positive subconcepts which they analysed under a ‘common elements of experience with descriptive expressions’ format. Labonte (1993) also identified the way health is conceptualised from an exclusively positive perspective, deriving the descriptive phrases from health professionals’ written descriptions of a recent time they had felt healthy.

In contrast, this study sought to understand health in two ways. As in the Labonte study, nurses were first asked to describe a recent time they had felt healthy and then they were asked to describe a time in their nursing when they had given ‘health’ care to a person in their care. The difference between the two studies
referred to above and this thesis lies not only in the way the data have been collected and analysed but also in the depth and breadth of the interviews undertaken. Labonte derived his health descriptions from a written task given to individuals attending health promotion training workshops. Parse et al. used a similar written task from a sample of 400 age-distributed subjects who described a personal situation in which the feeling of health was experienced. The data for this study have been gathered through repeated, in-depth, tape recorded interviews to enable access to the deep, rich data from which phenomenological reflection and analysis ensues. Subsequent to the interviews, each participant was asked to reflect on the question of whether they could have health or give 'health' care without the various aspects of health or care that they had identified. This was done in an attempt to identify what was the nature of health for these nurses and in nursing and to enable a critical examination of the phenomenon of health.

CONCLUSION

Having identified some of the positive concepts that describe health, a question remains about the comprehensiveness of the list of known positive health concepts. Do the identified concepts describe health for all health professionals? Even then, were it known that the full gamut of concepts which describe health had been identified, seeking to identify the way nurses' health concepts affect their practice of nursing would appear to be of great value to nursing. To date, there is evidence of few studies that investigate the way nurses actually implement their concepts of health in their nursing practice. As Winstead-Fry (1980) indicated, this may be due, in part, to the limitations that the scientific method has placed on the study of health. In the current era of significant advances in qualitative research methodologies, however, this can no longer be held to be a deterrent.

Questions regarding the applicability of definitions of health to nursing need to be asked in light of the contemporary push for nurses to become health-promoting practitioners. Many nursing definitions of health were developed in an effort to
describe what people actually meant by the term health.' However, closer examination of many of these definitions shows that they do not present to practitioners workable concepts that can be readily translated into practice. An explicit example of this is provided in Carboni's (1995) discussion of 'Enfolding Health-as-Wholeness-and-Harmony'.

Further, it would appear that in embracing positive concepts of health, nursing educators have made a series of assumptions about students' concepts and their ability to undergo concept change. The first of these assumptions is that beginning nursing students' previously-held concepts of health are amenable to the demands of contemporary nursing which includes health promotion practice. The second assumption is that students will, somehow, change their possibly questionable concepts of health in the direction of the positive concepts obliquely expressed as part of their course. This latter issue of concepts and concept change will be discussed further in Chapter Four.
CHAPTER 3

METHODOLOGY

INTRODUCTION

The underlying purpose of this research was to understand the way that health presents itself to the consciousness of nurses who are educated about health. This in turn was driven by a need to comprehend the way nurses understand the meaning of 'health' in health promotion in nursing. Having established the connections between the phenomenon of interest and nursing in Chapter Two, the task now is to establish the relationship between nursing and phenomenology and that is the overall intention of this chapter. Subsequent to the discussion of phenomenology, some of the hermeneutic and phenomenological contributions by nursing scholars and scholars in the field of health research will be reviewed. This is done in order to establish the relationship between nursing and phenomenology and, equally, to establish the applicability of the phenomenological method to nursing research. It is done also, to lay the foundations for Chapter Four, which describes the manner in which this study of the way health presents to nurses was informed by the philosophical framework of hermeneutic phenomenology in its existentialist form.

The manner in which this research was carried out was informed by phenomenology according to van Manen (1990), which is derived from the traditions of Husserl, Heidegger and Merleau-Ponty. I use the term 'informed by' advisedly, since I am not a philosopher but, rather, a nurse seeking to understand the phenomenon of health as it presents to nurses in their own lives and in their practice. The thesis is informed by two views of phenomenology between which there has been considerable discord (Crotty, 1996a; Benner, 1996; Paley, 1997),
but which I intend to demonstrate are, in some senses, consistent with each other and serve to extend phenomenology in valuable and meaningful ways. The first involves the traditional approach to phenomenology advocated by the European phenomenological philosophers Husserl (1931), Heidegger (1962) and Merleau-Ponty (1962), among others. The second approach is referred to by Silverman as arising from ‘American continental’ philosophy. It is informed by the insightful work of many North American (Benner, 1984; Parse et al., 1985a; Olson, 1986; Leonard, 1989; Bergum, 1989b; Reeder, 1991; Jasper, 1994; Kellett, 1997) and British or Australian nurse scholars (Kretlow, 1989; Taylor, 1991; Osborn, 1993; Koch, 1995; Holmes, 1996; Darbyshire, 1997). These scholars have given substance to a phenomenological approach which has shown itself to be of enormous value to the investigation of aspects of nursing that have previously been placed in the ‘too hard’ category.

Although the works of the European phenomenologists offer diverse approaches to phenomenology, Spiegelberg (1982) contends that they share a common core, which is the search for the objective reality of ‘the things themselves’. As an eminent historian of the phenomenological movement, Spiegelberg identifies this common core as essential if the common label of ‘phenomenology’ is to be given to them all. European phenomenology seeks to objectively examine the subjective reality of phenomena in our experience; what Willis (1996) refers to as ‘objectivising subjectivity as apart from subjectivising subjectivity’ (p. 219):

... they are attempts at genuinely executed fundamental work on the immediately envisaged and seized things themselves. Even when they proceed critically, they do not lose themselves in discussions of standpoint, but rather leave the last word to the things themselves ... (Husserl, 1970b: 44-45)

European phenomenological approaches also seek to reach beyond the cultural and learned understandings of phenomena:

In order to see the world and grasp it as paradoxical, we must break with our familiar acceptance of it (Merleau-Ponty, 1962: xiv).
Phenomenology is a determined effort to undo the effect of habitual patterns of thought and to return to the pristine innocence of first seeing (Spiegelberg, 1982: 680).

Phenomenology asks us not to take our received notions for granted but ... to call into question our whole culture, our manner of seeing the world and being in the world in the way we have learned it growing up (Wolff, 1984: 192).

Speaking of philosophy and phenomenology in America, Silverman (1987) clearly differentiated between it and the European version, asserting that ‘continental philosophy has come to describe quite precisely what we do here in America’ (Silverman, 1987: 1). In order to avoid confusion, I refer throughout to the philosophy and phenomenology that Silverman calls ‘continental’ as American continental since in Australia the word ‘continental’ is generally accepted as pertaining or relating to the continent of Europe (Collins Dictionary, 1987).

Silverman (1987) asserts that European philosophers and researchers are frequently surprised to find that American continental philosophers have taken directions, and conduct research, in ways that diverge quite significantly from their original sources. He adds that while a common language makes communication easier, American continental philosophy stands on its own apart from European philosophy and that these philosophical differences also apply to phenomenology. Silverman (1987) offers a comprehensive discussion of the way in which the tenets of European phenomenology come together with that of structuralism in American continental philosophy. This discussion does not, however, lead one to an understanding of the precise changes that have occurred in phenomenology in the American continental tradition. Nevertheless, studies in the American continental mode may be identified through their use of citations from American philosophers such as Hubert Dreyfus and Charles Taylor as well as Hugh Silverman. They may also be identified via phenomenological research
that takes all or part of its direction from nursing scholars such as Patricia Benner, Marilyn Ray, Jean Watson and Rosemary Parse, among others, who have based their research, in whole or in part, upon the thinking of American continental philosophers.

In this thesis it is argued that the phenomenological approach advocated by van Manen (1990) gives credence to both the traditional objective and the newer more subjective examination of phenomena and that such dual examination fosters greater breadth and depth of understanding of the phenomenon to be explored. Accordingly, despite the considerable debate about the lack of connection between the two differing approaches to phenomenology, this thesis attempts to show that while the two views exhibit slight epistemological differences they are not, otherwise, methodologically incongruent. One of the intentions of this chapter is then to scrutinise phenomenological studies in the American continental mode in order to identify the similarities and differences between the European and American continental approaches to phenomenology.

The phenomenological hermeneutical work of van Manen (1990) can be said to have influenced a significant proportion of the phenomenological and hermeneutical research in nursing and education at the present time, in both the European and American continental traditions. Although the traditional European approach to phenomenology is apparent in his writings, van Manen’s exposition of phenomenology as a human science effectively opens the way for exploration of lived experience from the subjective positions of those who experience phenomena, an approach which is of particular value in nursing. The phenomenological and human science approach is ‘expanded’ by van Manen (1990) from the phenomenological work of Husserl, the hermeneutical works of Heidegger, Merleau-Ponty and Schleiermacher and the human science work of Dilthey, among others.

In order to demonstrate the origins of the ideas expressed by van Manen (1990)
and subsequently implemented in this study, the works of founding authors in phenomenology will be discussed. In the work of van Manen, the often-extreme differences between the philosophies and the methodologies of the various phenomenological philosophers are not articulated clearly and this thesis required a thorough exploration of the ideas inherent in the work of van Manen. van Manen offers an almost seamless construction of phenomenological hermeneutics out of the writings of many philosophers and nowhere makes clear that philosophical differences exist. This chapter describes phenomenology as philosophy, as approach, and as method. It does so via a brief examination of the foundational work of Husserl and explores briefly some of the hermeneutic notions of Heidegger as well as some of the work of Merleau-Ponty in order to explicate the human science approach proposed by van Manen (1990).

THE DEVELOPMENT OF PHENOMENOLOGY AS METHODOLOGY

Phenomenology derives from the Greek word *phainomenon* which means ‘to show itself’ (Husserl, 1931) or ‘what shows itself; the self-showing; the manifest’ and is ‘thus the totality of what lies in the light of day or can be brought to light’ (Heidegger, 1977a: 74-75). Phenomenology is, first and foremost, a philosophy or a variety of distinctive yet related philosophies; however, it is also concerned with approach and method. Husserl (1931) considered phenomenology to be all three, philosophy, approach and method. As philosophy, phenomenologists hold differing views on epistemological and ontological questions and therefore on the way phenomena may reveal themselves through the phenomenological process. Thus, the character of phenomenology is diverse, and the assumptions inherent in the various phenomenological approaches to understanding, and the methods they advocate, differ greatly. Basically, traditional European phenomenology offers a way of examining phenomena as they first show themselves to us. It is a way to examine those first encounters before they are reflected upon and interpreted in light of our acculturation, while they are still free from theories about their causal explanation, in order to determine their real nature (Husserl, 1970a).
Husserl

Phenomenology as methodology began with Husserl (1931) who presented an alternative way of thinking to that offered by positive philosophy. He argued that modern science was in crisis for two reasons. Firstly, because it had forgotten that its own roots lie in the lived experience of the human life-world and secondly, because it treats consciousness as a physical thing among things rather than as a relationship between things. Recognition of the need to return to the grounding of truths in experience called for a new method which was capable of describing how human consciousness constitutes meaning through pre-reflective acts of perception (Kearney, 1994). In this light, Husserl proposed phenomenology as a radical beginning in the sense that it offered a return to the root of philosophical questioning. In doing this, he developed a particular form of self-reflective procedure in which the investigator refuses to permit themselves to accept anything as existing unless all possibility of doubt about it has been removed (Husserl, 1931). Kearney (1994) describes Husserlian phenomenology as resting ‘upon the radical conviction that meaning is neither in the mind alone, nor in the world alone, but in the intentional relationship between the two’ (p.15). The phenomenological process advocated by Husserl is epistemologic in that it is based on study of the nature and validity of human knowledge. By examining how the world first appears to human consciousness, it emphasises a return to reflective intuition to describe and clarify experience as it is lived and constituted in consciousness (Kearney, 1994).

From its beginnings, the catch-cry of phenomenology has been ‘To the things themselves’ indicating that its intent is to uncover, explore and describe the ‘uncensored phenomena’ of the things themselves, as they are immediately given (Spiegelberg, 1970: 20). Husserl’s (1970a) primary objective was to develop ‘apodictic’ foundations (i.e., those ‘evident beyond contradiction’ (Webster Dictionary, 1977: 39)) for all human science and, indeed, for human knowledge of any kind. As such, he proposed a method for achieving such a return ‘to the
things themselves' which Kearney (1994) describes as 'complex and indeed manifold' (p. 18) and which Husserl presented in a different way in each of his major works. As summarised by Kearney (1994), this method involves five principle phases. Firstly, Husserl proposed bracketing or suspension of the empirical or metaphysical presuppositions of the natural attitude engendered by culture and tradition. Secondly, phenomenological reduction is achieved when one is enabled to return to the 'generating axis' or real-life interactions of our intentional experience as they are before being 'overlaid by objectifying constructs' (Kearney, 1994: 19). Thirdly, what Husserl (1931) termed 'free variation' occurs when 'meaning is no longer confined to empirical actualities but unfolds in a free play of pure possibilities' (Kearney, 1994: 19). The fourth stage involves intuition of the essential nature of the phenomenon as it emerges, while the fifth stage culminates with a description of the essential structures of the phenomenon. Through this process, Husserl proposed that the 'essence' or basic nature of phenomena might be revealed.

**Heidegger**

With the publication of *Being and Time*, Heidegger (1962) moved the philosophical emphasis in phenomenology away from pondering the meaning of consciousness to contemplation of the meaning of Being. Acknowledging his debt to Phenomenology, which he understood merely in a methodological way (Heidegger, 1962), his approach was radically different to that of Husserl. These differences resulted from his questioning back to the meanings of the Greek concepts of *phainomenon* and *logos*. ‘Phenomenon’ had previously been held to mean ‘that which shows itself’. Heidegger (1962) postulated that, when combined with logos which means ‘reason’, it indicated the way ‘to let that which shows itself be seen from itself in the very way in which it shows itself from itself’ (p. 58). This revisioning of meaning by Heidegger resulted in the development of a new, hermeneutical approach to phenomenology.

Where Husserlian phenomenology had required a suspension of the ontological
question 'What does it mean to be?' in order to attend to the workings of consciousness (Kearney, 1994), this question became Heidegger's major project. Heidegger (1962) saw humans as beings, who experience objects in particular and individual ways, and proposed a particular form of hermeneutic phenomenology in his pursuit of the meaning of Being. This new approach had a considerable influence on the development of existential phenomenology. In his hermeneutical work, Heidegger employed two notions, the hermeneutic circle and historicality of understanding. These notions have influenced contemporary hermeneutics and need to be understood in view of Heidegger's (1977a) often cited claim that humans cannot have a world and a life at a sociocultural level except through acts of interpretation. Although not directly included in contemporary discussions of phenomenological methodology, these two notions do much to clarify the underlying assumptions of this hermeneutic phenomenological study in the existential mode. These two Heideggerian notions will be discussed in the section on 'the phenomenological reduction'.

Heidegger can reasonably be said to have been the creative force in hermeneutic phenomenology and to have contributed immeasurably to its current form. However, despite the inclusion of many Heideggerian concepts into contemporary hermeneutic phenomenology, any attempt to employ a strictly Heideggerian approach to phenomenology is fraught with particular difficulties. Firstly, Heidegger's outright rejection of humanism, established in recent years by several writers (Farias, 1989; Wolin, 1990; Holmes, 1996), does not accord well with the postmodern world in which nurses live and conduct research. Secondly, as Holmes (1996) submits, it is difficult to defend a phenomenological approach that is so markedly at odds with the value orientation publicly adopted by the nursing profession. In addition to these serious considerations, Heidegger is universally recognised as being the most inscrutable of the phenomenological writers and there is consensus that much of his work is only poorly understood. So, while his rejection of Husserl's 'method' of pursuing phenomenology and his reasons for doing so are clearly identified, the way of pursuit of a Heideggerian
study is less defensible, less clear and open to differing, even contradictory, interpretations.

THE PHENOMENOLOGICAL REDUCTION

Bracketing
All of the later works in phenomenology proceed in some sense from the original work of Husserl. For this reason, Husserlian ideas form the basis for understanding of phenomenology and, thus, must be included in any discussion of phenomenological constructs. Couched within the five phases of Husserlian ‘method’ lie some of the most complex aspects of phenomenology without which the deeply reflective endeavour of Husserlian phenomenology is not possible.

Husserl (1970a) saw reduction as the fundamental methodological principle. The first principle of Husserlian phenomenology is then the notion of bracketing or epoché in which he insists on a suspension of belief in the phenomenon as a way to return to it in its pure form (Husserl, 1970a). This epoché enables one to focus on the ‘what’ of the phenomenon (Crotty, 1996a). Rather than comprising the reduction itself, bracketing is what we ‘do’ to achieve reduction. In bracketing, we must call into question our very understandings and examine our presuppositions in our attempts to describe phenomena as faithfully as possible. Bracketing therefore seeks to foster one’s ability to forgo the objective understandings imbued in us by our acculturation so that we may return to ‘the things themselves’ as they exist in and with our being. In Husserl’s (1931) terms, this existence in and with our being may also engage with what is imagined about the experience of the object so that the act of bracketing to achieve the phenomenological reduction is ‘essentially [a] first person, self-reflective process’ (Hammond et al., 1991: 181). However, the very language we use to describe phenomenon is culturally constructed and words are tools which only have meaning in relation to general agreement about their use (Wilson, 1958). For these reasons, such a new beginning as demanded by Husserl has come under
criticism in more recent philosophical and phenomenological works.

A different approach to bracketing - the hermeneutic circle

Although Heidegger is commonly said to have rejected the phenomenological reduction, what appears in his notions of the 'hermeneutic circle' and 'historicality of understanding' present themselves rather as a revisioning of that reduction. In Heideggerian terms, the hermeneutic circle addresses the notion of pre-understanding of phenomena that in Husserl’s transcendental phenomenology need to be bracketed. The hermeneutic circle is a central concept in Heideggerian hermeneutics in which Heidegger insists that all understanding is circular in the sense that 'any interpretation which is to contribute to understanding must already have understood what is to be interpreted' (Heidegger, 1962: 194). Mehta (1976) discusses the notion of the hermeneutic circle as it appears in Heidegger’s work in relation to the ‘isness’ or ‘whatness’ of things. Asking the question ‘What is this thing?’ premises that the question is asked from within a pre-structure of understanding. This means that all interpretation, which is supposed to generate understanding and knowledge, must itself be based on a prior understanding of what is to be known through interpretation. The implication of this is that we are then moving in a circle that, according to the most elementary rules of logic, is a vicious circle. However, nothing is to be achieved by avoiding the circle altogether - rather, this is ‘radically to misunderstand the nature of understanding itself’ (Mehta, 1976: 161). Rather than adopting Husserl’s notion of bracketing in order to cope with prior understanding, Heidegger (1962) proposes the notion that a hermeneutic circle is created when one enters into the circle in the right manner. According to Mehta (1976: 162) the hermeneutic circle or ‘circle of understanding’ is not a circle in which some optional or chosen mode of knowledge revolves, but is rather ‘an expression of the existential pre-structure of Dasein’ (human existence or Being) itself:

Far from being ‘vicious’, the circle conceals within itself possibilities of a deeper knowledge provided it is understood that the first, last and constant task of interpretation is to assure itself that its prepossession,
preview and preconception do not come from inspired flashes and popular notions, but have been worked out on the basis of ‘the things themselves’ (Mehta, 1976: 162).

Historicality of understanding

In *Being and Time*, Heidegger (1962) assiduously attempted to uncover authenticity or ‘authentic Being’ in his search for a radical ontology. In doing so, he gives ominous significance to tradition and culture, asserting that Dasein (authentic existence) ‘falls prey’ to tradition (p. 42). He states that:

*When tradition thus becomes master, it does so in such a way that what it transmits is made so inaccessible, proximally and for the most part, that it (Dasein) rather becomes concealed. Tradition takes what has come down to us (through culture) and delivers it over to self-evidence; it blocks our access to those primordial ‘sources’ from which the categories and concepts handed down to us have been in part quite genuinely drawn. Indeed it makes us forget that they have had such an origin, and makes us suppose that the necessity of going back to those sources is something that we need not even understand* (Heidegger, 1962: 42-42).

In pursuing this line of thought, Heidegger clearly indicates that we must rigorously and persistently free ourselves from our ‘historicality of understanding’ if we are ever to achieve authentic Being. It can be seen therefore, that although Heidegger is said to have rejected the phenomenological reduction, he replaced it with reduction in another form.

The notion of reduction in contemporary phenomenology

Merleau-Ponty (1962: xiv) states that the principal lesson of Husserl’s phenomenological reduction is ‘the impossibility of a complete reduction’ despite the fact that he based his ‘Phenomenology of Perception’ (originally published 1945) on the phenomenological work of Husserl. Thus, along with Heidegger, he abandoned the phenomenological reduction as advocated by Husserl. Merleau-
Ponty affirmed an existentialist view that we are all in the world and since phenomenological reflection is carried out "in the temporal flux on to which we are trying to seize" there can be "no thought which encompasses all our thought" (p xiv) and, thus, no complete reduction.

Although van Manen (1990) described reduction in the Merleau-Pontean sense, his notion of reduction appears also to incorporate ideas from Husserl (i.e., eidetic reduction) and Heidegger (i.e., hermeneutic circle). In van Manen's words, Merleau-Ponty (1962) saw reduction as the term which describes the device of phenomenology that allows us to discover "the spontaneous surge of the lifeworld" (p. 185). van Manen proposes that several levels or types of reduction can be distinguished in phenomenology. The first involves the awakening of 'a profound sense of wonder and amazement' (p. 185) which provokes a questioning of the meaning of the phenomenon. Second, is the striving to overcome one's own subjective response and preferences in relation to the phenomenon which prevent one from being able to address the phenomenon or experience as it is lived. The third reduction is to strip away from one's thinking the theories, concepts and assumptions which we acquire through our life experiences and acculturation and see the phenomenon in a 'real' manner. The fourth is the eidetic reduction originally described by Husserl in which one is required to see beyond the particularity of lived experience and discern the essence that exists 'on the other side of the concreteness of lived meaning' (van Manen, 1990: 185).

In connection to the research of this thesis, several issues related to reduction present themselves. The first of these is that none of the European phenomenological philosophers was talking about 'doing research' in the sense of engaging with others as in the work of this thesis. The approaches to phenomenological reduction advocated by Husserl, re-visioned by Heidegger and interpreted yet again by Merleau-Ponty were all intended to be carried out by each philosopher himself or herself and did not describe a process that was to be
applied to other people. Paley (1997) shows that when Husserl described the reduction he made it clear that he was referring to himself and that he engaged in the reduction alone. Such an argument has the potential to merely re-present the phenomenological project as a solitary philosophical exercise in reflection. By contrast, however, it may also be interpreted as offering guidance to the type of research approach that has resulted from phenomenological thought.

In contemporary phenomenological research that includes participants, the phenomenological reduction is frequently taken to refer to the researcher only (Crotty, 1996a). Crotty indicates, however, that if European phenomenology is taken as the starting point of contemporary phenomenological endeavour, the reduction should include all those who participate in the research. In a study such as this, this means that each participant as well as the researcher must attempt to identify and describe experience as it occurred pre-reflectively. In addition to this, Paley (1997) points out that in Husserlian terms the original data of consciousness can only be described, not interpreted or discerned through any inductive process. Both Crotty (1996a) and Paley (1997) argue that the Husserlian project therefore permits neither induction nor deduction 'but only intuition on the basis of precise analysis and exact description' (Paley, 1997: 190). This means that, having identified pre-reflective experience, both the researcher and each participant must engage in intensive critical reflection on the nature of health in their lives in order for the phenomenon of health to be accurately described. It is recognised that such intense reflection may not characterise the way the persons participating in the study would, under normal circumstances, identify and describe their experiences. This type of scrutiny may be fostered, however, through the use of reflective questions about personal descriptions of the phenomenon and by consistently seeking descriptions of participants' pre-reflective encounters with health.

Merleau-Ponty (1962) indicated that what is described must be given to us first-hand, before we engage in reflection or talking or theorising about it. He further
states that ‘the real has to be described, not constructed or formed’ (p. x) thereby indicating that description must come from the participant and not merely be construed by the researcher. According to Merleau-Ponty, phenomena do ‘not await our judgement’ (p. x) but are what is given to us directly in our experience; they are not merely everyday accounts of experience as we have learned to expect them. In the traditional mode of phenomenology then, reduction calls for the researcher and each participant to individually engage in a laying aside of their own cultural assumptions and presuppositions about the phenomenon in order for each to be able to apprehend the phenomenon anew. Contemporary approaches to traditional phenomenology rarely call for the suspension of belief advocated by Husserl’s *epoché*.

**INTENTIONALITY: A CENTRAL CONCEPT IN PHENOMENOLOGY**

In the second phase of Husserlian phenomenology lies another complex notion without which phenomenology loses its meaning and force – this is the philosophical construct of intentionality. Husserl (1931: 241) described intentionality as ‘a concept which at the threshold of phenomenology is quite indispensable as a starting-point and basis.’ Despite Heidegger’s rejection of much of Husserlian philosophy and method, he affirmed intentionality as a fundamental theme of phenomenology. Furthermore, there is no evidence that any other phenomenological philosopher has done anything to dispel the primary importance of intentionality to the pursuit of phenomenology.

In phenomenological terms, intentionality represents the notion that every thought is a thought of something, every desire is a desire of something and every judgement an acceptance or rejection of something (Crotty, 1996a). Thus, consciousness is inseparable from intentionality and the common element among the various phenomenologies is their rejection of the Cartesian notion of the separation of the subject and object. Intentionality does not mean that we intend a purpose toward an object or event although consciousness is always intentional.
Rather, Crotty (1996a) refers to the Husserlian notion of intentionality as an epistemological concept that has to do with the union of object and subject. In other hands, for example those of Heidegger, intentionality takes on a slightly different meaning but never loses its centrality in phenomenology.

Intentionality is a philosophical term which gives name to the object of consciousness, the 'intentional object' (Hammond et al., 1991) which is not an object in the world. One of the ways this concept can best be understood is through the question posed by philosophers - 'How do intentional objects relate to existent objects?' - which shows that there may be a difference between the object as experienced and the object itself in existence. In natural science, which is ruled by objectivist epistemology, the meaning of an object is held to be in and of the object itself. However, Husserl (1931) maintained that meaning is only to be found in the relationship between the object and human beings.

The notion of intentionality in phenomenology is inextricably intertwined with the constructivist epistemological position described by Husserl (1931) who rejected the objectivist epistemology of the Scholastic philosophers. Husserl argued that meaning or knowledge could not be described as either completely objective or completely subjective. In constructivism, meaning does not reside in the world alone, nor is it created by human beings out of their own experience; rather, meaning is constructed out of human interactions with real objects in the world. In this respect, intentionality means that objectivity and subjectivity are brought together and held indissolubly by reason, which is consistent with experienced reality (Crotty, in press).

In this study, intentionality relates to the way that health is manifest to the participants - that is, what appears and is felt as health - and what it is that health, as it is present in their lives, is like. In other words, it asks the question 'What is health, as it presents in the lives and practice of nurses, like?'
EXISTENTIALISM AND PHENOMENOLOGY

The existentialist aim is to distinguish the experience of human beings living in the world. Existentialist philosophy asserts that what is distinctive about human existence is that it is active and that, by acting in the world, it develops its own character and interprets the world (Hammond et al., 1991: 96). In order, therefore, to reveal the nature of the subject and the meaning of the world in which it exists, the task of existential phenomenology is to begin by describing ordinary human activities in the world, and not thoughts, perceptions or reflections on ordinary activities (Hammond et al., 1991: 96). However, phenomenology does not only consist of lists of descriptions of particular experiences as phenomena; it 'is not mere speculative inquiry in the sense of unworldly reflection' (van Manen, 1990: 22) nor is it merely particular. Phenomenology consists of, first, discovering phenomenological themes, both individual and common, represented in each participant's experience and involves trying to determine what makes up the experience of the phenomenon. The driving force of phenomenology and the impetus for reflective endeavour is the question 'Is this what the experience is really like?' (van Manen, 1990: 99).

In Existentialism, the emphasis is on the importance of human experience. The methods that the existentialists employ in their interpretations of phenomena have a common presupposition which is that the relationship is an immediate one between the interpreter and the interpreted and between the inquirer and the inquired of. This means that the person who poses the question 'What is this thing?' cannot but pose it to their own self and cannot respond without starting from their own existence (Encyclopaedia Britannica, 1983b: (7) 75C). However, each existentialist philosopher developed an individual way of interpreting existence. Although explicitly denying an existentialist orientation, Heidegger (1962) did this perhaps more clearly than most. He pointed the way for existentialism in phenomenology by directing his thinking about the most abstract issues in ways that have everyday concrete practical implications (Dreyfus and Hall, 1992). To Heidegger (1962), the 'logos' of the 'phainomenon' employs
speech which manifests itself (i.e., that discloses what it is that one is speaking about and that is true) in the sense of uncovering what is hidden.

Although the phenomenon may appear through language about human practices, the meaning of human existence does not lie in human practices alone, for these, as objects of study for sociology do not help us to understand phenomena (Dreyfus and Hall, 1992). It is here that yet another Heideggerian notion gives direction to the existential project of this thesis. The term Dasein is used by Heidegger to denote the entity of ‘man himself’ (sic), not just as an entity occurring among other entities, but rather as a being for whom ‘being’ is an issue. In human being therefore, the word ‘Dasein’ as used by Heidegger indicates that persons, themselves, understand themselves in their own being and do so explicitly. Heidegger explains it thus:

*It is peculiar to this entity that with and through its Being, this Being is disclosed to it* (Heidegger, 1962: 32).

*Dasein always understands itself in terms of its existence ... to be itself or not itself... Only the particular Dasein decides its existence, whether it does so by taking hold or by neglecting* (p. 33).

In this study, Heidegger’s notion of Dasein was taken to mean that only to the nurses themselves would their being in health be disclosed. In addition, it was understood to mean that only in their own descriptions of health in their lives would the reality of the phenomenon of health for nurses educated about health be found.

It is clear, however, that it was not Heidegger’s intention to focus attention on humanism which he rejected on the basis that it places human subjects at the centre of understandings of the world (Heidegger, 1977a). Nevertheless, through his focus on average everyday practice, on what people actually do rather than what they say they do, he opens the way for an existentialist interpretation of his work. In pursuit of the meaning of Being, Heidegger (1962) describes simple skills. He shows how these simple skills embody a familiarity with the world that
enables humans to make sense of things (Dreyfus and Hall, 1992) and thus opens the way for an exploration of 'being in the world' as a way of understanding human experience. Although, in Heidegger’s hands, hermeneutic or interpretive phenomenology is ontologic (Heidegger, 1962), others, including van Manen, have used and modified the approach formulated by Heidegger to understand, in existentialist ways, human experience itself.

Where the Heideggerian project searched for the meaning of Being, van Manen’s (1990) phenomenology focused on ‘lived experience’ - a notion taken from the human science work of Dilthey (1985, 1987). van Manen contends that this is ‘the starting point and end point of phenomenological research’ (p. 36). Although Husserl (1977) described the experience of concrete objects exhaustively, Sartre (1958) was one of the first to introduce the notion of lived experience to phenomenology. In doing so, Sartre (1958) sought to provide phenomenological descriptions of concrete human experiences from which he aimed to extract philosophical examples of the nature of human existence (Hammond et al., 1991). van Manen (1990) seeks to explicate lived experience through the exploration of ‘the lived world as experienced in everyday situations and relations’ (p. 101). For this reason, despite the differences in their approaches, the existentialist orientation that grew out of the work of Heidegger and is seen in the work of Sartre can be seen also in the work of van Manen.

HERMENEUTICS

Hermeneutics, literally translated means ‘the science of interpretation’, generally with reference to authoritative writings or sacred scripts (Runes, 1981: 126). Reeder (1988) states that, more recently, interest in hermeneutics is concerned with understanding and interpretation as processes (i.e., epistemology), and with modes of being (i.e., ontology) and that history, art, myth and human action have taken a place in hermeneutics with writings and scripts. Describing hermeneutics, Reeder (1988) offers the following analogy:
Hermeneutics is like a road map for understanding the terrain of language: the signs of spoken and written expressions point out connections between the speaker or writer and the world in which he or she lives' (p 194).

She identifies three distinct interpretations of hermeneutics: the hermeneutic circle, dialogue between 'worlds that are incommensurable' and require translation, and human practices in which understanding is in a concrete and opaque relational entirety but is not fully able to be articulated in common sense terms (p. 196).

In this study, the hermeneutic approach adopted was that of the hermeneutic circle described above. The approach also includes the notion of dialogue between persons who lack a basis of comparison in their frequently fragmented descriptions of health. Thus, each participant is understood to already know that which was to be known (i.e., health) through interpretation of the data relating to themselves, even though they may not have clearly recognised it prior to interpretation. To explicate the participants' understandings of health, a hermeneutic approach was achieved by entering the interview process in an appropriate way. This was achieved by asking the question in a way that encouraged reflection on experience and by ensuring that the interpretations of the phenomenon were worked out on the basis of the thing (health) itself. The dialogue between persons – that is, the researcher and each participant - was frequently conducted in unfinished sentences with meaning conveyed by expression, tone, gesture and even by the inability to articulate clearly what was meant. In this study, these cues to meaning have been interpreted into the narratives as text and the messages conveyed have subsequently been clarified and validated by the participants.

Gadamer (1975) described the work of hermeneutics as not being concerned with developing a procedure of understanding; rather it is to clarify the conditions in which understanding takes place. In this way, he opened the way for
phenomenology in the American continental mode. Clarification of the conditions in which understandings of phenomena take place calls for exploration of the lived-world in which people exist and extends phenomenological scrutiny beyond the scope of the phenomena alone. The extension of hermeneutic phenomenology into the arena of exploration of conditions in which phenomena occur implies a change in the focus of phenomenology, away from the more objective one of traditional phenomenology and into the realm of peoples' subjective experiences.

AMERICAN CONTINENTAL PHENOMENOLOGY

One of the reasons for confusion between the European and American continental versions of phenomenology arises because the proponents of American continental phenomenology cite European reference texts more than they cite American continental philosophy:

... not because they are not significant, but because the [American] style is less argumentative and disputative. [American] continental philosophers are more concerned with extending the understanding of an issue as it has been initiated in the methodology ... (Silverman, 1987: 6).

According to Paley (1997), another reason for confusion in phenomenology in nursing lies in the way phenomenology itself has been imported into nursing. He describes three 'tiers' in phenomenological literature in nursing. Husserl (1931) himself makes up tier one. Important philosophical commentators, like Spiegelberg (1982), Merleau-Ponty (1962) and Ricoeur (1981) comprise tier two. Tier three is occupied by the philosophically minded social scientists including Giorgi (1970), Natanson (1973) and van Manen (1990). Paley describes this as significant since it means that the methodological and conceptual chain leading back to Husserl has at least three links in it, which increases the chance of misinterpretation of Husserl's meanings.

In Husserli (1931) terms, phenomenology involves a searching critique of
inherited and prevailing meanings of phenomena. It is intended as a radical beginning in the sense that it offers a return to philosophical questioning so that one may learn to see the world anew, as it really is, rather than as it is constructed through acculturation. An examination of various works in phenomenology in the American continental mode shows that, there, it means something quite different to the more objective stance of European phenomenology. For example, Tanner, Benner, Chesla and Gordon (1993), Jasper (1994), Isaak and Paterson (1996), Bousfield, (1997), Kralik, Koch and Wotton (1997), Theobald (1997) and Thibodeau and MacRae (1997) conducted research projects which involved exploration and description of everyday understandings of experience itself. Research studies such as these are intended to foster understanding of the events in peoples’ lives and allow the reader to understand the perspective of ‘the other’ in ways that have previously been closed to us.

A focus more towards the subjective than the objective

The change to a more subjective mode of phenomenology is, however, a subtle one. The phenomenology of Husserl and other European philosophers sought to objectively examine the subjective reality of phenomena in human experience. The American continental approach to phenomenology has undergone modifications that have taken it away from this common task of European phenomenology and into the realms of exploration of the subjective experience of individuals. In other words, it seeks to examine subjectively the subjective reality of phenomena in human experience, to allow the subjective to speak so that it may be understood. The following citations indicate the change clearly:

*This qualitative methodology is characterised by inductive reasoning, description, discovery of the subjective meaning of the phenomenon and its effect on the participant’s behaviours. (Yong, 1996: 74 citing Omery, 1983)*

... the interpretation was based on a phenomenological paradigm which focused on the subjective perceptions of students and supervisors. (Hallett et al., 1996: 578)
... allowance for existential phenomenological factors focuses on the foundation of the separateness and identity of each person. The caritive factor rests on the personal, subjective experience of the person as the foundation for understanding. (Watson, 1985: 205)

the invitation 'Tell me what it was like for you.' (Thibodeau, 1997)

This means that the core task of American continental phenomenology is to understand the subjective reality of the experiences of the persons engaged with the phenomenon rather than the more objective reality of the phenomenon itself. Thus, American continental phenomenology seeks to establish the nature of the subjective lived experience of the people it studies (Saltonstall, 1993; Wondolowski and Davis, 1991).

A change in the focus on experience

In traditional European phenomenology, lived experience is used as a tool to access descriptions of phenomena in their primordial or original form as they were in the physical reality (Husserl, 1931). Descriptions of phenomena may then be subjected to objective scrutiny by asking 'Is this what the experience is really like?' (van Manen, 1990: 99). Schuhmann states that European phenomenology does:

... not simply restate the popular view, but makes comparisons and asks for legitimacy ... In the answers to these questions about legitimacy, in these demands, a determinate, objective world, the world pertaining to the senses as it surrounds us, becomes constituted. This is a totally pure and presuppositionless reflection upon givenness and the phenomena that hover before us and that we are unambiguously aware of in perceiving and thinking (Schuhmann citing Daubert, 1985: 11).

In European phenomenology, this focus on the primordial form, the 'immediate, original data of our consciousness' (Pickles, 1985: 95) removes it from self-conscious thinking processes:

It is not our experience after we have developed or applied ways of understanding or explaining it. It is experience as it is before we have
thought about it (Crotty, 1996a: 53).

As such, it requires that descriptions of experience be sought as they occurred prior to reflection. In other words, descriptions of pre-reflective experience are solicited as a means of accessing 'real' descriptions of phenomena.

In contrast to this, phenomenology in American continental mode demonstrates that the focus is on the exploration and description of everyday experience itself (Henderson and Brouse, 1991; Marr, 1991; Wondolowski and Davis, 1991; Kellett, 1997):

... phenomenology describes the experience of the ordinary and everyday lifeworld (Walters, 1995: 19).

It becomes apparent that there are parallels between phenomenology and nursing when one considers that the phenomena of interest to nursing are intimately connected to the subjective experiences of patient and nurses as people ... (Taylor, 1991: 79).

Such description is acceptable regardless of whether it is of 'immediate' experience or experience that has already been reflected upon and interpreted by the person who does the describing:

**Phenomenology is an approach to viewing and researching lived-experience within a world** (Wilkes, 1991: 229).

**Phenomenological researchers strive to understand and describe lived experiences** (Swanson-Kauffman and Schonwald, 1988: 97).

These descriptions of experience may also include thoughts and interpretations of experience as they occurred after the immediate experience was over. The following example, taken from a study of critical care nurses' lived experience of unsuccessful resuscitation highlights this difference:

**Phenomenologists are able to learn the meaning of a phenomenon when the participants share stories and reflect upon their experiences pertaining to the phenomenon ... The participants' stories were obtained by means of paradigm exemplars and interviews. A paradigm case**
exemplar has been described as 'a clinical episode that alters one's way of understanding and perceiving future clinical situations' (Benner, 1984: 296 cited by Isaak and Paterson, 1996: 690).

This example makes it clear that the nurses interviewed for this study were not asked for pre-reflective experience, but to describe an episode that, in their judgement, had changed the way they viewed their clinical practice. The exemplar that was requested of them was thus already an interpreted experience rather than one described in its 'primordial form'

The focus on 'everyday' experience: a change in the way culture is viewed

The focus on the everyday aspects of experience rather than on the way phenomena present themselves is also a move away from European phenomenology. In European phenomenology, while the exploration is directed toward the phenomenon as it is experienced, every effort is made to remove the cultural and everyday inherited understandings of the phenomenon so that it may be seen afresh as it really is. Thus, a search for everyday understandings dissipates the effect of the phenomenological reduction that seeks to eliminate traditional and cultural understandings. In doing so, it demonstrates a change in the way culture is viewed within American continental phenomenology.

Both Husserl (1931) and Heidegger (1962) were severely critical of the effect that culture and tradition may have on a true examination of phenomena. It can be shown therefore that the European approach seeks to describe the universal or unchanging aspects of phenomena as free as possible from the cultural context in accordance with the task of phenomenology initiated by Husserl (1931). The American continental approach seeks to describe experience per se. This focus on experience in and of itself places the examination of phenomena in this mode within the context of the culture in which it is examined. Such an approach has the ability to foster understanding of others as they experience life events within the context of culture and is of great value to nursing. This is particularly so
where:

*Phenomenological perspectives of the human experience can offer nurses creative methods for enhancing holistic care* (Kretlow, 1989: 9).

For this reason, the emergence of the American continental approach to phenomenology appeared at a fortuitous time for nursing, since:

*Nursing today, with its individualistic approach to care, shares many of its underlying beliefs and values with the school of philosophical thought known as [American continental] phenomenology* (Jasper, 1994: 309).

Nursing is concerned with what it means to be ill, what it means to be in care and with knowing what the experiences of patients are like:

*What is important is the experience as it is presented, not what anyone thinks or says about it. Therefore, investigation of phenomena important to nursing requires that the researcher study lived experience as it is presented in the everyday world of nursing practice ...* (Carpenter, 1995: 35).

**Epistemological position**

Crotty (1996a) asserts that the more subjective focus of American continental phenomenology is incompatible with the traditional task of phenomenology and that it espouses an epistemological position that is in direct opposition to the constructivist position of traditional European phenomenology. However, although many nursing authors fail to state their epistemological stance, Benner (1984) has discussed her constructivist position at length. Following in Benner’s footsteps, many nurse researchers have adopted the constructivist epistemological position she describes in phenomenology. Therefore, it would appear that while the focus in American continental phenomenology is somewhat more subjective than that of European phenomenology, the epistemological position of each is still within the constructivist paradigm.

It is apparent that the increased emphasis on subjective experience in more recent
phenomenological research means that there has been some change in the epistemological stance of phenomenology, when it is interpreted in the American continental mode. However, this appears to be more a matter of a few decimal points of change than a move towards the entirely new (for phenomenology) subjectivist position as Crotty (in press) indicates. Benner (1984) and Tanner, Benner, Chesla and Gordon (1993) presented clear arguments that, in nursing, knowledge cannot be understood to be individual and based on personal experience since much of nursing is so clearly learned out of the reasoning of science. This constructivist position is exemplified by the ‘art and science of nursing’ discourse so prevalent in recent years. Thus, the notion of intentionality that is inextricably linked to the constructivist epistemological position, while not precisely the same in American continental phenomenology, is not so different as to make it untenable.

EUROPEAN AND AMERICAN CONTINENTAL PHENOMENOLOGY

While the criticism has been made that modern American continental thought has adopted an ‘anything goes’ mentality, particularly in the social sciences (Bloom, 1987), such criticisms have been debated vigorously (Damrosch, 1995; Levine, 1996). Basically, two major differences exist between the American continental and traditional European approaches to phenomenology. The first of these is that the American continental phenomenological question does not seek for ‘pre-reflective’ experience but includes thoughts and interpretations of experience of the phenomenon in the data collection and analysis. Secondly, American continental analysis focuses on describing participants’ lived experience within the context of culture rather than searching for the universal or unchanging meaning of it outside the cultural context as a means of understanding the phenomenon.

Although each approach claims traditional phenomenological thought as their foundation, the differences in the way culture is viewed indicate that some of the
assumptions that underlie traditional and American continental phenomenology are different. In traditional phenomenology, the assumption appears to be that phenomena may have universal meanings which may be inherent in phenomena from culture to culture, almost a universal 'truth value', as it were. In American continental phenomenology, the underlying assumption, although not stated, appears to be that phenomenal meanings may be culturally constructed and may therefore be found in descriptions of experience per se. Aside from these differences, each of the approaches espouses the notions of intentionality and the phenomenological reduction that are central to phenomenology. Each of them advocates the intense reflection on the phenomenon that is the hallmark of phenomenology.

Both Crotty (1996a) and Paley (1997) critique phenomenological research in nursing, indicating that it is not true to the intent of traditional European phenomenology. However, while not detailing the nature of the changes in American continental phenomenology, Silverman (1987) indicates that this is a philosophical change rather than a change instigated by nursing researchers. He makes the point that such changes as have occurred mean that a new generation of phenomenologists are marking out clear and original paths in phenomenological research and describes the future of hermeneutic phenomenology as particularly bright.

According to Crotty (1996a), the newer version of phenomenology serves as an illustration rather than as a critical examination of phenomena. This proposition is upheld by Silverman's (1987) statement that American continental phenomenology is more concerned with understanding than with objective examination and description. In this thesis, it is precisely this illustrative function which assists in bringing the phenomenon into sharper focus when put together with traditional phenomenology. This is done in order that the phenomenon of health may be understood in all its breadth and depth.
Both the traditional European and the American continental approaches to phenomenology have value to nursing. The European approach has value in that critical analyses of phenomena as they present in nursing are necessary for deeper understanding of the universal meanings of nursing phenomena. In this study, a critical analysis of health as it presents in nursing is necessary for deeper understanding of the meaning of health in health promotion, which is a nursing responsibility. The American continental approach has merit for two reasons. Firstly, it is in keeping with the trend towards more human research in the postmodern world in which people live and in which research is conducted. In addition, the reorientation of phenomenology toward human science rather than the more ‘critical’ approach of traditional phenomenology (Crotty, 1995) clearly addresses the needs of a discipline such as nursing, given that a requirement of nursing is to understand the human condition rather than phenomena as such.

Such an evolution of research methodology as has occurred in phenomenology is very much in keeping with the academic tradition. However, Morse (1996) makes the point that changes to method [and methodologies] must involve ‘conscious deliberate decisions [and] a clear rationale’ (p. 468). While there are many recent works on phenomenology that would appear to substantiate the changes that have occurred, few of them even acknowledge that such changes have taken place, much less address with any clarity the nature of the changes.

Despite this lack of acknowledgment, the melding of the human science work of Dilthey into the phenomenological works of Husserl and others (van Manen, 1990) would appear to be built on reasonable foundations. Husserl himself acknowledged that his friendship with Dilthey had turned his attention to ‘the historical life out of which all of the sciences originated’ (Encyclopaedia Britannica, 1983a: 68). This friendship could therefore be said to have contributed to the development of the text ‘General Introduction to Pure Phenomenology’ (Husserl, 1931). According to Dilthey (1987), understanding can be achieved by reproducing and reliving the experience of others, a trend that
can be detected in American continental phenomenology.

The changes that have occurred in American continental phenomenology have, therefore, resulted from the integration of the work of Dilthey but have also resulted from the blending of perspectives from the respected philosophical traditions of North America. Silverman (1987) affirms this through his discussion of American continental philosophy and its effects on phenomenology. Simultaneously, he affirms the 'reasonableness' of the foundations for the American continental approach to phenomenology in his discussion of the fact that hermeneutics in American continental philosophy takes its lead from Heidegger but also from Schleiermacher and Dilthey, and that it has come to stand in its own right.

The second argument for the use of American continental phenomenological methodology is advanced by Crotty (1996b) who acknowledges the value of such an approach to a discipline like nursing. Except where he discusses studies which he describes as methodologically flawed (a description with which Silverman might take issue), Crotty's (1995) critique of the 'new' phenomenology is based on the observation that the particular type of 'critical analysis' called for in the European approach is not used. The focus of American continental phenomenology is, however, different to that of European phenomenology where the aim is to understand the phenomenon objectively. Rather than using lived experience merely as a tool to access phenomena as in the traditional approach, the American continental approach allows fuller investigation of 'lived-experience' itself. For this reason, such research can lead one in the direction of uncovering the meaning of lived experience from the subjective perspectives of the persons who participate. In nursing, this approach has particular value in that it allows us to understand the perspective of 'the other' in ways that have previously been closed to us. The American continental approach therefore has the ability to foster understanding of many of the complex and perplexing conditions in which humans find themselves and thus address
nursing's central concern, which is caring for people.

In pursuit of a more complete understanding of health in nursing, this thesis has used both the traditional European as well as the American continental approach to hermeneutic phenomenology. The human science approach of van Manen is, in principle the one used for this study and will be discussed further in the section on 'theoretical framework' in Chapter Four.
A summary of the differences between European and American continental phenomenology

<table>
<thead>
<tr>
<th></th>
<th>European phenomenology</th>
<th>American continental phenomenology</th>
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<tbody>
<tr>
<td>The value of lived experience</td>
<td>‘Lived experience’ is used as a tool to access phenomena.</td>
<td>Allows investigation of ‘lived-experience’ itself - experience is explored in its own right.</td>
</tr>
<tr>
<td>The way experience is viewed</td>
<td>Seeks pre-reflective experience of phenomena. Interpretations and thoughts not included.</td>
<td>Seeks descriptions of experience per se. Interpretations and thoughts included.</td>
</tr>
<tr>
<td>The way culture is viewed</td>
<td>Regarded with suspicion</td>
<td>Unchallenged</td>
</tr>
<tr>
<td>Assumptions</td>
<td>Phenomena may have universal meanings.</td>
<td>Although not stated, it appears that phenomenal meanings may be constructed culturally.</td>
</tr>
<tr>
<td>Epistemology</td>
<td>Constructivist. Knowledge is regarded as a blend of experience and reason.</td>
<td>Constructivist but with somewhat more subjective orientation. There is more focus on individual knowledge based on personal experience.</td>
</tr>
</tbody>
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PHENOMENOLOGICAL RESEARCH IN NURSING

There is a rich supply of phenomenological studies that address issues of concern in nursing, mostly in the American continental mode. Research studies in nursing that employ a phenomenological approach have focused on diverse areas of the lived experience of both patients and nurses. In the text ‘Phenomenology
and Nursing Research’, Crotty (1996a) discusses 30 such studies although this is done to illustrate, through critique, their lack of the critical approach which Crotty sees as the only ‘true’ phenomenology (p. 8). Despite these differences of opinion, in recent years the use of the phenomenological approach to research in nursing has been increasing steadily and both the traditional European and the American continental approaches have been employed in numerous studies. Benner (1994) referred to 21 doctoral dissertations not discussed by Crotty, all of which employed interpretive or hermeneutic phenomenology, mostly in the American continental mode. Koch (1995) reviewed an additional seven phenomenological studies not mentioned by the others and Streubert and Carpenter (1995) another 19 studies not included elsewhere.

For example, Taylor (1991) used a ‘hermeneutical phenomenological’ approach informed by Heidegger and Gadamer to research the phenomenon of ordinariness in nursing. She described the effects of various aspects of ordinary nursing encounters that enhance nursing and thus make accessible to nurses a deeper understanding of nursing. Osborn (1993) used Parse’s theory of ‘human becoming’ to examine what it is like to live with the effects of stroke in order to enhance nurses’ understanding of the experiences of patients who suffer from stroke. Benner (1985) used a Heideggerian approach derived from American continental philosophy to explore the phenomenon of quality of life, while Kretlow (1989) examined illness using a methodology which was not explicated in the journal report of the study.

Although it is not possible in this thesis to address such a plethora of phenomenological work in nursing, some studies are particularly relevant. In a phenomenological study of the transformative experience of childbirth, Bergum (1986) interviewed six participants in order to comprehend the transformative experience of motherhood. Each participant was interviewed approximately six times over the period of time from when they made the decision to become parents, during pregnancy, and after the birth of their child. Analysis of data
from transcripts was performed according to van Manen’s approach (1984) via the tracing of etymological sources of words used in the descriptions, searching of idiomatic phrases, exploring childbirth literature and artistic sources, and attending to personal experience (Bergum, 1986).

Olson (1986) completed a particularly moving portrait of the life of illness endured by herself and her five siblings, all of whom died of kidney failure and related causes. Using the research methods of reflective reading, interviewing, writing, and incorporating excerpts from literary texts into the data for hermeneutic reflection, Olson performed a thematic analysis to derive answers to the central question of her thesis ‘How can we understand the life of illness?’ Such studies as these, while not addressing health directly, gave methodological direction to this study. They serve also to create understanding of the human condition and can only assist nurses in their efforts to become health-promoting practitioners.

Addressing health directly in a study of the lived experience of health, Parse et al., (1985a) surveyed 400 ‘subjects’ aged from 7 to 65 years who were asked to describe in writing a situation in which they experienced health. Use of the term ‘subjects’ is an unusual and generally unwelcome one in phenomenology, given phenomenology’s rejection of the objectivist epistemological position that is represented by the term. Parse’s use of the term therefore implies a lack of familiarity with the epistemological position of phenomenology although the term was not intended to convey quantitative connotations. Subsequently, Parse et al., (1985b) interviewed only two people to derive an understanding of what it was like to persist in change. In both cases, the ‘subjects’ descriptions were analysed through ‘processes of intuiting, analysing and describing the six operations of scientific explication of phenomenological analysis’ (p. 29) described by van Kaam (1969).

In the first case, the modified phenomenological study was directed toward
evolving a structural definition of health as it is experienced in everyday life. As a result, Parse et al. (1985a), generated a complex listing of almost exclusively positive subconcepts of health, which they analysed under a 'common elements with descriptive expressions' format. There are 120 descriptive expressions reported in this study under such common elements as 'spirited intensity', 'fulfilling inventiveness', 'symphonic integrity', 'exhilarated potency' and others. Although these descriptions may create potent images of health for some, it is my belief that cultural differences in language use may inhibit many Australian nurses from relating to the images that these descriptions are intended to evoke. If this is the case, such images of health do little to advance the cause of health promotion in this country.

Another phenomenological study has relevance to this thesis in that it provides a different way of viewing the construct of health. The study is a phenomenological exploration of the lived experience of health in the oldest old, undertaken by Wondolowski and Davis (1991), in which over 100 'oldest old' were asked to respond to a statement about health. Data collection and analysis were performed according to 'the van Kaam modification of phenomenological inquiry' developed by Parse et al. (1995a) (Wondolowski and Davis, 1991: 114). This resulted in a structural definition of health as 'an abiding vitality emanating through moments of rhapsodic reverie in generating fulfillment' (p. 115). As a result of this study, the authors make the claim that nursing practice could be guided by the practice proposition - 'sharing moments of remembering clarifies meaning and prompts changing ways of becoming' (Wondolowski and Davis, 1991: 117). In my opinion however, it is doubtful whether the pragmatic practice of nursing in Australia benefits from such propositions in the way the American researchers may have anticipated.

Saltonstall (1993) explored the embodied aspects of health using phenomenological method, concluding that health is grounded in a sense of self and a sense of body and that gender is a leitmotif for health. However, rather
than asking participants to describe experience to elicit recall of the first, pre-
reflective encounter with the phenomenon to obtain data, Saltonstall used
questions like ‘Do you consider yourself a healthy person?’ and ‘How do you
account for your healthiness?’ This is in direct contravention to the philosophical
basis of phenomenology which urges a return to the grounding of knowledge in
human experience (Husserl, 1931) rather than thoughts, perceptions or reflections
on ordinary activities (Hammond et al., 1991).

Benner (1985: 5) states that hermeneutics or interpretive phenomenology ‘allows
for the study of the person in the situation, offers a way of studying the
phenomenal realms of health and illness, and overcomes the problems of extreme
subjectivity or objectivity’. Phenomenological hermeneutics has been used to
understand the everyday practices of nursing and the meanings and knowledge
embedded in nursing skills. It offers a different kind of understanding, since
phenomenological hermeneutics assumes that the study of common, everyday
understandings and practices is different to the study of objects or biophysiological events (Benner, 1985). In this study of the way nurses
experience health and what it is that health is like, no attempt has been made to
describe health from the measurable perspective of contemporary scientific
deduction. Rather, health is described through reflection on the manifestations of
experience to determine the nature of health in nursing for the people in the
study.

The position from which I speak about phenomenology
With the growing acceptance of qualitative methodologies, a number of writers
have described the necessity for the researcher to explicate the position from
which they approach not only the topic under investigation but also the
methodology (Lather, 1986, Sandelowski, 1986). This is because there is no
detached objective position from which to speak about human being
(Sandelowski, 1986). The methodology for this study was chosen for several
reasons related to my work and my own understandings of the world. As stated
previously, I am a community health nurse. By definition, community health is based on the notion of respect for individuals; that is, it is built around the belief that the choices people make, and the actions they take, make sense to them in the context of their own lives and experiences. For this reason, it was Heidegger's notion of Dasein or 'being-in-the-world' that started me on this phenomenological journey. His proposition that persons, themselves, understand themselves explicitly in their own existence, and that, in some senses, they choose or are enabled to acknowledge or ignore the meanings of their experiences and thus decide the mode of their being, accorded with the guiding spirit of community health. Thus, my intention to use phenomenological method in the study of the ways health presents itself to nurses and in nursing arose from three main sources. Firstly, I accepted the Heideggerian premise that the persons I wished to study would best understand the phenomenon I wished to study. Secondly, I understood that intentionality refers not to conscious choice or deliberate action, but relates to the way each participant experiences health and what health, as it manifests itself to them, is like. Thirdly, I understood that such an examination of the phenomenon as it first presented itself to individual nurses would enable me to get closer to understanding what this thing called health is like in nursing.

The methodology for this study incorporates the notions of reduction as described by van Manen and includes the Heideggerian notions of the hermeneutic circle and historicality of understanding. In this study, phenomenology was used as philosophy that guided the approach, and, hence, determined the methodology, which in turn determined the mode of inquiry and the method of interpretation of the phenomenon.

CONCLUSION

Examination of the two approaches to phenomenology from a methodological perspective shows that while there are some differences between the two methods
of inquiry, the two do not appear to be incongruent except in their focus on experience and in their attitudes to the significance of cultural and traditional meanings. Indeed, there would appear to be some justification for the viewpoint that the American continental approach extends the phenomenology of Husserl to encompass both intercultural as well as intracultural perspectives. Viewing each approach from the methodological perspective shows that the central concerns of intentionality and reduction are, generally, incorporated into the phenomenology regardless of the mode that is adopted. Each approach advocates engagement in the profound reflection on the nature of the phenomenon that is the hallmark of phenomenology. There are slight differences in the type of data that are collected, with traditional approaches focusing on pre-reflective experience and American continental approaches focusing on experience per se. Hence, there is a difference also in what is analysed. These differences, however, would appear to be two sides of the same coin and offer a means to extend phenomenology in valuable and meaningful ways. It is possible, via the work of van Manen for example, to incorporate both approaches to inquiry, thus broadening the applicability of phenomenological research to nursing.
CHAPTER 4

METHODS

INTRODUCTION

This study was initiated to discover the way health presents itself to nurses in their own lives and in their nursing practice. In interviewing nurses about their experiences of health, I was interested not only in the nurses’ subjective experiences but also in the essential meaning of health for them as it was revealed in the more objective sense by traditional phenomenology. Although I was interested in a philosophical examination of the notion of health as it appeared in the broad context, I did not seek to know what it meant to be healthy in the generic sense. This was due to the fact that although traditional phenomenology calls for a deliberate and persistent laying aside of all that the participants had been taught about health, it was recognised that such reduction was a near impossible task (Heidegger, 1962). What I was interested in was uncovering, or ‘getting back to’ the way health presented itself to nurses, specifically nurses educated about health promotion, in their own lives and in their nursing practice. Thus, I did not seek to understand what the nurse’s individual experience of health was like, but rather, the overriding question was ‘What is the phenomenon of health in nursing like?’

When engaging in any qualitative research, but particularly in phenomenological research, methodology must be clearly distinguished from method. In phenomenology, methodology represents the philosophic framework which must be assimilated so that the researcher is clear about the assumptions of the methodology (van Manen, 1990), that is, the assumptions about knowledge and existence, which underlie the choice of methods in the project. Assumptions
arise out of the values reflected in the philosophic framework that is to be employed and can be distinguished in the way a particular philosopher views epistemological and ontological questions. Although all research is value driven, few research approaches accord such significance to clear recognition of the values and assumptions inherent in the theoretical framework as does the qualitative domain. The underlying assumptions of the methodology chosen for this study are existentialist in nature. What is valued in the approach of this thesis is subjective human experience that is then analysed as objectively as is possible for humans; thus, objectivity is also valued to some extent.

The purpose of this chapter is to describe the methods used to gather and analyse the data for the research. Because of the nature of phenomenology, I sought ways other than interviews for data production. In an attempt to devise an alternative way of accessing the participants' immediate experience of health, each of them was asked to engage in concept mapping as a strategy to access and record that experience prior to engaging in the interviews. This decision was reinforced later by Crotty's (1996a) claim that interviewing does not engender contemplation of the phenomenon in silence as is recommended by Spiegelberg (1975). This chapter addresses the initial phases of the research. It discusses the nature of the question, the participants in the study and describes and evaluates the use of concept mapping as a strategy in phenomenology. It also describes the nature of participation and how participants were accessed and the methods of data collection and analysis.

**The nature of the question**

When one looks at the literature on the topic of health, it can be seen that there has been a considerable amount of research directed toward the creation of a list of validated concepts by which people identify health. Undoubtedly, such a list would be invaluable. Once the concepts were identified and validated, it would be possible to compare the meanings of health for different socio-economic
groups, for groups from different cultures or from different educational and age viewpoints and so forth. Questionnaires could be developed and distributed and the task of understanding health for large sections of the population could be much simplified. While such a goal is not in any way an objective of phenomenological research, this research will ultimately contribute toward that end because it will enhance understanding of health. Phenomenology is concerned with that which comes before lists of concepts or such like; that is, it is concerned with the question of the meaning of the phenomenon itself rather than with ways to define it.

Within questions of meaning, the preunderstandings of the person, the context in which the phenomenon takes place and the story surrounding the phenomenon often cannot be made fully explicit (Benner, 1985). It is these meanings, however, which open one to the possibilities and conditions for action (Benner, 1985) and which, in the case of notions of health, influence the ways nurses use their personal meanings of health in their care of people. This research acknowledges that human beings, with meanings constructed by language, culture and prior experiences, are different to objects. This fact makes reductionist research inappropriate in this particular case, although part of the intention of this research is to further understand the meanings of health so that future research about health, inclusive of reductionist research, can be made more practicable.

When discussing meaning, Benner (1985) asserts that there can be no separation between knowledge of the events and the meaning of the events for humans, since meaning does not reside solely in the situation, but is rather a transaction between the individual and the situation. In effect, this is intentionality in action; that is, the person in the situation both constitutes and is constituted by the situation. Thus, the way the participants in the situation experience and perceive health both frames the situations in which they find themselves even while they are framed by the situations. The question of health in nursing is one of meaning. Since health is not a simple concept, in the context of nursing, the questions
become 'What are the meanings of health for nurses?' and 'How do these meanings constitute health-focused care in nursing?' In light of the latter question, it is acknowledged that the constitution of health-focused care is mediated also by the person-as-patient, who is the focus of health care, and by the health care system itself. The meaning of health in nursing is sought in this study through an exploration of the experience of health for the participants and their experience of giving health-focused care to persons in their care.

The nurses in the study
I live in a world composed largely of nurses because many of my friends are nurses and the nature of my work involves daily interactions with nurses about nursing. Despite this fact, over the years of this study I have spoken with many nurses in a way I have never spoken before. All have given of their time with generosity and with a willingness to engage in discussion, debate and reflection on the nature of health that is held to be central to nursing. To the nurses who were participants in this study, I owe a special debt of gratitude for the often arduous task of reflecting on and attempting to challenge their own cultural understandings of health as they had learned them, growing up. For some of them, this reflection precipitated a life change as they came to realise that elements of their life prevented them from reaching the peaks of health that they had experienced at previous times in their lives.

One of the intentions of the study was to explore whether the way health presents to nurses who have been educated about health promotion is a significant factor in the way they practice nursing. Health promotion was not universally introduced into Australian nursing education until 1987 when the recommendations of the Better Health Commission were implemented. The participants in the study were, therefore, all registered nurses who had graduated with a Bachelor of Nursing qualification after 1990 and who had been introduced to health promotion concepts during their education. Nurses who met the criteria
and participated were employed in hospitals in the Perth metropolitan area or, in two cases, Western Australian (WA) country hospitals. Hospital nurses were chosen because there is evidence that community nurses practise health promotion more frequently than do non-community nurses (Martin, 1988). Twelve nurses participated in the study.

Two participants, one male and one female, were engaged in the pilot phase, helping me to develop as a researcher and assisting me, through their responses, to recognise weaknesses in my interviewing technique. They also helped me to refine the way questions where asked and participants were prompted to delve into their experiences of health. Initially, ten participants were engaged in the actual data collection for the study. However, the data from one series of interviews have not been used because analysis showed that despite his willing efforts, this participant was unable to access his immediate experience prior to interpretation. Although able to focus on the phenomenon, he found that he could not describe it without reinterpreting and explaining all that he recalled. He also felt that, ultimately, he could not do as Wolff (1984) suggests is the inescapable task of phenomenology, which is to call into question his received notions of the world.

The two nurses who participated in the pilot phase were accessed via recommendations from post-graduate students in nursing. Subsequently, these two nurses were asked to recommend practitioners with whom they worked for inclusion in the study and three participants were achieved in this way. Another three participants were gained by approaching a post-graduate class in nursing and requesting introductions to nurses whose undergraduate degree was completed outside of WA. This was done to avoid drawing participants only from the two WA universities that offer degrees in nursing. The remaining four participants were sought through post-graduate students of the School of Nursing. The sample of nurses who participated in this study is therefore a purposive one. Because phenomenology seeks, directly, people with experience of the
phenomenon under investigation, purposive sampling is considered appropriate to this type of research.

The data for this thesis have been drawn from that provided by the remaining nine nurses. Although the participants all worked in hospitals, they were employed in a variety of specialty areas in nursing. Two of these nurses worked in the acute care setting. One nurse was a student in midwifery although she had four years as a graduate in the acute care area prior to taking up study again. Two other participants worked in midwifery, one in rehabilitation care, one in intensive care, one in paediatric nursing and one in the operating room / recovery room setting.

**Protection of participants: anonymity, confidentiality and informed consent**

Each of the nurses was contacted by phone and asked if he or she would be willing to consider participation. An appointment was then made with them during which the nature of the study and the nature of their participation were explained. A copy of the Information and Consent Form (Appendix 1) was given to them and they were given a further opportunity to ask questions and seek clarification about the process. All were advised that they had the right to withdraw completely from the study and that they could withdraw all or part of the data they had contributed at any time.

When each participant was satisfied about the requirements of the study and had agreed to participate, both the researcher and the participant signed two copies of the consent form and a copy was retained by each. The consent form outlined the purposes of the study, the voluntary nature of participants’ involvement in the study and their right to withdraw at any time, an assurance of anonymity and that all information provided by them would be treated in a non-identifiable manner.
Identification of participants on interview transcripts and narratives is via a pseudonym. The identity of the participants is unknown to any other person than myself and names and details about participants are kept in a secure place, separate to the data. In keeping with university regulations, the data set, including the transcribed interviews, notes made before and after interviews and the researcher's journal(s), will be kept in a secure place for five years from the time of completion of the research, after which time they will be destroyed.

CONCEPT MAPPING

Concept mapping is a strategy developed originally by Novak and Gowin (1984) to assist teachers to effectively structure classes for better teaching and learning. Concept maps are intended to represent meaningful relationships between concepts in the form of propositions. They serve as a technique for externalising the concepts and propositions relevant to a given topic in order that they may be examined and discussed. Through them, meanings can be shared, discussed, negotiated and agreed upon. This study sought to incorporate these points. It was directed toward examination and discussion of the concepts by which nurses describe their immediate experience of health and toward explication of those concepts. Since Novak and Gowin (1984) indicate that propositional linkages arise out of a person's life experiences, it was anticipated that they would assist in understanding more fully the way the participants experienced health. The strategy appeared, therefore, to be worthy of consideration in the context of this research, which was focused on arriving at a shared understanding of the meanings of health in order that those understandings might be described accurately.

Although positive notions of health are incorporated into nursing education programs, it cannot be assumed that merely because health teachers include such material that students will readily assimilate positive health concepts. It has been shown that students come to education with pre-existing conceptual frameworks
which are based on incidental knowledge and which are highly resistant to change (di Gennara, Picciarelli, Schirinzi and Bilancia, 1992). Thus, little is known about the way nurses actually conceptualise health and it was anticipated that the use of concept mapping as a strategy would assist in facilitating understanding of the way the nurses in the study experience health.

However, it was not only for these reasons that it seemed appropriate to use concept mapping. The decision was made to include concept mapping to assist in data collection for the reasons above but also with several additional reasons in mind. The first of these was related to the need to access the participants' immediate experience and to attempt to address the notion that only in silence can immediate experience be recalled (Spiegelberg, 1975). The other two reasons grew out my own experience as a participant / informant in several qualitative research studies. The first emerged from an observation that some interviews did not appear to facilitate access to the immediate experience that was the focus of the research. Thus, I sought a strategy that would allow participants to reflect at their leisure and organise and record their recall of the experience they wished to describe to me. This was to be done so that aspects of their experience would not be overlooked and might be more readily included in the descriptions.

The last reason is more complex and the best way I can think of explaining my experience is to offer a metaphor. Many texts claim that counselling is a non-directive process but, if one has ever counselled or been counselled, one is aware that this is not necessarily so! The counsellor directs the process by the very manner in which questions are asked. In the same way, it seemed to me, the interviewer might direct the exchange between him or herself and a participant. I wanted to find a way of allowing the participants to both recall their past experience and organise that recall, and I wished to use that to guide the interview process. This last reason was twofold; I wanted to facilitate their access to their immediate experience and to protect the participants against my leading them astray from description of their own experience and into paths of
my choosing. My perception of concept mapping in this context was also twofold; I wanted to fulfil the need to allow them to reflect in silence as well as use the process as a strategy to enhance rigour. The aim of this section is to discuss briefly the notion of concepts in phenomenological research and report on the use of concept mapping as a strategy to facilitate recall of immediate experience and enhance rigour.

Conceptual thinking and phenomenology

In many phenomenological texts the notion of concepts and conceptual thinking is specifically spoken against in the context of phenomenology. This position appears to have arisen from Heidegger’s (1977b) statement that ‘there is a thinking more rigorous than the conceptual’ (p. 235), a position which Habermas (1992: 203) refers to as a ‘pretension’. Habermas describes this attitude as connected to ‘the claim that few people have privileged access to truth’ (p.203) and associates it with the destruction of the principle of equal respect for all. He further states that such reasoning detaches philosophical thinking from the pursuit of science (Habermas, 1992) and indicates that adherence to rationalisation of this kind is in direct conflict with the intent of phenomenology which is to uncover the essence of phenomena. Taylor (1995) asserts that any method that allows people to access and piece together their abstract ideas is suitable as a way of getting at phenomena. She continues this exposition by stating that “asking whether you can ‘live a concept’ is like asking whether life is based to some extent on ideas and imagination.” (Taylor, 1995: e-mail letter). Since concepts are ideas and ideas are of interest to how we live our lives, concepts (and therefore concept mapping) appeared to be congruent with the objectives of a phenomenological examination of health.

The role of concepts and concept mapping

Concepts are developed throughout life, while propositions or words which indicate the relationship between concepts arise out of lived experience
where concept meanings are learned through the 'composite of propositions in which the concept to be learned is embedded' (Novak and Gowin, 1984: 15). For this reason, both the concepts which identify a given object or event and the propositions which connect those concepts may be highly individual. Concept mapping, as developed by Novak and Gowin (1984), was seen as a way for participants to, as it were, take out and examine the concepts which described their immediate experience of health. It was these notions that they were attempting to describe to me so that, together, we might understand clearly what pre-reflectively they held to be true. The process of concept mapping offered a way for the participants to reflect upon their experience and identify the meanings health had for them. Novak and Gowin claim that people:

... constructing concept maps often remark that they recognise new relationships and hence new meanings, or at least, meanings they did not consciously hold before making the map (1984: 17)

von Minden and Nardi (1993) observe that concept maps provide a basis for dialogue to make explicit what is often tacit knowledge.

It is not intended in this section to describe in detail the process of concept mapping, a full discussion of which can be found in Novak and Gowin (1984). Rather the aim is to illustrate the value of concept mapping in identifying immediate experience and in negotiating with the participants a shared understanding of the meanings of health for them.

As the name implies, concept mapping takes the pictorial form of a map on which an individual displays the names of concepts pertinent to a given object or event. Once this is achieved, the person developing the map represents the connections between the concepts via propositions that indicate the meaning of the relationships. It was anticipated therefore that the maps would provide an avenue for myself as researcher and each participant to explicate understandings about particular propositional linkages that were integrated into given situations, or to identify missing links in the experience which were not subsequently spoken
about in the interviews.

**Incorporating concept mapping**

Because concept mapping had not previously been used in the context of phenomenology, the strategy was trialled and some refinements were made during the pilot phase of the research. In order to facilitate quiet reflection on the phenomenon, it was considered necessary to allow concept mapping to be completed before the interview schedule began. This was done so that participants could identify in their own minds the way the phenomenon had actually presented to them, prior to beginning to talk about it in the interviews. The process of concept mapping was introduced to participants and explained via an example other than health to avoid corrupting the participants’ subsequent maps. The process was discussed and explained until the participants signified that they felt able to use the strategy to develop their own maps of their health experience. Participants were then asked to develop a concept map of the event of health, which they would later describe, in order to identify more completely their own understandings of what was involved in the episode. Two weeks were allowed for the development of the maps because Novak and Gowin (1984) have indicated that sometimes two or three maps need to be developed before they sufficiently display the concepts held by a person.

It was anticipated that after maps were completed, each participant would be asked to explain and discuss them at the end of the first interview. It was intended that this be done in order to see if any aspects of the experience had been forgotten during the interview or if my questions about aspects of the event had led me to direct the conversations away from their immediate experience. Subsequent to this discussion, participants were to be asked to reflect on the concept labels which identified their health experience in order to critically examine whether these concepts were essential to health or not.
Results of using concept mapping

Despite the fact that the process of concept mapping was trialled and appeared promising, the maps developed by the participants did little to advance the aim of the research or to clarify or correct the data generated during the interviews. In most cases, the maps were far simpler and less descriptive of experience than were the interviews. In only one case was the exercise deemed to be useful. The participant ‘Anne’ stated ‘I’m a list person; I make lists for everything and so making the map helped me to put it all into place and check that I’d told you everything [about my health experience]’. Two of the participants did not complete the maps at all, finding them too complex and stating that they were unable to express themselves adequately in this way.

Concept mapping was intended to be a tool to facilitate access to immediate experience so that the participants might more readily describe their experiences. It was also intended to enhance rigour in the data gathering process by acting as a strategy to ensure that the interviews followed the participants’ experiences and were not diverted into paths of the researcher’s choosing. However, it did little to facilitate recall of immediate experience and none of the resultant maps provided information in any depth. In addition, participants reported that they did not generally find them helpful in assisting them to describe health. One participant described them as helpful to her ‘in organising her thoughts’ although the resultant map was not informative. In general, the maps were not used to guide the subsequent interview(s), as they were far too simple to do so.

Although not as useful as anticipated, the ideas introduced by concept mapping were helpful in some ways. As part of the process of concept mapping, participants were to be asked to consider whether one could have health without recourse to the concepts identified and, subsequently, to identify in what ways the various concepts were essential to the notion of health. Despite the apparent failure of concept mapping as a strategy, these last two procedures were carried out in relation to the participants’ descriptions of health and contributed to
a critical examination of the phenomenon. After the interview schedule was completed, participants were asked the two questions outlined above, about health and about health care. Participants sometimes responded that one could have health without a particular concept or notion identified during description of the phenomenon. Several times they explained this by saying that they had never previously been asked to examine the connection between their actual experience and what they had assumed to be the case with regard to health. In other words, their preconceptions about health intruded into their descriptions of their health experience and it was only through the use of this strategy that this intrusion was identified.

Using the ideas instigated by concept mapping, a list of concepts, which identified the health experience for each person, was examined for ideas that reflected the nature of health for that person. In this way, participants were able to distinguish which aspect(s) of their experience was / were most explicit of health for them.

At the completion of the second phase of the interviews when experiences of health care had been explored, it was intended that participants be asked to examine the experience of giving health care in the same way described above. In this way, it was proposed that the relationship between the meanings of health care and the activities of health care for each nurse could be examined. However, this last idea generated by descriptions of the process of concept mapping was particularly unsuccessful. Very little analysis of the relationship between the meaning of health care and the way health care was offered resulted from this activity.

RESEARCH METHODS

The mode of inquiry

When phenomenological researchers speak of 'method' they refer generally only
to the research technique and the procedure for carrying out the research. Given the nature of qualitative methodologies however, this generally means that a certain mode of inquiry is implied by the notion of method (van Manen, 1990). The particular methods employed depend on the philosophic assumptions inherent in the theoretical framework. A student of phenomenology is first required to explore the various phenomenological approaches in order that he or she may clearly distinguish and explain the parameters that apply to the selected approach.

The methods chosen for this research were those advocated by van Manen (1990) and included personal reflection, attending to personal experience, exploring health literature, tracing etymological sources of words used in description and the searching of idiomatic phrases to illuminate the phenomenon of health in nursing. Reflection and writing on the phenomenon was undertaken both at the beginning and throughout the research in order to understand my cultural view of the phenomenon, my biases, and how I came to understand the phenomenon in the way that I did. A journal was kept to record personal experiences of conversations and interviews with the participants, and to assist me in recognising the influence of personal biases and feelings on the research. This was done so that my personal interpretations of descriptions or events could be more fully recognised in order to eliminate them from the interpretive process. Because of my being-in-the-world of nursing and as a human being with an understanding of health, my immersion in my own preconceptions was seen as part of my being. Nevertheless, I attempted in so far as I was able to be free from my presuppositions about the phenomenon and about nursing and to understand and record them in order that I might enter into reflection upon them in a phenomenological manner.

The nature of participation

The first meeting was negotiated with each participant in order for us to get to
know each other so that a feeling of trust could begin to be established and so I could introduce them to the strategy of concept mapping their experience of health. The participants were unknown to me prior to the research being undertaken. For that reason, the first formal interviews did not take place until after the participants had attempted concept mapping (two participants did not complete their maps) and when the initial feeling of 'talking to a stranger' had passed for each of the them. The twelve nurses gave of their time freely and generously. They participated willingly, not only in the time required for the interviews but in the cumulative hours that were spent for us to get to know each other well enough to be able to speak easily and freely to each other. Phenomenology requires a return to the immediacy of experience as it is lived in order to access the nature of the phenomenon under examination. Such deeply personal information is not given easily to a stranger and, therefore, these 'getting to know each other' times were an essential part of the interview process. The nurses seemed to want to talk about their experiences of health and of giving health-focused care and all consented readily when invited to participate.

My relationship with these nurses has been companionable and pleasant and, in several cases, individuals remained in touch with me after the interviews were completed. Each participated for their own reasons and they were not asked to explain why they did so. Some volunteered the information that they were curious about the way the research would be conducted as they had learned about qualitative research during their education. Two participants thought they would learn something about research that would be of value to them in the challenging world of nursing employment. Several told me later that it was an opportunity to talk to someone about themselves and their own experiences and to be listened to by someone who wanted to hear their story. Whatever their reasons, these nurses have allowed me to 'touch' or connect with their experiences in such a way that has made the phenomenon of health in nursing more accessible.

Of the final nine participants who provided the data for this thesis, one was
interviewed only three times, two others were interviewed four times each, three were each interviewed five times, two were interviewed six times and one participated in eight interviews. Those who participated in fewer interviews were, generally, those interviewed as I became more experienced in the interview technique and was better able to direct them toward the type of reflective discussion which phenomenology requires. Seven women and two men aged between 23 years and 39 years comprised these nine participants. The data for this thesis were gathered, therefore, from 46 interviews with nine participants. The interviews were conducted over a period of 24 months from June 1995 to June 1997.

The nature of the interviews

The in-depth interviews took place over periods of time varying for each person from three months to nine months. With each of these nurses, I asked them to first recall a time when they felt healthy and then to describe that experience to me as it had happened in their lives. Subsequent discussion focused on the questions ‘What was it like to feel healthy?’ and ‘How does it feel when you are healthy?’ The following statements and questions are examples of the ways I initiated and then prompted conversation with the twelve nurses:

Initial question: I want you to think of a time when you felt really healthy and describe the experience, as it happened.

Prompt questions: What was it like?
Could you give me an example?
What did it feel like to be healthy?
Describe the experience of body, of space, of time.
What is it like now? How is it different?

The second phase of the study involved the same type of questions, this time about health-focused care. For example:

Initial question: I want you to think about giving health care to someone in your care and tell me about that experience, as it actually
happened.

Prompt question: What was it like?
What comes to light when you focus on this care?
Could you give me some examples?

Initially, it was anticipated that there would be three phases in the data collection process. It was the intention in phase three of the study to ask the participants to describe their experience of congruence or incongruence between their experiences of health and their experience of giving health-focused care. Phase three became redundant, however, when it became clear that participants experienced neither congruity nor incongruity between the first and the second experiences; this will be discussed further in Chapter Seven.

Data collection was, therefore, conducted in two phases that included repeat interviews with the participants in the study. During the first phase, participants were asked to describe an experience of health that they could recall clearly and in detail. In the second phase, they were asked to describe giving health care to a person in their care. Participants were asked to describe the experiences in an immediate way; that is, they were specifically asked to tell their stories as they had happened, without interpretation of the experiences.

Participants had been asked to think about and identify their pre-reflective experience during concept mapping. However, the dialogue that was set in motion during the subsequent interviews evoked broad descriptions of recent experiences and statements about what health meant to them generally, rather than what health was like. Attentive listening used by the researcher throughout the sessions generated new questions from the insights, nature and content of each interview. Further insights and elaboration of meanings from other experiences of health were provoked by questions seeking clarification which also, at times, elicited descriptions of expectations of future events (Reeder, 1991) associated with health. As in the study by Reeder (1991), descriptions
of contrasting events such as illnesses, setbacks or areas of ‘unhealth’ in the participants’ lives were spontaneously shared in the interviews and served to provide rich descriptions associated with the meaning of health for each participant.

Each interview was audiotaped, then transcribed and a narrative was derived from it before both transcript and narrative were returned to the participant for clarifying discussion and validation of their accuracy. Initially, the intention was that each interview would be transcribed and the transcription returned to the participant for reading and reflection prior to the next meeting. At this second meeting, discussion was to focus on clarification and validation of the essential elements of the experience before the next interview took place. However, the second participant in the study questioned this process, stating that reading the transcripts which were an exact reproduction of the interview complete with pauses and hesitations appeared to be a waste of time since they did not ‘say’ much to her in their verbatim state. Subsequent to this event, a narrative or story of the person’s experience was derived from the transcript of interview, using the participant’s own words. Both transcript and narrative were returned to the participants for discussion, clarification and validation of the essential elements of the experience before moving on to the next part of the interview process.

Although clarification and validation was sought for both the transcript and the narrative, the narrative was given more focus in order to establish it as a true interpreted record of the participant’s story. The word ‘interpreted’ is used here because frequently participants left sentences unfinished or only alluded to feelings or events using gesture, tone of voice and expression rather than direct words and these were interpreted into the text as language. Particular attention was paid to those parts of the story that were interpreted to ensure that I had interpreted the given messages completely and accurately. This will be discussed further in the following section, entitled ‘The narratives’.
At the end of the second phase, participants were asked to begin to consider critically the descriptions they had given. The final interview with each participant was then devoted to asking them to challenge their own descriptions of health and health-focused care. They were asked to consider whether health (and subsequently, health-focused care) would be the same if any of the individual elements they had described were removed from the experience. In other words, they were asked to consider objectively whether health and later health-focused care would still be health and health-focused care without any or all of the elements they had described. In this way, a critical or objective examination of the essential elements of health and health-focused care was sought.

The narratives

A narrative is ‘a story or an account of events and experiences’ (Collins Dictionary, 1987). Narratives of health tell of life events and experiences in relation to health and are thus contextualised and personal accounts that can not be replicated. They are also filled with previous experiences which may not ever be able to be fully explained (Benner, 1985). With a narrative, the story just is; nothing can be done to change the story. For that reason, much of the interpretive work of this thesis was done during transcription and narrative writing. Interpretations and description of the meaning of gestures, tone of voice and even hesitations and uncertainty were included in the narrative and were clarified and validated by the participants as part of their story. It is acknowledged that while the tie between the reader and the narrative is personal also, what can be recaptured though narrative or story are ways to approach human experience (Bergum, 1986) in order to describe it.

During the narrative-writing part of the transcriptions, phrases and descriptive words about health used by participants in interviews were traced to their etymological source in order to explore the ties to the lived experience from which the words sprang. Discovering how the source of words was maintained in
the experience being described assisted me to fully understand what participants were attempting to convey. In a similar way, idiomatic phrases that might have local or regional meanings, although rarely used by the participants in this study, were explored for their meaning because common expressions are born out of lived experience (van Manen, 1990) and have a wealth of experience to convey.

From the audiotaped interviews with each of the nine nurses, the narratives of experience were developed cumulatively. This means that they were developed initially from one interview and then reworked after subsequent interviews to integrate clarifications or changes to the meaning that arose from the clarifying and validating process. While the actual descriptive words used are exclusively those of the participants, at times the narrative sequence has been reordered to give clarity to the story. For example, in several of the interviews on health-focused care, participants told me about the final stages of care before they mentioned that they had cared for the person for some time. The narratives that appear in Chapters Five and Seven are thus the end result of such reworking. Each narrative was written and then rewritten, sometimes many times, and each appears in its interpreted state and has been validated by the participant to whom it relates.

There are two narratives for each participant. The first describes their experience of health while the second describes the experience of giving health-focused care. Initially, I intended to integrate these two narratives into one composite story for each person, pulling together their narrative of health experience with their narrative of health-focused care. As the study progressed, however, it became clear that the two stories were often very different and, since there was little continuity from one to the other, greater clarity was not to be gained by merging them into one story.

Despite the fact that the participants were asked to recall and describe their immediate experience of the way the phenomenon of health presented to them,
what they have mostly done is describe what health means to them cognitively. This is what Crotty (1996b) describes as a crucial pre-phenomenological process that prepares the ground for participants to really address their experiences. As data, however, the participants’ inability to give sustained consideration to pre-reflective experience gives clear indication of the difficulty in asking people to forgo their inherited and learned traditions of thought. This is the task that Heidegger (1962: 311) refers to as a ‘fantastical exaction’ and this thesis has in no way contradicted that description.

The narratives are therefore composed of a combination of pre-phenomenological thought and description of immediate experience. For this reason, in the ‘experience of health’ narratives, excerpts from the data that represent truly ‘phenomenological’ elements have been indicated by the use of italics, in order to distinguish them from the pre-phenomenological data. The ‘experience of health care’ narratives have been addressed differently and this will be explained in the introduction to Chapter Seven. In Chapter Five, the analysis in traditional phenomenological mode has focused only on the identification and discussion of original experience. In Chapter Six, analysis in American continental mode focuses on broadening the exploration to encompass the lexical themes that emerged from the narratives and the language that was used to describe the phenomenon.

The decision to include the narratives was made for several reasons. Firstly, the narratives are already interpreted pieces of work and have been composed as phenomenologically as possible to best describe the experience of the person in the situation. Secondly, it came to my attention when reading a variety of research reports that one of the most obvious differences between quantitative and qualitative studies is that in quantitative research the data are there so that one may verify them oneself. It seemed to me that data could be made more readily available in qualitative study reports and I sought ways to do this. More recently, Paley (1997) reinforced the decision to include the data as part of the
thesis when he said that nursing research 'comes close to being unintelligible' when it attempts to describe the process of identifying essential structures of phenomena (p. 187). I have tried throughout to present the data in such a way that the direction of the study is clear and to address the different forms of analysis in such a way that they are clear and distinct from each other.

Method of analysis

The purpose of phenomenological research is to attempt to grasp the essential meaning of something (van Manen, 1990) while the purpose of hermeneutics is to 'mediate the unfamiliar into understanding' (Reeder, 1988: 196). The task of each involves the reduction of text from intensive interview transcripts in such a way that it becomes distilled to its elemental components (Tesch, 1987). In this study, to grasp the basic meanings of health as it was experienced by the nurse participants in their personal and professional lives, data analysis was accomplished in two ways.

In the traditional European approach, emphasis was placed on a critical examination of the immediate experience of health and providing health-focused care for each participant. This was identified via intensive critical reflection on the descriptive data by both the researcher and each of the participants until all the elements of the experiences were identified. Analysis in this mode was completed by writing and rewriting the narratives of experience in collaboration with each of the participants and then through further reflection and writing on the phenomenon. In this writing and rewriting, the essential elements of the experience were further clarified and these are the focus of the chapter in the traditional phenomenological mode.

In the American continental approach, as well as focusing on the immediate experience of health for the participants, attention is also given to the subjective meanings embedded in descriptions of experience to give a sense of the
individual in active engagement with the phenomenon. In this approach, the narrative accounts of the experiences are allowed to speak for themselves in the construction of the analytical text. This type of data appears to be more readily achievable than the more objective data of traditional phenomenology that requires a considerable amount of additional work on the part of the researcher and each participant.

Indeed, it became apparent as the interviews progressed that participants could not tell their stories of experience in any sustained, pre-reflective way. Interspersed with short interludes of uninterpreted descriptions of experience were long segments where participants detoured into description of thoughts about and interpretations of the event they were describing. These more subjective data are of great value as they hold the key to discerning the way nurses interpret health, whether those interpretations reflect positive or negative concepts of health, as well as the ways those interpretations interact with their nursing practice. This differs from the type of data achievable through traditional phenomenology which, in this case, focuses only on the immediate experience of health in the lives and practice of the participants. Traditional phenomenology excludes thoughts about health and interpretations or reflections on ordinary activities related to health or health-focused care.

For some of the participants it was obvious that a beginning level of analysis had already taken place when they described personal reflections about their experiences. These were couched as meaningful insights (Reeder, 1991) into their experiences rather than descriptions of events. First level analysis may be initiated in the interview process by the very act of attentive listening on the part of the researcher to responses (Reeder, 1991).

Although the actual process of analysis for each of these two approaches, traditional European and American continental, differs only slightly, the type of data that is included is different in each case. In analysis in the traditional mode,
only verified and critically evaluated descriptions are included in the search for understanding of the nature of the phenomenon. In the American continental approach, the subjective data are also included to illustrate the people in the situation and the human relationship to the phenomenon. Subjective data may appear as descriptions of the phenomenon that do not stand the scrutiny of critical reflection but are nevertheless part of the person's experience of the phenomenon; they may also appear as summative, evaluative comments on the experience. Therefore, while the method of conducting the analyses is similar in both approaches, what is focused on and drawn into the light of understanding differs slightly between the two approaches. Because of the close relationship of these two different types of analyses, in this thesis they have been dealt with in different chapters to illustrate the subtle differences in the information they convey about the relationship of the phenomenon of health to nursing.

Data analysis in both modes was completed via three interrelated processes: thematic analysis, analysis of exemplars and the search for paradigm cases. During thematic analysis the interview transcripts were analysed for relevant anecdotes which illuminated the ways nurses encounter health and the relationship of health to their nursing practice in concrete situations. Discovering phenomenological themes, represented by the participant's experience, involved trying to determine what made up the experience (van Manen, 1990). This was largely achieved during the interview process when I took back the interpreted transcript/narrative themes to the participants for validation. The validated themes then became objects for reflection in follow-up interviews. In these interviews, both myself and the participant weighed the appropriateness of each theme by asking ourselves 'Is this what the experience is really like?' (van Manen, 1990: 99).

Themes are seen as foci or threads around which phenomenological interpretation begins to take shape (van Manen, 1990). The search for meaning within the themes involves both the researcher and each participant giving shape to
previously unclear constructs by identifying the differences between incidental and important themes. This is achieved by determining the important quality of a theme which leads to discovery of the qualities without which the phenomenon loses its fundamental meaning (van Manen, 1990). The process of achieving this requires that each participant determine whether the phenomenon would still be the same for them if the theme were deleted from it. In this way, the essential elements of health as the participants experienced it and the relationship of these elements to their health-focused nursing practice were identified.

Exemplars serve to convey aspects of either themes or paradigm cases, and may act as substitutes for ‘operational’ definitions in interpretive research (Benner, 1994) because they add nuances and distinctions that enable the reader to recognise the pattern of the phenomenon. Exemplars are used throughout the analyses to illustrate discussion points and appear as direct quotes from the narratives or interviews. Paradigm cases show as strong instances of particular patterns of meaning in the data and are useful to indicate themes more clearly than ‘elemental units such as words or phrases’ (Benner, 1994: 115).

**Writing and rewriting**

Hermeneutic phenomenology is essentially a writing, reflection and rewriting task (van Manen, 1990) and this is the way this analysis has proceeded. Each participant’s story was written and then rewritten after clarification and to include new data that emerged in subsequent interviews. When themes began to emerge, the thematic analysis was itself written and rewritten, sometimes several times, after it had been reflected upon and after further consultation had taken place.

When the participants were telling their stories of health, they frequently used the second person singular ‘you’ instead of the first person ‘I’ to describe a particular aspect of their experience. Although at first this seemed a little confusing, several of the participants indicated that it occurred when they were able to look at the
phenomenon of health and ‘see’ it as it really was, rather than seeking to discover it through reflection on their experience. These sections are given in the text, exactly as they were described. Sometimes also, participants described what health was not. Since these passages appeared spontaneously when participants focused on ‘the what’ of the phenomenon, these also have been included exactly as they were described.

**Limitations of the study**

Some of the limitations of this hermeneutic phenomenological study are implicit in the method and can be identified readily, while others are less obvious since they are not easily perceived. There were no expectations in this study that the findings would be generalisable to all nurses or that the study could be replicated to yield the same data. It was anticipated, however, that the study would foster understanding of the phenomenon of health in nursing, sufficient to form a basis for other types of research in both the qualitative and quantitative domains.

While results of qualitative studies are not generalisable, the collection of thick descriptive data may increase the possibility of comparison of the study context to other contexts (Crabtree and Miller, 1992; Caelli and Mott, 1997). However, the section of this thesis that involves a critical examination of health in nursing acknowledges that there is a possibility of transferability but makes no claim that it is inevitable (Crabtree and Miller, 1992). An extension or evaluation of this work would require a similar study be performed, using a similar dual phenomenological approach, with nurses who meet the same criteria as used in this study.

My own experiences of being a nurse engaged actively in health promotion have influenced this research even while the research itself had the potential to cause me to question the very meaning of my work of the last 19 years. It has been my aim throughout to seek the reality within the stories of experience as they were
told to me. However, I was ever mindful of the problem of truth or reality as it related to human experience. Sandelowski (1996) discusses the trouble with truth in human science as truth being plural rather than singular, of truths as social products of the moment, and as truths of different worlds. Others have described it thus:

‘When talking about their lives, people lie sometimes, forget a lot, become confused and get things wrong; yet they are revealing truths. These truths don’t reveal the past as it actually was, aspiring to a standard of objectivity. They give us instead the truths of our own experiences’ (Personal Narratives Group, 1989: 261 cited by Sandelowski, 1996: 115).

Bollnow (1974) refers to truth as something ‘profoundly painful which cuts into our lives’ (p. 15) and discusses the fact that effective self-mastery is required in order to bear that pain. He points out that those who are afraid of themselves will find some excuse to avoid the truth either by suspending discussion of the topic or by turning to something not as threatening. While full recognition of the truths of these data may never be achieved, it is not apparent to me what truths may have been avoided or left unexplored because of reluctance on my part to face issues that question my life and my work. It is possible that these limitations will only be addressed through continued exploration of the data, through rethinking and refocusing, deepening and clarifying the ideas expressed in this thesis.

**Ethical issues**

The ethical issue of this study that was more problematic than protection of participants relates to the qualitative and human science nature of it. As participants explored their lived experience of health, they came also to clearer recognition than ever before of the areas in their lives that caused their unhealth. In some cases, this resulted in participants making decisions about lifestyle change based on what they had learned about themselves through participation in the research. Similarly, there was recognition from some participants that, as
human beings, they were only rarely given the chance to talk about their experiences and, in that way, enabled to reflect on them and realise the meaning of their life experiences to them. Such recognition has the potential to alter the way participants regard the people and conditions in their lives and requires to be taken into account when contemplating such research.

In research such as this, there is the potential for change for both the participants and the researcher, which may not be recognised prior to embarking on the project. For example, one of the participants in this study resigned her job at the completion of the interviews saying that she had never before realised that her job had such an influence on her health. I was quite disturbed by this event, particularly as she chose a nursing position that required a move away from all that was familiar and dear to her, and a commensurate change in the area of nursing practice in which she engaged. Although this move turned out well for her and for others in the study who had made changes to lifestyle and patterns of behaviour as the result of being involved in the study, there was no guarantee that this would be the case.

Phenomenological research does not have a transformative or critical agenda, as is the case in the critical social sciences; however, it is accepted that change can occur as a result of interpretive awareness. Transformation or change, which is decided by participants themselves, is not of itself an ethical problem. It does, however, present ethical challenges to the researcher. Respecting an individual's right to make his or her own decisions is an ethical issue. It needs to be acknowledged that such issues might arise and the implications of that for the researcher need to be recognised. In such a case it must surely be part of the researcher's role to provide support and be available should the participant want to talk through choices that were instigated by the research. The researcher should be prepared to do these things, should the need arise.
Rigour

In qualitative research, the problem of rigour continues to 'arouse, beguile and misdirect' (Sandelowski, 1993: 1). Sandelowski warns against the danger of making a fetish of rigour in qualitative research and thus making rigour an unyielding end in itself. In order to maintain the 'artfulness, versatility and sensitivity to meaning and context that mark qualitative research' (p. 1), it is necessary to enable the evocative, true-to-life stories of human experience to speak for themselves. For this reason, the word 'trustworthiness' is commonly used in qualitative research. The trustworthiness of the data is said to be able to be established if the reader is able to audit the events, influences and actions of the researcher (Koch, 1994).

In addition to trustworthiness, Guba and Lincoln (1989) use the terms credibility, dependability and transferability in relation to qualitative research. The credibility of a study is enhanced when the researcher describes and interprets his or her experience as researcher. One way to attend to the credibility of a study is to keep a journal in which the content and process of interactions between researcher and participants are noted, including the researcher's reactions to events in the research (Koch, 1994). Credibility may also be achieved through the provision of evidence of thorough understanding of the relevant philosophical underpinnings and the nature of their concurrent application to the phenomenon (Caelli and Mott, 1997). The dependability of a study is ensured via the provision of an audit trail, while transferability refers to the possibility of comparison of the study context to other possible contexts.

Strategies to ensure rigour in this research were implemented at each stage of the research process. After each interview was transcribed, transcriptions and narratives were returned to the participants for clarification and validation prior to embarking on the next stage of the research. This clarification process was used also to pursue investigation of the meaning of pauses in conversation, tone-of-voice, or actual description that remained unnoticed until the audiotape
was transcribed.

Rigour was achieved in the interpretative process by firstly asking each participant to examine the final interpreted data relating to themselves for completeness and accuracy about the experiences that they had each described. Secondly, each participant was asked to interrogate the themes that emerged from their descriptions of experience to ascertain whether the phenomenon would remain the same if the theme were deleted from it; in other words, they were asked ‘Is this what health (or health-focused care) is really like?’

Rough field notes were made during the audiotaped interviews and after each interview and discussion to ensure that non-verbal communication (for example, tone of voice, gestures) was not missed. These were written up and expanded immediately the interviews were over (Benner, 1985; Leonard, 1989; van Manen, 1990). A journal was kept to record my personal experiences of the conversations and to assist in recognising the influence of personal biases and feelings on the research (Lipson, 1989). This was done so that my personal interpretations might be more fully recognised in order to eliminate them from the interpretative process. Descriptive words used by participants were traced to their etymological source in order to explore the ties to the lived experience from which the words sprang. Subsequently, meanings were clarified with participants to ensure that I had fully understood what they were attempting to convey (van Manen, 1990). Reflective extracts from my personal journal that are considered to be critical to the analysis are included in the thesis in order to explicate as fully as possible the ‘position from which I speak’ (Lather, 1986).

In order to demonstrate as clearly as possible the way this analysis proceeded, data display tables which indicate the way themes were derived are included in Chapter Six. In relation to thematic analysis, participants themselves identified and prioritised themes from their own data. Where there was ambiguity
between a descriptive word or phrase used by one participant and a different word or phrase with a similar meaning used by another, the opinions of other researchers were sought in allocating them to appropriate themes. Further discussion of the mode of involvement of other researchers is included in the introduction to Chapter Six.

Phase two of the interpretative process involved the identification of exemplars or strong instances of particularly meaningful dimensions (Leonard, 1989; Benner, 1985). It included also the identification of vignettes from the data that captured the meaning of a position in regard to health and nursing practice in such a way that the meaning may be recognised in another situation. The final phase of interpretative analysis involved the identification of paradigm cases or strong instances of particular patterns of meaning in the data which embodied the descriptive information necessary for understanding of the phenomenon (Leonard, 1989). These exemplars and paradigm cases are examples of the participants’ own words and are left to speak for themselves.

In order to provide an audit trail so that the rigour of the process may be scrutinised, extracts and examples of transcripts are made available in the form of appendices (See Appendices). Additionally, the narratives are given in their entirety in Chapters Five and Seven. Extracts from the journals that indicate the way the data were approached are included in the text of the thesis.

CONCLUSION
The methods of data collection and analysis that were used in this study were chosen to accord with the philosophical approach that guided the research. The need to distinguish between methodology (i.e., philosophical approach) and methods (i.e., ways of conducting the research) arises out of the philosophical foundations of phenomenology as a research approach. Based as they are in epistemological and ontological stances that distance them in some ways from
each other and from other approaches, phenomenological endeavour demands that the methods employed are synchronous with the philosophical assumptions that guided the study.

In this study based on the existential phenomenological approach explicated by van Manen (1991), emphasis has been placed on exploration of the experience of human beings living in the world. Because the distinctive factor in human experience is that it is active and, by acting in the world, develops its own character and interprets the world, every attempt has been made to foster the voice of the participants themselves in this exploration of health. Although the writing and rewriting has been done solely by the researcher, the participants in this study were in some sense regarded as co-researchers since without them such an exploration of the nature of health in nursing would not have been possible.
CHAPTER 5

THE PHENOMENON OF HEALTH

The exploration that has taken place in this study in order to describe the nature of the phenomenon of health was characterised by the notion of the phenomenological moment. A phenomenological moment occurs when one is open to the possibilities of meaning of a phenomenon that is offered to our experience (Crotty, 1996a). As may be anticipated, phenomenological moments are rare. Attempts to foster ‘phenomenological’ thinking in participants was not always successful, just as thinking phenomenologically oneself is a moment-by-moment thing, even perhaps the ‘fantastical exaction’ that Heidegger (1962: 311) describes it as being. Sadler (1969) describes it as being ‘no less than an existential encounter with a world which has a potentially infinite horizon’ (p. 7).

Humans are born into a world of meaning, are taught meaning and, to think phenomenologically, need to reach beyond these learned meanings to ‘take a long, hard look at the objects of immediate experience’ (Crotty, 1996a: 5). This is done in order to be open to the possibilities of what phenomena really are. The participants and I have attempted to do this in the current study. Nevertheless, I and each of the participants found it extraordinarily difficult and time consuming to try to think beyond the constraints of culture, tradition and upbringing and ‘see’ the phenomenon of health as it presented to each of us in our own lives. The use of concept mapping as a strategy to invoke recall of pre-reflective experience showed that even in silence and contemplation, it was very difficult, even impossible for some, to see beyond those constraints. Still, in the rare instances when the phenomenon could be grasped in a pre-reflective way, we found that we were again constrained. ‘Seeing’ was glimpse by glimpse and fragment by fragment and we were limited by language in our attempts to explain what
it was that we 'saw' as we each recalled the phenomenon in our own experience.

Despite the fact that the participants attempted to challenge their own understandings of health and endeavoured to engage with the phenomenon in a pre-reflective way, this was not always successful. What they have discussed with me is primarily and for the most part what the word 'health' means to them, notwithstanding all the talk we engaged in about them laying aside inherited and prevailing understandings and asking themselves 'What is health like as I immediately experience it?' Admittedly, they were discussing what it meant to them personally and individually, but many of the descriptions were not of the way health immediately appeared in their experience. In spite of this, glimpses of the way health presents itself to them did appear and it is these that have formed the central core from which the description of health in traditional phenomenological mode proceeded.

The participants in this study, Anne, Sarah, Didi, Holly, Bill, April, Sally, Rick and Charlotte had varying success in their attempts to reflect on their experiences in a phenomenological way. As the narratives show explicitly, much of what was recounted to me about health was pre-phenomenological data (Crotty, 1996b) which were included in the narratives in order to show the context in which health was encountered. While the achievement of this sort of data was a crucial process which prepared the ground for the participants to really address their experience of health, it led only with great difficulty to true phenomenological reflection.

By phenomenological reflection, I mean that each participant was invited to try and 'see' the phenomenon of health, and later, health care, as it presented to them in their immediate experience. They were asked to put aside their thoughts and reflections about what it was like and try to 'see' what it was really like. Additionally, they were asked to focus not so much on what it was like for them, but rather on what it (health) was like. Initially, they were asked to recall a time when they felt truly healthy and describe the way that health presented to
them in their lives, but subsequent discussion focused on ‘What was it like to feel healthy? How does it feel?’ rather than, ‘How do you feel when you are healthy?’ Some found that recognition of what it was like came to them as small, fragmented glimpses at odd times not necessarily related to my discussions with them; others could not comprehend the notion of the phenomenon ‘revealing itself to them’ at all. Of the nine participants, Bill and Rick found this the most difficult, although this may not necessarily be a phenomenon related to gender. In both cases, they questioned whether the task was possible for them. Nevertheless, they each contributed valuable data about the unreachable or inexpressible aspects of health that will be discussed later in this chapter.

Charlotte created the environment for her own phenomenological moments when she observed spontaneously that health is only achieved through being able to overcome early teaching and through learning to see health as that which it really is, rather than as she was taught it. She pointed out that the notion of health by which her grandfather had operated was that one was healthy as long as one was not dead. This led us to wonder if health is perhaps a changing notion, having different meanings from one generation to another and from culture to culture.

In this chapter, the narratives of health in which the phenomenon of health is embedded are given in their validated entirety. These narratives were extracted from the interview transcripts of the experience of health (which, in most cases, covered between two and four hours of interviews) and the very brevity of some of the descriptions serves to show how difficult it is to recall that experience in its immediacy. This is followed by an ‘analysis’ of those immediate experiences in order to grasp the nature of health in the lives of these nine nurses. It must be noted, however, that the term ‘analysis’ is perhaps a misnomer in phenomenology, where the clear aim and only task is to describe, as nearly as possible, the nature of the experience of a phenomenon.

To each of the participants, health presented itself in an individual way; that
is, each described their experience of health in a way that was not shared in its original sense with the others in the study. The purpose of this chapter is then to present the experiences of each participant in order that the reader might know the origins of the discussion of the nature of health that follows. It is acknowledged that health, as nurses who are educated about it encounter it, may be different to health as the general population encounters it. I say this advisedly, despite the fact that the participants were asked to put aside their learned and cultural understandings of health. Heidegger (1962) makes clear that such complete reduction is only rarely possible and this thesis makes no claims that it was achieved. For that reason, this exploration of the phenomenon of health pertains only to nursing and, even then, perhaps only to these nurses at this time.

THE NARRATIVES

Anne - the experience of health

The last time I felt healthy I just had a general feeling of contentment and ease with myself, with what I was doing and with how I was working, with my environment in general. I felt I'd made some good decisions. I had been in a relationship that I needed to get out of but it didn't work out and I was just so damn relieved to not have that worry in my life. Everything kind of got behind - my work was lagging, and my personal life and my home environment; I couldn't see my desk (laughing)! I had things to do and I wasn't getting them done; just general stuff that everyone has to do that I just wasn't getting done. I thought, 'I can't exist like this; I'm stale'. So I started to achieve what I wanted. I went away and achieved some personal goals, came back and house sat and thought 'This is what I need to do - I need to move out [of home], I need my space and I need to be more of an individual' for a while. I came [back] home on excellent terms with my parents - the most comfortable I've been at home, ever, and it's been wonderful.

I'd taken on a new job and I felt very comfortable with the job that I was doing
and I felt that I was achieving good things in it. I was very content with where I was living and had a good relationship with my family. I was in a relationship that was very comfortable and happy. I felt like I was keeping in touch with people and I was doing all the right things. I was financially secure and emotionally secure and I was living in a very pleasant environment.

My job was achievable. Even though it was busy and there were a lot of tasks to do and things to do, my employer’s expectations matched my capabilities. So, while it was a challenge, I didn’t feel as though I was doing something that I might have felt unsafe doing or might have been uncomfortable with. I was giving good care; I could feel it and I got that reaction from my patients ... and I was learning and I reckon I’m at my happiest when I’m learning.

At home, I’d decided that I might as well clear out of my room the things I didn’t want or need around me and I managed to give myself more space and make it a very aesthetic room. It’s my own bedroom and it’s quite large and light and I just had things that I wanted in it; you know, [I] hung pictures on the wall and got my room very balanced and aesthetic. For me, balance means that everything has a place and it looks good there, that I have space but I have a functional room, like a desk that you could see, that isn’t covered in stuff. For example, I had a very large stereo unit and rather than have that, I got a trim tape deck. I like space. I like to be able to see surfaces and things. I’m very aesthetic and I really am a balance person. I like to have everything just right, or else I’m annoyed by it. It’s just balance! In life, you’ve got to achieve a balance in everything you do, to be healthy. Before this, I’d lost the plot in a very big way. To find a balance, I had to resolve all the things that weren’t working in my life.

When I feel healthy, I feel as though my skin is clear. I feel as though my mind is clear. I have energy. I have a great deal of concentration. I’m very awake! I’m very happy. I’ve got a pretty sharp sense of humour and that’s at its peak when I’m healthy. I feel thin! You-know how you can feel bloated if you have a lot
of salt in your diet or eat certain foods or when your hormones are going crazy. It's that you don't feel like you're carrying that extra fluid and that extra weight that makes a difference. *My shoulders aren't tense and things like that. Health is in the way I react, too! You come across something and you say "Oh, that's unpleasant; let's deal with that" rather than "Oh, my God, this is unpleasant, this means something terrible!" and you wonder how you are going to be able to deal with it. When you're healthy, you just react differently. You feel as though you've got the capacity, the emotional capacity and resources to go "Huh" (sound of optimism), this is a problem, let's deal with it. Rather than think, "Oh my God! Let's leave this one in the too-hard basket and let it fester there for a while" (laugh).

So, health is where your needs don't outweigh your resources; it's balance. You can have the challenges as long as you've got the resources to meet the challenges and you can manage them whether they're personal or work challenges. Once the scale tips into your challenges outweighing your resources, if you don't correct that or if you can't facilitate some sort of action to balance that, that's when stress happens and health goes out the door. During this time when I had taken control of my life, I had good job satisfaction and my diet was behaving itself and I was getting enough rest and sleep and I was doing what I wanted to do activity and socialisation wise. *It was like it was all fitting into place.*

**April - the experience of health**

Two or three weeks ago, I had about a week when I'd slept well. You know, I'd been to bed before 10 p.m. for a couple of nights; been for a couple of good, long walks during the week and eaten well, so I was feeling healthier. *You can tell when you're feeling healthy by the way you wake up in the morning and just leap out of bed. You have that kind of feeling like 'Okay, I've got jobs to do; let's get on and do them!'*
I'm doing this course and I've just been so busy, but since I got the first couple of pieces of assessment in, I've really started to get it together and I started to think 'I can do this!' Since I've been a student, I've established a routine and I see the whole week and I know when I've got to do certain things. I'd rather start the day nice and early and put a whole heap of energy into the start of the day. Then, as my energy level decreases, I have less work to do because I've done a lot during the morning.

When I can get into a routine, my days are organised. The evening before or in the morning I go for a nice long walk. Then I get up around six thirty and get started. I do my stretching routine straight away, have my breakfast and I'm in that car and I'm down there, working, quite early. Going to university, getting a whole lot of work done, like several hours of study done, I feel like I'm getting somewhere. It's an achievement! Then, when I go home, if it's my turn to cook, I cook a really nice meal of food that I think is good for us and then I'll do another hour or two of study and be in bed by 10 p.m.

When I'm healthy, I feel like smiling! It definitely makes you feel happy. I keep thinking of it in the negative, that it's (life is) not overwhelming, so therefore I feel like I can do this, I can pass this course. I feel like I can be available to my friends and the people around me. Having a real good day like that, I feel like I can do it the next day, you know. It's like 'I went for a walk yesterday, I can do that again today!'

When you're healthy, attractiveness shows; you feel more attractive. I feel like I'm doing the best for my body. I know because I've done so much study and I can see the long-term effects of not doing the right sort of things. I know that I think 'Yes, that's a good thing to be doing for this body.' I know that walking is good for my bones and I know that eating certain foods is good for other things. It's that feeling of doing the right thing for my body. (When I'm healthy) I feel ... I don't know how to put it (laughing) but I feel like touching people, like my friends
and that; just going up to them and putting my arm around them.

In my relationship with God, I know that when I'm talking to Him and reading the Bible on a daily basis, I know that I'm open to Him and He speaks to me and they're the times when I'm healthy. That's hard to say, but, when you're healthy, in your spirit you know that you can overcome; that you have the strength to overcome things and not lose hope. Feeling healthy, feeling on top of things is sort of like telling yourself 'Okay, mate, you can keep going on.' You've got to keep on going, so that's health in my spirit, to keep on going towards my major life goals.

My strongest and fittest time was in 1989. I quit working in the job I'd been in and I went to do show jumping with horses for a year. When I think back to then, my clothes just fell off me I was so slim. I was lifting stuff and working in the paddocks and riding two or three times a day. I was very fit and strong but I wasn't happy. It's got to be both fit and strong and happy at the same time, really, to be health. I can contrast that to the last half of 1995, which was very socially and spiritually happy for me. I had hurt my back the year before and it took me a while to get over that, but, on the other hand, I was very happy and yeah, healthy. It's hard to put the two together.

**Bill - the experience of health**

A few weekends ago when I was at my sister's party and after that, I felt really good. I think it was because I was out socialising with all my sister's friends, just meeting a whole lot of new people and enjoying myself. I'm extremely shy so I think I felt pretty good because I was quite relaxed that night. I met heaps of people even though there were only about six girls there and about thirty-five males. Even though I knew all her girlfriends anyway and I was a little bit disappointed, I still had a great time and felt good. Before I went, I was feeling extremely nervous because I was going to meet new people and I was very, very
apprehensive. But once I got there and relaxed a bit, it was great. It was familiar and I wasn't bored. I'm not exactly a huge partygoer because I'm extremely shy and being shy is a big problem for me. This night, I was relaxed, I was really happy. I was just feeling like I was in a good mood, basically.

Normally when I'm feeling healthy I want to get out and do something. I hate waiting around, like when you've got to go to work; there's nothing worse than that. I just want to go out and do something. I'm in a good mood and I just want to go and play sport. I feel happy! I'm usually happy all the time anyway because I'm a pretty easy-going bloke, but yeah, definitely, if I'm feeling really good, I'm always happy. So, when I'm healthy I want to get out and do stuff. I just feel ... not a buzz ... but it's just a sort of 'Yeah, all right!' feeling.

Charlotte - the experience of health

You asked me to reflect on health and I would like to talk about where I am today, but I need to reflect back on where I've come from to health. I'd like to go back about six years, [to] when I felt rotten, then build up to how I feel today which is the best I've ever been and the best I can ever remember in my adult life.

I guess it all comes back to a marital break-up and what led up to that. I had no diagnosis of depression but I found health was very hard work. Feeling well, feeling good and being able to do things on a day-to-day basis were very hard. I think that related to stress but also to actually having to physically work twelve-hour days, five days a week and do call on weekends as well as bring up a child. Looking back, I felt irritated all the time and I just tried to get through each day. I wasn't sleeping, which made me feel miserable, made me less able to cope. All these things that I was feeling then are gone now and I'm able to cope with stress, to feel good about myself, to work and to sleep eight hours a night, which is wonderful.
For me, health relates to emotional things. My marriage was failing and I was in a job where I felt that there was no hope for promotion because I wasn’t qualified. I was a hospital based RN with no degree qualifications. My health related to how I thought about myself; I had no sense of self-worth, of being important to anyone, to myself in particular. I didn’t feel valued at work because it was a vicious cycle, I guess. Because I was tired, I automatically assumed I wasn’t doing my job well. I know now that that wasn’t so, that I still performed well. But I felt I wasn’t because I didn’t feel as good as I feel today about myself, health wise.

Then, I had no social life. My friends had stopped visiting because of my ex-husband and so I had lost social contact. Today, health is found in my friends being able to call in and say hello. Those things make me feel good because they reflect on how I feel now about my health and myself. I knew that the answers had to come from within me so that’s when I took a conscious decision. I stopped working long hours. I stopped doing weekend call every weekend. I took positive constructive steps that meant that I had a change in lifestyle. Money was hard but the change was constructive in that there was a reduction of stress. I gave up all my committee work and consciously made the decision to spend more time with my son. I took long-service leave to be able to work out what I was doing and to be a full-time Mum. That decision alone made me feel a hundred percent better and able to cope again, because I could spend time with him. It was so important to my feelings of self-worth and goodness and to feel that I was a whole person. I had felt very fragmented!

Now, I don’t feel fragmented any more; I feel well. I have a sense of wellbeing and a sense of self-worth as a person. I feel complete. I feel healthy. I feel wanted, I feel well, and I feel as if my head’s together. I feel as if all those compartments and parts that make up a woman’s day-to-day running and [are the] components of her life, I feel as if all those have joined together and that in all of those joining together, it’s the best I have ever felt in my entire life. I feel as if all those components, like, you know, working Mum, student, registered
nurse and all the other components, you know, so-and-so’s friend, someone else’s companion and Mum, all those bits are joined together. That makes me feel as if I’m functioning well, that I’m worthwhile, needed, and wanted. It’s like I’ve taken charge; like I’ve grabbed hold of the steering wheel of my life and I feel good.

To me, relationships are very important because how my relationships work reflects on how I feel about myself. [They reflect] on my wellbeing, my health, [on] what I think of myself as a person. Friendship to me is a two-way street, it’s not one-way, with one person putting out all the effort and energy to make a friendship work. Now, for friendship to work for me, it has to be a two-way street. In health I’ve made the conscious decision that it’s okay to let friendships die, it’s okay to do that!

Now, if I’m not sleeping, so what? I get up and read a book and have a cup of tea, whereas before I’d get really stressed about that, I’d get tied up in such a knot about not getting eight hours sleep. Now, I think ‘Well, so what; there’s the next night!’ That’s because the circle’s turned, I feel so good, I feel so healthy, I feel so well, I feel so together!

I think your previous life, like your childhood, impacts on how you react, on how you feel today as an adult. And I know I’ve had to deal with a lot of things that I was brought up with and challenge what I was taught as a child. What I’m doing now, as an adult, to feel well is the absolute reverse of what I was taught as a child. And I’ve learnt that that’s okay to do that; that it’s okay for me to sit down, for example, and it’s okay having take-away once a week and I’m not a bad mother because I do that. Good things, to me, are things that make me feel good, that make me feel well, like playing with dinky toys with my son for half an hour or sitting down having a cup of tea with my husband out on the front step watching a sunset.

I can’t think of anything more to improve my health now; I’m in the best
health I've ever been, in my entire life. I don't know how I could improve it any more. I have energy. I work a ten-hour day and it's like I want to come home and I want to do more things. I feel good and at the end of the day, even though after travelling I've had a twelve hour day and I come home and I'm tired, it's not like an absolutely totally depleted feeling; like you've got nothing left to give. I know I've got more to give when I come home and I can spend half an hour talking to my son and reading a book and not feeling like I've got three million other things to do and I really shouldn't be there. I know I've still got to go and do this, this and this but I don't get stressed about it because I know I can do it, that I'm not going to be absolutely exhausted at the end of it and just wanting to get into bed.

Health for me is quality of life and I look at health as 'you're a long time dead!' I fill my life as much as I can in the daylight hours with whatever I can because we're this much alive (holding up fingers close together) and that much dead (holding out arms far apart). I don't want to miss out on too much and doing makes me feel good, feel well about myself and my life. For me it's normal, but I know a lot of people look at me and they shake their head. They say to me 'Take time out. Sit down and smell the roses.' well, I do. On a weekend, I think it's wonderful because I've never had a home before and I take a wonderful pleasure in gardening. I've just started to grow roses. I go and talk to my roses and prune them and fertilise them and in the house I've got vases of roses because I take ten minutes morning and evening and cut a vase of roses. My energy level is normal for me. I know a lot of other people look at me and say I'm manic but, for me, that's normal. Life is out there to be lived. You do, while you can; you just don't know what's going to happen. Please God let me stay as good as I am now. I don't want to be anything less than I am now.

Didi - the experience of health
The most recent time I felt really healthy was during the last semester break. It
was a time when I didn’t have to get up and go to Uni. (Australian abbreviation for university) or go to work, that I could just have time to do anything I wanted to do. So it was probably because I wasn’t rushed, didn’t have to take the kid to school and then get to Uni, or get up and get to work and get the lunch done before I went to work and that sort of thing. Just the feeling of being able to do anything I wanted to do in my own time. Time to do whatever I wanted to do.

Sleep’s a big thing with me. As long as I get my eight hours sleep, I’m fine, but if I don’t, that’s it! *Health makes itself present by me not being tired. I’m able to share out the things that I like to do to stay healthy, like exercise. It’s like I’ve got the energy to pay attention to those things. So, I’m less tired, more energetic; I’m more able to cope and laugh things off or deal with things. You’re more apt to be relaxed [when you’re healthy], more able to pace yourself and you enjoy life [more]. Health puts a smile on your face; you’re more positive. That means you’re more patient. It means you do things like eat properly and you’ve got energy and you make it to the end of the week without flagging. When I’m rested and I feel healthy, I’m more energetic. I’m not so tired. I know when I’ve had it; I sit down and as soon as I stop, I just go to sleep. But, when I’m healthy, *I’m energetic and happy; I’m not snappy, not grumpy.* My family certainly knows when I’m stressed and when I’m not feeling too well. But when I’m well, *I have energy, I feel energetic and happy and keen to do things and I get more done. I’m more organised; I don’t sort-of half do things and think "Oh, that’ll do!"

Most definitely, exercise is a big thing, for me. *Health is sort of like a surfer; the more exercise you get, the better you feel and the more energy you’ve got; that is definitely me!* When the semester ended, after the last exam I could feel myself just go ‘thunk’. I came to a full stop and then you just start to wind down. I got up early and went for a walk the next day and I felt great from then on. The interesting thing was [that] I had a cold when I was on holidays; I got the flu for a week. Just a head cold and stuff, but I thought it was interesting because I felt so good.
Holly - the experience of health

Two weeks ago I completed a marathon which had involved two to three months of hard training and a steady progression of my fitness. I felt very healthy afterwards not only physically but in my mind as well. I felt a great sense of achievement and for me that's a feeling of health; it was like a feeling of completeness. I felt capable. I felt physically fit and of course fitness is part of physical health; so I felt physically healthy, more so than I did before the run because I was still building up then.

It's strange that after the run I felt healthy when my muscles were so tired. I mean, the following day it was hard for me to walk because my legs were so sore. So, it was more of a mental state of health. Physically, before the run I was very healthy, but after the run my body was actually quite fatigued. But mentally I felt healthy, sound. It was just a good feeling! There was completeness in it in the fact that every part of me had been addressed. I don't mean complete as in over, but complete in that my spiritual, my bodily and my mental needs had been met. It's like an almost primitive feeling of being ... (she hesitated). I guess because we are so caught up in modern technology, it's something that you are doing with the resources that you have, that you're born with.

When you asked my about health, I immediately thought of the marathon. I felt very healthy after that, but fitness is only the physical side. I see healthy as being at peace and I get that when I run, I feel good and I'm happy. Being spiritually okay is healthier for me, so being spiritually at peace is very important to me as well. I'm a Christian, so for me, spiritual health is found in my relationship with God. I often feel very remote and not in touch; it's a feeling of struggle. Feeling in touch with your spirit is a gift, and if you don't have that, it's a very empty feeling. So health comes to me mentally; I know I'm healthy when I feel at peace. In this peace is a feeling of happiness. I'm happy to be alive and appreciative of
everything good and of people around me and I view things with rosy coloured spectacles. Being at peace involves other people as well; it needs to involve the people I care about and I need to be at peace with them. That’s very important, so peace is not just an inner thing, it’s also an interactive thing.

The physical goes hand in hand with the spiritual. When you take away the tensions of your body, it allows your mind to be at peace; you’re on another plane and you feel more in touch with your spirit, or that’s what I find anyway. For me, running is a way of keeping fit, but also, I find it very relaxing and it clears my mind. It’s time alone, time that I give to my body and as a result of that, I feel better about myself. I think being physically healthy is important to being mentally healthy.

There’s something about finishing a run and just relaxing; the quality of relaxation is so much more than if you were to just sit down and have a cup of coffee. I just feel there’s a peace in it. I think your body takes the brunt of a lot of the stress and you don’t realise that you’re stressed until you relax and that stress flows away from you; like your arms and shoulders are stiff and your mind is racing. When you’re running, you’re working too hard to be able to keep stressful thought processes going, so it’s a break and it provides room for other things, peaceful things. You can get to a stage where you rarely have time to examine yourself and your own thoughts. Time alone means that you are inwardly directed and it makes you evaluate things that you can otherwise go for days without even bothering to think about.

When I’m healthy I’m very different. When I’m not feeling good about myself, I’m not very approachable and not very nice to the people around me; I can be irritable and everything is terrible. I don’t mean that I go through huge turns where I’m horrible and then nice to people, it’s just everything seems a lot better when you’re feeling healthy. I’m quite an emotional person. I react very quickly to things initially, but then my emotions can also change quickly. For example, if
I watch a film, I [can be] very much influenced by it and I carry those feelings from the film, those strong feelings. They may not last that long until they dissolve, but when I'm feeling healthy, negative emotions are less intense and they're worked through quicker. Physically, I always feel healthy, but mentally I don't always feel healthy.

**Rick - the experience of health**

I think my own personal concept of health has changed through my lifetime. As a child, being healthy was being outside and running in the sour-pods and eating them. Where I grew up we had paddocks and paddocks of little yellow flowers with green stems and you could break them and eat them and they had a slight acidic taste and they were called sour-pods. That's what health was [for us] as children, going out exploring and running about, but it's swung towards the physicality of health not being as important as I've grown up. [Now] it's more the mental and the psychological components that are important.

During adolescence, the psychological realm of health became evident because you're testing your environment and getting in trouble and doing all those things that teenagers do. [You] realise that you've got responsibilities that you didn't realise you had, and that when you've busted the rules you get in trouble; then you fall to bits because it's not good to be in so much strife. You don't realise that you could even get into so much strife by doing things; you didn't think about your actions, you just did things!

Now, I feel good about myself when I can do things for other people and help them. I really enjoy doing unexpected things that are going to be accepted, I suppose. I think one of the reasons I wanted to do nursing was because I wanted to make a mark on this world and I wanted to do something that was actually going to be positive. I don't know if you've ever had a job where you just love going to work? Occasionally they come to me and it's just wonderful. It's sad to
leave them; it really hurts to leave them.

One of the healthiest times in my life was when I had a job like that. It was a one-ward hospital and I was introduced to everybody [when I started] and we just got on well together. We were all quite social and it was a really good feeling. You knew that if you said to somebody that something needed to be done and that you hadn't had time, they'd say that was fine. You never felt as if you'd been bludging (Australian slang meaning wasting time at the expense of others). It was also because we were allowed to have flexibility of care. For example, allowing people to sleep outside if that's what they wanted to do. We had Aborigines in our care and you could take their mattress and put it under a tree and that was acceptable; it was just so nice, it was actually like caring! It took the military out of nursing and just got on with taking care of people, which was really nice. I felt quite good about myself while we were there, and with the people around me; I really enjoyed spending time with them. It was a quite wonderful time; everything was in balance, the whole gamut of my life.

It was a small country town and a fruit-farming area, so we had fresh fruit all the time, bags and bags of fresh fruit. There was a little reef up the road where we dived and we could catch lobsters, prawns, crayfish etcetera; anything you wanted. Just around the corner from where we were living, there was a place where we would go for a nighttime walk. We'd take a packet of water crackers with us and pick oysters and eat them raw, off the rocks. There were all these natural things around us and it was just wonderful. So, for me, health was in the cohesion and the feeling comfortable and the being with people but feeling comfortable being with them. I felt really well, it was like when you wake up [in the morning] and you feel really focused and you could do anything.

Sally - the experience of health

When I'm healthy, I've got more energy; I feel refreshed and a lot more alert;
everything's so much better, like you go to work and you don't feel depressed about going to work. Instead of complaining about having to go to work, you look at the positive aspects of it. It's like you're not really going to work, you're going to go and socialise with your friends but work happens to be there at the same time. When I'm healthy, when I feel really healthy, I feel alert, I feel alive. I've got energy and everything's good, like, it doesn't matter what happens in the day, it doesn't bother me.

On other days, when you feel less healthy or you're feeling a bit sad or a bit depressed, someone can just say something really insignificant, or just make a comment or a sarcastic joke or something like that, and it'll just get to you and you'll feel really 'off' about it and get upset. [So] it's not necessarily physical, health. Health is more [a] mental [thing] than actual physical health; physical health is subservient to mental health. If I'm feeling mentally healthy, I'll be physically healthy because my mind tells me I'm feeling good. When I'm healthy I don't feel upset about anything that might have happened at work, I'm not upset about anything, I feel good! And when I'm feeling positive, I eat well and I exercise and I feel all the physical things. If I'm feeling lousy mentally and I've had a bad day at work or someone has died or they've switched someone off a ventilator or something like that, I feel a bit down and out about that. Then I tend to sort of slump around or smoke more or I don't exercise or I don't sleep well and all those sort of things.

When you feel really healthy you just feel so much better. You just glow. You go out and it's nothing to do with being either fat or skinny, you still glow. Your skin glows and it shows in your smile and your eyes light up and you just look much better. And even if you wear the same clothes, your hair looks shinier and you look neater, fresher. When I'm feeling really healthy, I feel like I look good so that when I go out, it just comes out naturally, anyhow. I wouldn't have to fake a smile or pretend I'm being happy because that just happens!
You just feel happier; you feel alive and you really enjoy life. You’ve just got much more energy when you’re feeling healthy! And it reflects in other things when you’re feeling healthy. Like, you wonder what you’ll have for dinner and you’ve actually got the energy to go down to the shop and buy fresh veggies and come home and cook them because you’re feeling really good. If you weren’t feeling that way, you’d just stop at McDonald’s on the way to work and Kentucky Fried Chicken on the way home and then you get all this weight building on. Because you’re feeling really unhealthy, you eat unhealthily and do no exercise. Health is all about having energy and feeling good.

This last week I’ve been feeling really good. I’ve just had holidays and I feel really alive and motivated and we’ve had really good days at work. The people that I’ve been working with are all fun and friendly and they talk to you. Some days you can work and the people next to you don’t talk to you. It doesn’t help you, it doesn’t create a team approach and that makes you feel lousy. But we’ve had really good days and I feel really healthy. It’s like nothing beats you when you’re having a good day! Nothing beats you, you just feel really good about everything. I mean, you’ll be driving along and you’ll get caught in a traffic jam and you can look out of the window and think about the trees and what’s going on around you. I was driving long-distance a couple of weeks ago and there were massive roadworks on the main highway and I was just stuck there for twenty minutes in the middle of nowhere. I was feeling really good and I thought ‘Oh well, I’m not in a hurry, I’ve got nothing to do.’ I wasn’t impatient about anything and I looked around at the bush and talked to the people on the ‘Stop’ and ‘Go’ signs and had a look at what they were doing and it wasn’t stressful. I was actually enjoying the scenery and feeling relaxed being where I was and enjoying the drive. The fact that I had to wait in the middle of a dusty road for 20 minutes was incidental. Yet if I was feeling unhealthy and stressed and in a hurry to get to wherever I had to go, I would have been sitting there getting all worked up and feeling impatient and wanting to just drive through; that’s the difference health makes.
When you're healthy it's like you just don't feel the stress. If I'm feeling healthy, I will have got up earlier in the morning because I wouldn't have set the snooze button back to 'sleep' three times. *I'd have sprung up out of bed and had a shower and felt really good, then you get in the car and off you go.* But when you're feeling really tired and unhealthy and lousy you do set the snooze button. When you're healthy, *you think straighter, you think clearer and you don't get so 'het up' about things.* You actually think more logically about things as well. *Everything's relaxed; everything just flows along and goes okay.* Basically, health is about *feeling good* and then once you feel good you're so much more in control and you've got much more direction. You're able to achieve things that you want to achieve. *Mentally clear is how I feel, when I feel healthy.*

**Sarah - the experience of health**

I suppose the last time I felt truly healthy was about two years ago when I'd lost a fair amount of weight. *It was like feeling really, really positive about yourself and really happy and confident.* Mainly it was about being happy; *being happy and quite content that you're at that spot [in your life].* [Being] healthy is not necessarily about being able to jog miles, it's about feeling that, if you want to go for a two hour walk, you can go and do it. It's not about peak physical fitness; it's about being able to be involved in life and activities without being exhausted.

One of the main reasons why you feel good in this situation is because weight loss increases your self-confidence and all that goes with that. I wasn't at any particular point in my life. I was going through Uni. still and I wasn't in any real stage where I'd completed anything or felt satisfied as far as I had finished my nursing or travelled or anything. I was just sort of in the middle of stuff. *Health is about feeling able to be involved in things, involved in life.* It's not any thing, it's not being able to run a marathon; it's not being able to do specific things, it's *about feeling able to do things.*
I’ve been very lucky in the fact that I’ve never been really sick, so for me to compare the way I am now to health is not really that much of a difference. But two years ago when I lost that weight, I felt a lot better about myself, but the difference was not that great. I was a student and I just decided to start swimming and got physically quite fit. I was fairly contented in the fact that I knew where I was going and knew exactly what I wanted to do. Health is when you feel good and contented in yourself, when you know where you’re going and you can see your future. It’s like a control situation; you’ve got control. That’s why I felt quite good then, because I knew what I going to do and I was in control of what I was doing.

I’m still very much into travelling, but I’ve been involved with a guy for five years and he can’t travel to the same degree that I can, so that’s got a bit to do with the way I feel now. People like to have control of what’s going on and they like to know exactly what is going on. If you’re not quite sure, it makes you a bit unhappy and that’s part of health as well. The fact that you don’t quite know what you’re doing is a stress and if you’re stressed at a particular point of time then you don’t feel particularly healthy. There’s always a little bit of anxiety that comes from not quite knowing what you want to do and that has a lot to do with how you feel mentally.

Health is about feeling good about yourself, about feeling reasonably physically fit, about being happy, about knowing where you’re going, about being able to do what you want to do as far as walk at your own pace for two hours if that’s what you actually want to do.

I think what makes a lot of people unhappy with their health or where they are at a particular point of time is comparing themselves to [other] people; that makes people very unhappy. You look at Elle Macpherson or whoever you look at when you look at magazines or you go into a shop and the clothes are all a size ten and
that preys on you and makes you very unhappy. *Being content is a very big part of being healthy* and being constantly challenged with the need to be a certain thing is very difficult for most people.

Weight is quite a big issue for me because I’ve always gone, up down, up down, up down, up down. It’s not that I actually feel so unfit when I’ve got an extra five kilos on because I can still exercise the way I want to. But it makes me unhappy because you go into a shop and you try and buy something for yourself to fit into, and nothing fits because of the expectation for you to be a size six. You go out (shopping) feeling quite good about yourself, but when you come out from that place, you feel quite revolting.

**DESCRIBING ORIGINAL EXPERIENCE**

Although it is not always obvious from the narratives above, describing original experience was much more difficult for the participants than was describing what was thought or felt about the experience of health. However, since all of the phenomenological writers have described the extreme difficulty that is encountered when attempting to see beyond cultural and learned meanings of the world to see phenomena as they really are, this difficulty was anticipated. Indeed, Merleau-Ponty (1962) goes even further and describes phenomena as ‘indeterminate’ and states that ‘nothing is more difficult to know than precisely what we see’ (p. 58). It is all the more remarkable then, that nurses’ daily interactions with people who experience health in many different ways do not make the phenomenon of health almost invisible to them. For that reason, the difficulties that were encountered in attempting to foster phenomenological thinking among this group of nine nurses, although considerable, were not as profound as were anticipated.

The narratives were derived, generally, from two or more interviews and from discussions about the phenomenon which gave evidence that the participants
commonly found it very difficult to focus in any sustained way on immediate experience and describe what health was like. In the interview transcripts particularly, there were frequently long analytical passages about what health meant to a participant rather than attempts to clear away what was thought or learned about health and describe the actual advent of health to their lives. Attempts on my part to refocus the conversations when descriptions of thoughts or interpretations were forthcoming proved to be largely unsuccessful. These attempts more frequently produced tangled, unintelligible and inarticulate sections in the interviews and were abandoned as I acknowledged that only through allowing participants time, space and musing conversation about health could I achieve the descriptions such research demands. Thus, the difficulty of the task was recognised in my own immediate experience and the attempt to explore health phenomenologically became itself a phenomenology of phenomenological exploration.

Merleau-Ponty (1962) states that what appears to us in our immediate perception, does not come into the world with meaning attached; it is in fact very uncertain and vague. As humans, we give meaning to the world around us. However, as humans, we inherit cultural understandings of the world. We learn how to see the world (Marton, 1986) and cease to question whether these meanings are real or not; in other words, what becomes taken for granted becomes ‘obvious and invisible at the same time’ (Hardison, 1989: xiii).

Each of the participants moved between the obvious and mere glimpses of the invisible aspects of health and presented descriptions that, together, form a composite although incomplete picture of the way health appears to nurses. It is incomplete for several reasons. Firstly, only nine nurses participated and there may be many other faces of health than those described by nine persons. Secondly, it is not known whether health would or could present in a universal way to different people or across different cultures and life experiences. It is also incomplete because of the sheer difficulty presented by the
phenomenological reduction itself, which indirectly poses the question ‘How can one ever know that one has grasped what he or she sets out to illuminate?’ Nevertheless, this section of analytical description in the traditional mode addresses the way health immediately presented to these nine nurses in order to form a composite, descriptive picture of health.

By using the word ‘composite’ to describe what is revealed in this section of the analysis, I do not mean to imply that the data were synthesised or combined in such a way that commonalities were sought for. It was quite the opposite, in fact. Although several of the participants at times used similar terms to describe health, the sense of what they related to me clearly identified their descriptions as being different to each other. Indeed, when such things as tone of voice, gesture and the context of the experience are taken into account, the similarities of word usage frequently appeared to be more clearly related to constraints and limitations of language than to be indications of similar meanings. This is not to say that some similarities of meaning did not occur, but, rather, that they were not the rule. This section focuses then on both the similarities and differences in the way health appeared in the lives of each of these nine nurses. The differences are important since they show the many faces that similar words may convey. These differences are, however, subtle. They show the phenomenon of health as ‘indeterminate as it is in its primordiality’ (Crotty, 1996a: 152) but, still, bring with them what Merleau-Ponty (1962) describes as an ‘atmosphere’ of meaning that is important if health in all its complexity is to be understood.

An example of this atmosphere of difference can be seen in the narratives of Anne and Sarah. Anne described health making itself evident as ease and contentment that would appear to be reflected also in Sarah’s use of the word ‘content’. However, the encounters with health they were discussing were subtly different. Where Anne was referring to ease as being part of the way health came into her life, Sarah gave a picture of something more transient and which was dearly gained and fleeting rather than a free-flowing sense of ease. This was despite
the fact that Anne had made significant changes in her life in order to reorient her life away from feeling ‘stale’. Even so, the ease and contentment which health brought to Anne arrived unannounced in her life and made its presence felt as comfort and companionship. Meanwhile, there was a sense of trouble and unsettledness about Sarah’s description that gave evidence that health, in this case, was not easy but rather something that needed to be striven for.

THE NATURE OF HEALTH

The manifest attributes of health

While health was not easy to describe, for each of the participants it became obvious to them in some way in their lives. Even those like Bill and Rick, who found it quite difficult to access immediate experience of health, described it as being obvious to them when they were feeling healthy. Being asked to describe what it was that was obvious was the difficulty, however, and several participants used the phrase ‘You just know’, which was said in a helpless way that implied that it was too difficult to explain.

For all of the participants, health, when present, was clearly apparent to them in their lives and the task of this research was to try to access how health became noticeable to them. Even Rick, who found the description of health most difficult, gave an account of feeling focused and empowered by health. Common among the ways health was manifest for the participants was happiness. Yet happiness, in and of itself, is not indicative only of health. It is feasible to say that one could be happy when one was very ill and close to death, but then perhaps one could experience health at such a time as well. The question of whether happiness is indivisible from health occurred to me again and again but always came back to the feeling that it would be non-sense to say that happiness is an essential part of the experience of health. Despite this fact, many of the participants described health as bringing happiness into their lives. They made it clear that, while health and happiness may not be synonymous, happiness is
encountered in their lives as part of the experience of health.

The question engendered by the notion of happiness, as part of health is ‘What is it about health that may make one happy?’ The participants described ‘feeling good’ as part of health as well as feeling on top of things and feelings of being ‘in control’ or being empowered. Charlotte describes the manifest appearance of health in her life as:

... like I’ve taken charge; like I’ve grabbed hold of the steering wheel of my life

However, being in control of one’s life would not necessarily make one happy.

Several of the participants described the feeling of energy and, looking back over the narratives, there is a sense that energy is apparent in health. Along with the sense of energy there is a feeling of enthusiasm in all of the descriptions as well. There is also an impression of life being achievable. There’s almost a feeling of optimism in the descriptions. These convey an atmosphere that, for the moments of time that health is present, life is as good as it is possible for it to be. Having got this far, the data given by Sarah presented me with another question obliquely related to the idea of happiness being found in health ‘Is contentment with where one is at a particular moment in life part of what health is?’

For the moment, I focused on the question of whether contentment is part of health and I went back and read and re-read the narratives to see if contentment was manifest in the descriptions of health. Sarah gave several descriptions of contentment that indicated that it was this aspect of health that contributed to the happiness found in health for her:

- Mainly it was about being happy; being happy and quite content that you’re at that spot (in your life).
- Health is when you feel good and contented in yourself, when you know where you’re going and you can see your future.
- Health is about feeling good about yourself, about feeling
reasonably physically fit, about being happy, about knowing where you're going, about being able to do what you want to do.

- Being content is a very big part of being healthy.

Upon scrutiny, I think that the following descriptions from other narratives also give an atmosphere of contentment that I had overlooked previously:

- *I feel complete. I feel wanted. I feel well. I feel as if my head's together. I feel as if all those compartments and parts that make up a woman's day-to-day running and components of her life, I feel as if all those have joined together and that in all of those joining together, it's the best I have ever felt in my entire life* (Charlotte).

- *You can tell when you're feeling healthy by the way you wake up in the morning and just leap out of bed. You have that kind of feeling like 'Okay, I've got jobs to do; let's get on and do them!'* (April).

- *I just feel ... not a buzz ... it's just a sort of 'Yeah, all right!' feeling* (Bill).

- *I feel happy! I'm usually happy all the time anyway because I'm a pretty easy-going bloke, but yeah, definitely, if I'm feeling really good, I'm always happy* (Bill).

- *I feel so good, I feel so healthy. I feel so well, I feel so together!* (Charlotte).

- *It (health) was like a feeling of completeness. I felt capable* (Holly).

- *Mentally I felt healthy, sound. It was just a good feeling! There was completeness in it, in the fact that every part of me had been addressed* (Holly).

- *I feel good and I'm happy* (Holly).

- *You just feel happier; you feel alive and you really enjoy life ...* (Sally).

- *Health is all about having energy and feeling good* (Sally).

Reflection on these statements indicated that, in health, there is the sense of satisfaction with one's situation that is the hallmark of contentment. Health therefore has a manifest and almost tangible quality of contentment that
includes feeling happy, feeling alive, complete, energised and optimistic. Despite these appealing attributes, however, health can almost instantaneously hide its face from us.

The transient nature of health
Looking back over the narratives it is clear that it was not only Sarah who conveyed an atmosphere of health as transient in nature, that is, that it passes quickly ‘into and out of existence’ (Webster’s Dictionary, 1983) in the lives of the participants. Anne gave clear indication of this when she described health as being the ability to meet challenges and gave an example of how stress from lack of balance obliterates health. Sally described the effects on her health of traumatic events at work or when she was forced to work with people who did not talk to her and did not share. Sarah also alluded to the ephemeral nature of health when she described the way she felt after visiting a clothing store where the clothes were rarely available in her size. Rick, for whom accessing the immediate experience of health was very difficult, described working and living among people who were friendly and accepting as an essential prerequisite for health. During the interviews, Rick described many incidents when his health had been adversely effected by a lack of warmth and acceptance. Thus, for him, health was banished when he had to live or work with lack of acceptance, affirming the fugitive nature of health for him.

Didi also acknowledged that health could be short-lived when she described it being banished by fatigue, as did April. Although not included in the narratives, Holly gave an account of the way health ‘fades’ over time, even when physical fitness and a feeling of achievement persist. In these ways, health was portrayed as an evanescent phenomenon, tending to vanish like vapour in the face of fatigue, threats or challenges, but flitting in and out of the lives of the participants, never wholly departing, rarely wholly present for extended periods of time.
However, for Charlotte and Bill the transient nature of health described by the others was less evident and it was clear that health was more the norm than otherwise for them. Indeed, Charlotte’s description makes it clear that health is not an event, as with the other participants, so much as an outcome that was only gradually achieved but which remained relatively stable from day to day and week to week. For Bill, this was also the case. The atmosphere that pervaded the interviews and discussions with Bill was that nervousness due to shyness obliterated his experience of health only temporarily and that health in the form of happiness and energy was the more constant state for him.

Can it be said then that health is transient in nature? Even here, it seems that health is complex and convoluted and there is no simple answer since two of the participants indicated otherwise. Still, any description of health needs to include the fact that, for many people, the experience of health is an ephemeral one.

The elusive nature of health

In the descriptions gathered for this study there are several explicit indications that there is about health an indefinable character, an elusiveness that defies ready description or even, at times, recognition. However, it was not only in this way that the elusive nature of health was expressed. In almost all of the interviews, the elusiveness of the phenomenon of health was expressed in long pauses, in stammered, evolving sentences and, finally, in desperation almost, with a statement that almost invariably started with the phrase ‘It’s like ... ’. The more explicit examples of this are:

- *It’s like an almost primitive feeling of being ...* (she hesitated) (Holly).
- *... it was like a feeling of completeness. I felt capable* (Holly).
- *... it was like when you wake up [in the morning] and you feel really focused and you could do anything* (Rick).
- *Health is sort of like a surfer; the more exercise you get, the better you feel and the more energy you’ve got* (Didi).
• *It's like a control situation; you've got control (Sarah).*

This elusiveness from description on the part of health may also apply to its ability to be recognised as well. When pressed to describe what was obvious about health when he was feeling healthy, Bill laughingly said that, aside from feeling happy and energetic, he was not able to describe it because 'it was all so tucked away'. After much thought, he stated 'I just don't feel that I'm able to [describe it]'.

Recognition that health is an elusive phenomenon is not new (Salk, 1978; Seedhouse, 1986; Antonovsky, 1987; Gadamer, 1996). Indeed, this elusiveness is illustrated by the many attempts to define health that have dogged nursing and the health movement since the 1960s. However, the very fact of its elusiveness is itself, in part, a description of the nature of health. Of themselves, the faltering attempts by the participants to relate what health was like in their lives gave focus and outline to the atmosphere of intangibility which health brings into the lives of those who experience it.

**The embodied nature of health**

A great deal has been written in the last half of the 20th century in rejection of the clinical or medical model of health. This model saw health only as the absence of the signs and symptoms of disease or disability (Smith, 1983). Despite the rejection of the model, however, no one has seriously postulated that health could possibly be other than an embodied phenomenon in some sense. For that reason, assumptions about the nature of that embodiment were among the hardest aspects of health for me to put aside; to open my assumptions to sincere exploration and to try to remove my presuppositions about the nature of health. However, while the exploration indeed revealed health as embodied for the participants, few descriptions began with a focus on the body. Anne and Sally, however, provided clear descriptions of what the embodiment of health is like.
Despite the fact that only two participants portrayed it clearly, descriptions of the corporeal nature of health occurred repeatedly during the interviews. Holly made it explicit when she described the physical as going hand-in-hand with the spiritual and her examples of the way health was present in her life related to the interaction between body and spirit. In Anne’s description of ease and contentment, there is a strong sense of embodiment, which is reinforced by her portrait of herself in health as having clear skin, a clear mind, energy, being ‘awake’ and ‘feeling thin!’ While Anne made it clear that ‘feeling thin’ was a metaphor for health, both Sarah and April also gave an impression that this was health, metaphorically speaking, for them as well.

The physical, embodied aspect of the nature of health was also reflected in the narratives of all but one participant as energy. The only exception to this was Sarah, who did not give any clear examples of health presenting in corporeal ways. Nevertheless, her description of health as being able to be involved in things and of being able to go for a walk if that is what she felt like doing shows that, for her too, health is a physical, embodied experience.

Some of the strongest and most complete descriptions of health related to its embodied nature. For example:

- **When I’m feeling healthy I want to get out and do something. I just want to go out and do something. I’m in a good mood and I just want to go and play sport. So, when I’m healthy I want to get out and do stuff (Bill).**

- **I have energy. I work a ten-hour day and it’s like I want to come home and I want to do more things. I feel good and at the end of the day, even though after travelling I’ve had a twelve hour day and I come home and I’m tired, [but] it’s not like an absolutely totally depleted feeling, like you’ve got nothing left to give. I know I’ve got more to give when I come home. (Charlotte).**
• Health makes itself present by me not being tired. I'm able to share out the things that I like to do to stay healthy - like exercise; it's like I've got the energy to pay attention to those things. So, I'm less tired; more energetic ... (Didi)

• I have energy, I feel energetic and happy and keen to do things and I get more done. I'm more organised; I don't sort-of half do things and think 'Oh, that'll do!' (Didi).

• Health is sort of like a surfer. The more exercise you get the better you feel and the more energy you've got (Didi).

• When I'm healthy, I've got more energy; I feel refreshed and a lot more alert; everything's so much better, like you go to work and you don't feel depressed about going to work (Sally).

• When I'm healthy, when I feel really healthy, I feel alert, I feel alive; I've got energy and everything's good; like, it doesn't matter what happens in the day, it doesn't bother me (Sally).

• You've just got much more energy when you're feeling healthy! And it reflects in other things when you're feeling healthy; like, you wonder what you'll have for dinner and you've actually got the energy to go down to the shop and buy fresh veggies and come home and cook them because you're feeling really good (Sally).

Both Anne and Sally gave wonderfully evocative descriptions of the embodied nature of health. Indeed, when read by other participants at the end of the study, these descriptions aroused in them a response in which recognition, acceptance and acknowledgment were integrated. Here, indeed, were pictures of health as they had experienced it:

• When I feel healthy, I feel as though my skin is clear. I feel as though my mind is clear. I have energy. I have a great deal of concentration. I'm very awake! I'm very happy. I've got a pretty sharp sense of humour and that's at its peak when I'm healthy. I feel thin! You-know how you can feel bloated if you have a lot of salt in your diet or eat
certain foods or when your hormones are going crazy. It's that you
don't feel like you're carrying that extra fluid and that extra weight
that makes a difference. My shoulders aren't tense and things like
that. (Anne)

- When you feel really healthy you just feel so much better. You just
glow, you go out and it's nothing to do with being either fat or skinny;
you still glow. Your skin glows and it shows in your smile and your
eyes light up and you just look much better. And even if you wear the
same clothes, your hair looks shinier and you look neater, fresher.

When I'm feeling really healthy, I feel like I look good so that when I
go out it just comes out naturally, anyhow. I wouldn't have to fake a
smile or pretend I'm being happy because that just happens! (Sally).

The picture of health

The descriptions above bring into focus another possible face of the experience of
health and the question emerged, 'Is there a picture of health?' or, put another
way, 'Is health a phenomenon that can be seen?' Certainly, the notion that health
is a visible phenomenon is not a new one and brings to mind the many
descriptions and stories I have heard from parents of sick children over the years.
The cry of 'But she (or he) looked so healthy, yesterday (or this morning or
whenever)!' is a familiar one to nurses and the appearance of health is therefore
one nurses have learned to distrust. Nevertheless, this study has committed me to
as impartial an examination as I can achieve and I attempted to objectively
examine the pictures of health offered by Anne and Sally. In doing so, I
recognised that several other participants described health as visible in some way,
although none so clearly as Anne and Sally. April's contribution was that
attractiveness showed through when one was healthy, while Didi described health
as putting a smile on your face. In addition to this, Anne, April, Bill, Charlotte,
Didi, Sally and Sarah all described health as being happy which, while it is a
visible emotion, cannot only be ascribed to health. Nevertheless, the happiness or
contentment that can be found in the picture of health offered by Sally remained an abiding one, which consistently confirmed that health is a phenomenon that at times may be seen.

Thinking about this question of the visibility of health, I asked myself if health as felt is more evident to the one who feels it than it is to others. Although most individuals have had the experience of being told at some point(s) in their lives that they look healthy, this does not appear to be a reliable indication that health is present in an individual’s life. Indeed, many would also have experienced being told this when they were feeling far from healthy. For this reason, the notion that health may be a visible phenomenon is a difficult one.

Still, despite these reflections, it does seem to be possible to picture health. I asked myself if this was perhaps because we are bombarded with pictures of health every day of our lives on television or in the print media. I was left then with the question ‘Is the famous athlete portrayed in advertisements truly experiencing health, or is the picture presented by health in such visible form merely a picture of fitness?’ Thinking of this, I remembered all the elderly and far from fit people I had cared for over the years and the way I could sense from their appearance or mood, if not the presence of health in their lives, at least an indication that health might be present. Is this then what is part of the experience of health; not so much the picture of health itself but physical or mood indicators that health may be present that can only be confirmed or denied by the person experiencing health? What seems to be certain is that although such indicators may be present, they do not, of themselves, confirm the presence of health.

**Health: a transformative experience**

For many of the participants, health presented in such a way that it changed the way they experienced other events in their lives. Sally described this transformative quality of health in the following passage:
It’s like nothing beats you when you’re having a good [healthful] day! Nothing beats you, you just feel really good about everything. I mean, you’ll be driving along and you’ll get caught in a traffic jam and you can look out of the window and think about the trees and what’s going on around you. I was driving long-distance a couple of weeks ago and there were massive roadworks on the main highway and I was just stuck there for twenty minutes in the middle of nowhere. I was feeling really good and I thought ‘Oh well, I’m not in a hurry; I’ve got nothing to do.’ I wasn’t impatient about anything and I looked around at the bush and talked to the people on the ‘Stop’ and ‘Go’ signs and had a look at what they were doing and it wasn’t stressful. I was actually enjoying the scenery and feeling relaxed being where I was and enjoying the drive. The fact that I had to wait in the middle of a dusty road for twenty minutes was incidental. Yet if I was feeling unhealthy and stressed and in a hurry to get to wherever I had to go, I would have been sitting there getting all worked up and feeling impatient and wanting to just drive through; that’s the difference health makes.

Despite what Sally had to say, can it be said that the experience of health consistently transforms the ordinary events of our lives? In search of indications of this, I once again went back to the narratives and read them again and found that Holly had given indication that health was an experience that changed things for her when she said:

When I’m healthy I’m very different ... it’s just everything seems a lot better when you’re feeling healthy.

Confirmation that health may change the way we experience our lives merely gives birth to another question; that is, ‘If health is a transformative experience, what does it change?’ Anne gave a hint of the possible nature of such change when she said:

Health is in the way I react, too! You come across something [that is disagreeable] and you say ‘Oh, that’s unpleasant; let’s deal with that’
rather than ‘Oh, my God, this is unpleasant, this means something terrible!’ and you wonder how you are going to be able to deal with it. When you’re healthy, you just react differently. You feel as though you’ve got the capacity, the emotional capacity and resources to go ‘Huh (sound of optimism), this is a problem, let’s deal with it’, rather than think, ‘Oh my God! Let’s leave this one in the too-hard basket and let it fester there for a while’ (laugh) (Anne).

The passage above and the following passage from Holly indicate that what is changed in health is the emotional response to the world around us:

When I’m feeling healthy, negative emotions are less intense and they’re worked through quicker.

This notion is reinforced by April’s and Didi’s statements that, in health:

- I don’t know how to put it but I feel like touching people, like my friends and that; just going up to them and putting my arm around them (April)
- ... you’re more positive, that means you’re more patient (Didi).

and by Sally, who said that when in health:

- ... it doesn’t matter what happens in the day, it doesn’t bother me.
- ... I don’t feel upset about anything that might have happened at work, I’m not upset about anything, I feel good.
- When you’re healthy it’s like you just don’t feel the stress.
- When you’re healthy, you think straighter, you think clearer and you don’t get so ‘het up’ about things. You actually think more logically about things as well; everything’s relaxed, everything just flows along and goes okay. Basically, health is about feeling good and then once you feel good you’re so much more in control and you’ve got much more direction and you’re able to achieve things that you want to achieve; mentally clear is how I feel when I feel healthy.

Reflecting on these various indications that health may be a transformative
experience that changes our emotional response to the world and the events in it which impact on our lives, I wondered how this could be objectively examined. There does not seem to be any way of doing this, except through the type of exploration that has taken place in this study and by reflection on my own experience of health. I asked myself the question, ‘How does health make me feel?’ Certainly, it is true that the things that annoy or distress me when I feel less than healthy, no longer seem to do so nearly as much when I feel healthy. Examining this line of thought from the obverse side proves more telling, however, in this examination of health. When I feel very far from healthy, I feel as if the troublesome aspects of my life are gaining advantage of me, whereas, in health, I feel as if these things are manageable. So for me as for Sally, when I’m healthy, it is a case of not feeling the stress of occasions or events that might at other times cause me stress. If seems then that health may indeed transform the emotions rather in the way one tunes in a radio; health turns the emotions on to a program that is different to that of unhealth.

Still, I was not convinced that health was a transformative experience and I began to reflect on the health of those around me. I thought of my daughters, all young adults whose normal state is abounding health but who, in their relatively rare moments of feeling unwell or in a state of unhealth, view the world despondently and somewhat negatively. I thought of my friend Amy, who only last week had described to me how awful were the circumstances at her place of work and who, the very next day, told me how much she enjoyed her job. When I asked her what had changed her opinion so radically, she responded that she had not been feeling very well when she spoke to me the day before. Was it the state of health of each of these people that transformed their opinions or emotional responses to the world around them? This is not a question that one can answer definitively, one way or the other. About health having a transformative effect on human emotions, the most that can be said is that it seems possible, even probable that it does.
Health is ‘of the spirit’

In recent years, much has been written in the nursing literature about ‘spiritual health’ although descriptions of what is meant by such a phrase are frequently vague and leave one with no clear impression of what is meant by the term. This is a phrase that is easy to distrust. Our history and culture in Australia have shown us that frequently, when the spiritual has been spoken of, the underlying intention has little to do with spirit and more to do with obedience to some social norm or cause. Having taught health for some years, I have also become accustomed to the common response of nursing students that they find this aspect of the literature about health hard to relate to. So I felt eminently prepared to approach this dimension of the narratives of April and Holly with all of the suspicion and doubt which phenomenology calls forth. All the more reason then, because it was quite unexpected, that I came to understand with surprise and wonder that health as I was being shown it was indeed ‘of the spirit’ just as much as it related to any other part of human being.

On the surface of things, what April and Holly had to say about the spiritual face of health was self-evident because they were both devout persons:

- [In health] you have the strength to overcome things and not lose hope (April).
- I'm a Christian so, for me, spiritual health is found in my relationship with God. I often feel very remote, and not in touch; it's a feeling of struggle. Feeling in touch with your spirit is a gift, and if you don't have that, it's a very empty feeling. So health comes to me mentally; I know I'm healthy when I feel at peace. In this peace is a feeling of happiness. I'm happy to be alive and appreciative of everything good and of people around me and I view things with rosy coloured spectacles. Being at peace involves other people as well; it needs to involve the people I care about and I need to be at peace with them. That's very important, so peace is not just an inner thing, it's also an interactive thing (Holly).
• *The physical goes hand in hand with the spiritual.* When you take away the tensions of your body, it allows your mind to be at peace; you’re on another plane and you feel more in touch with your spirit (Holly).

• *Feeling healthy, feeling on top of things is sort of like telling yourself ‘Okay, mate, you can keep going on’* (April).

• *I did it today; I feel like I can do it the next day* (April).

However, the sense or the atmosphere that emerged from these statements gave me pause. What they were talking about here was having a sense of hope and a sense of peace in their lives, both of which had been described in different ways by the other participants and which I had taken for granted until now.

Although some of the participants could not relate to the godly aspects of April’s and Holly’s descriptions most conveyed that, in health, it was easier to feel strong and more positive about things in general. In this way, the notion of health as ‘of the spirit’, is closely related to the notion of health as a transformative experience. April and Holly made it clear, however, that it was only when the spiritual aspects of their lives were in order that they experienced health. In the transformative experience scenario, it is health that transforms other aspects of daily life. In this scenario, it is the spirit that helps to bring health into being. Review of the narratives shows that, in health, these nine nurses were more positive about life in general than they were at other times and Didi clearly affirmed this with her statement about feeling positive when she was healthy. It is clear then, that while the phenomenon of health is closely intertwined with the human spirit, health can be said to show itself in a positive view of the events and circumstances in one’s life.

The spirit is the pervasive, quintessential element of the human psyche but it is not something that can be grasped and explained easily. One’s spirit may be described as one’s driving force or as an animating or vital principle, but these are hard notions to take hold of and to see at work in our lives. Indeed, I had sensed
a tendency in the other seven participants to shy away from discussion of any
spiritual aspect of health. This did not come to my attention until the last part of
the final interview with each of them. This final few minutes of the last interview
was not phenomenological in nature and had been designed to elicit the way they
had experienced the interview process and to seek answers to several questions
about health education of interest to me as a teacher. During this question and
answer segment, several of the participants described feeling a reluctance to
engage with the notion of spiritual health introduced to them when they were
students. As Bill put it, he was “... not too comfortable with this spiritual health
stuff that they taught us at university”. When asked why this was so, he replied,
as did several others, that they had not been brought up to be religious.

I began to question as a result of these conversations. I wondered whether the
lack of clarity about the possible nature of health of the spirit, or even the
possibility that it existed, had something to do with a cultural reluctance to engage
with a notion that is for many people a deeply emotional one. Engagement in
discussion about deeply held beliefs and values is not the custom in Australia. I
have a clear memory of being told as a child growing up in Australia that it was
‘not done’ to discuss religion, sex or politics with any person outside the confines
of one’s own home. So I began with a question to myself about whether this
might be an explanation of my own inability to explain clearly to my students the
notion of health of the spirit. From this question I rapidly progressed to an even
more daunting one, ‘Was this silencing code of right and wrong perhaps the
source of my own inability to see whether health of the spirit was an essential
component of health?’

I began to wonder what it would mean to have health of the spirit and to question
whether the data were showing it to me and I was unable to see it. The question
of what it would be like to have health of the spirit persisted and it demanded that
I go back to the narratives yet again. Careful re-reading of the narratives showed
there is a sense of peace in some of the descriptions of health that, while they
reflect the peaceful aspect of Holly's description, do not contain any direct spiritual connotations. Despite this, there is a pervasive sense that, in health, these nine participants felt at one with their own ambitions and with the driving forces in their lives. In many of the narratives, this appears as an atmosphere of contentment or what Anne describes as 'ease'.

What is clear from these ruminations is that health of the spirit is a truly holistic notion, that it cannot be seen separately from a person's whole being. It cannot be separated out and described in any independent way; it cannot be dissected and explained. Nevertheless, these nine nurses have shown me for the first time some of the dimensions of health of the spirit. One of those dimensions appears to be a kind of joyousness, a blitheness that on careful scrutiny appears in many of the narratives, but is particularly encapsulated in Sally's various descriptions of what health is like. It also appears in Sarah's broad statement that health is 'feeling good about yourself'.

The social nature of health

Holly introduced the idea of health as a social phenomenon when she said:

*Being at peace involves other people as well; it needs to involve the people I care about and I need to be at peace with them. That's very important, so peace is not just an inner thing, it's also an interactive thing (Holly).*

Rick also assigned to health a social character when he indicated that for him:

*... health was in the cohesion and the feeling comfortable and the being with people, but feeling comfortable being with them (Rick).*

Until I had read and considered these descriptions, I can truly say that I had taken the social character of health for granted, which meant in effect that I had failed to really consider the nature of health. This was truly a case, as Merleau-Ponty (1962) describes, of a thing being more difficult to know when it is precisely what is seen.
Alerted by these two descriptions to the social nature of health, it became clear that there were other descriptions of the social character of health in the narratives. For example, Sally discussed it when she described 'feeling good' as a result of working with compatible people. Anne identified it, not so much by description as by her actions when, at the completion of her research involvement, she told me that she had never previously recognised the effect on one’s health that one’s job could have. She subsequently resigned from her job as a result of her recognition of the social character of health in her life. April alluded to the social nature of health in the interviews in the following ways

- [When I'm healthy] I feel like I can be available to my friends and the people around me (April).
- [When I'm healthy] I feel ... I don't know how to put it (laughing) but I feel like touching people, like my friends and that; just going up to them and putting my arm around them (April).

Later, in contrasting health with a previous time in her life when she had been less than healthy, April had clearly identified health with being socially and spiritually happy.

Taking these descriptions into account, the data suggest that health is dissipated by unfavourable social interactions. Indeed, these data go further than that and indicate that one cannot be healthy in the presence of conflictual or disturbing social exchanges. While many individuals, myself among them, might agree that this was the case, the question remains 'Is the phenomenon of health then dependent on favourable social interactions?' Perhaps the only way such a proposal can be explored is by looking at the reverse side of it. According to some fictional literature, there are individuals who thrive on dissent and opposition, or at least we are told that this is so. However, examination of what I know of human nature after many years in nursing makes me conclude that I have never met a person like this. In my own experience, I have observed that unfavourable social interactions cause distress and concern and contribute to a
diminution of the feeling of health for many people.

Can it said then that the opposite is true, that favourable social interactions actively contribute to health. The following passage provided by Sally would seem to suggest this:

_The people that I've been working with are all fun and friendly and [they] talk to you. Some days you can work and the people next to you don't talk to you. It doesn't help you, it doesn't create a team approach and that makes you feel lousy. But we've had really good days and I feel really healthy. It's like nothing beats you when you're having a good day! Nothing beats you, you just feel really good about everything._

The very word, interaction, implies however, the involvement of two persons. It is impossible to say what comes first and this generates the following questions; ‘Does the healthful person generate an aura of approachability that makes social interaction more feasible?’ or ‘Does the social interaction facilitate the feeling of health?’ It would seem that these questions could not be answered from these data at this time. The only thing that can be concluded from this study about the social nature of health is that health is in some sense dependent on friendly or sociable human interactions.

**Health: a state of being**

One of the things that are very clear from the narratives of health provided by the participants in this study is that one does not ‘have’ health, one *is* or is not healthy. Health is therefore a state of being and as such does not appear to open itself to exploration in any but qualitative ways. The reader might well ask why this is relevant at this late stage of this analysis of health and what this has to do with the nature of health itself. This statement is not couched as a defence of qualitative research, or indeed of phenomenology. It is rather recognition, perhaps for the first time, of the nature of health itself. Some years ago, Labonte (1993) stated that relational experiences of ‘being healthy’ were not easily
rendered into simple, quantifiable measurements. This statement has taken on new meaning as a result of the exploration that took place in this study. As a state of being, perhaps the only way that one can understand health in all its complexity is if one explores within oneself what it is like to be healthy. Such a statement means that the very nature of health itself gives direction to the way it may be understood.

SUMMATION

This chapter has explored the nature of the phenomenon of health via descriptions of the immediate experience of health in the lives of nine nurses. The phenomenological exploration that was conducted and is here reported on was characterised by the idea of the phenomenological moment. However, while the phenomenon of health has, in some senses, come into clearer focus as a result of this exploration, each reader will interpret this text through the screen of their own experience and no promise of clarity can be offered from these pages.

In this study, the nature of health was revealed through the original experience of the participants in the study. Health was revealed as manifest in the lives of the participants, with most descriptions conveying a sense of contentment that showed as feelings of happiness, feeling alive, complete, energised and optimistic. Health also revealed itself as transient in nature, passing quickly and without notice into and out of the lives of seven of the nine participants. Although obvious in some ways, health simultaneously eluded clear description and even at the completion of the exploration with each participant was characterised by the atmosphere of elusiveness that is captured in the descriptions. For all the participants, health was an embodied phenomenon with a common element of energy and a sense of wellbeing. These, together with a sense that life was manageable and achievable gave to it a distinctive spirit even while the spirit simultaneously helped to make life manageable and achievable and thus contributed to health. For all of those who participated, health presented as
having the ability to transform their emotional responses to daily life events in such a way that it made those events more acceptable and the tasks of life more achievable.

Despite the limitations imposed by its elusiveness, as a nurse whose professional career depends on an understanding of the phenomenon of health, I can now say that I understand it more clearly because I have explored it to see what it is truly like. I no longer understand it as others have taught me to see it. If this will make me a better teacher and I am able to pass on just some of this understanding to others, this study will have been worth the effort. Despite this feeling of achievement, however, summarising what I have found was extremely difficult, since the primary lesson of this exploration was that it was necessary to learn to see for oneself what the phenomenon of health is truly like.
CHAPTER 6

THE LEXICAL DIMENSIONS OF HEALTH

INTRODUCTION

In Chapter Five, the discussion focused on health as described in its immediacy by the participants. However, the participants also described health in thoughtful, interpreted ways. Of themselves, these descriptions provided insights into the ways the participants experienced health as well as conveying information through the language used in the descriptions. In the words of van Manen (1990: 17) 'human life needs knowledge, reflection, and thought to make itself knowable to itself, including its complex and ultimately mysterious nature'. For that reason, such thoughtful, reflective and interpreted descriptions of experience as given by the participants provided a broader canvas on which to paint a description of health than was provided by traditional phenomenology. This is the canvas that is provided by the American continental approach to phenomenology which allows for interpreted descriptions of lived experience itself and 'makes us thoughtfully aware of the consequential in the inconsequential, the significant in the taken-for-granted' (van Manen, 1990: 8).

As a general rule in phenomenology in nursing, the distinction is not made between the immediate experience of a phenomenon and the participant's thoughtful descriptions of it. Recently, however, there have been a number of critical analyses of the way phenomenology in nursing research has been conducted (Crotty, 1995; Crotty, 1996a; Crotty, 1997b; Holmes, 1996; Paley, 1997). These analyses indicate that phenomenology as it has developed in nursing is different to that of the European phenomenologists. When put together with the philosophical work of Silverman (1987) which also clearly describes the
presence of distinct differences between European and American continental phenomenology, a re-examination of the way phenomenology has been used in nursing research is clearly necessary.

In order then to address the methodological differences between traditional European and American continental phenomenology described earlier in this thesis, Chapter Five described the phenomenon of health as immediately experienced. This chapter seeks to describe what was thought and perceived about health by the participants. It also seeks to clarify the meanings that emerged from the language they used to describe health and the contexts within which such descriptions were embedded. Benner (1994: 99) described interpretive phenomenology as ‘engaged reasoning and imaginative dwelling in the immediacy of the participants’ worlds’, a description which effectively distinguishes this type of phenomenology from the objectivising projects of the European phenomenologists. In reasoning within the context of the ‘worlds’ or cultures in which people live and have their being, this approach to phenomenology places within the reach of nursing the means to understand the life worlds of the people for whom nursing exists.

Benner (1994) offers further insights into American continental hermeneutic phenomenology when she describes the fact that this approach respects both commonalities and differences. She makes it clear, however, that saying that something is not (its absence or opposite), while a form that may help clarify a description, is an insufficient endpoint for phenomenological research in this mode. She asserts that ‘accounts of difference without accounts of commonalities ... set up false dichotomies and oppositions’ (p. 100). This is in stark contrast to what Crotty (1996b) has had to say about the search for commonalities which he vehemently disputes is even remotely a goal of traditional European phenomenology.

In the phenomenological work of van Manen (1990) the search for both the
differences and commonalities in textual descriptions of phenomena are specifically described. In keeping then with the pursuit of phenomenological understanding in the manner described by van Manen (1990), this chapter explores my own personal experience where relevant. It examines also the individual ways the participants described what health means to them. It searches for meanings of words used in descriptions and thematically analyses the descriptions of health.

The language used to describe participants' interpretations of health experience was frequently similar to that used to describe immediate experience. For that reason, there are sections in this chapter that appear to reiterate what was said in Chapter Five. Closer reading of them will show, however, that in this chapter, etymological search of word meanings is used as a tool for clarifying and understanding meaning, as is the definition of terms and comparison between different sets of data. In this way, the analysis in the American continental mode is broader than that of traditional phenomenology that permits the focus of analysis to encompass only immediate experience itself.

The task of this analysis was to first try and 'see' health as it really is, unclouded by learned notions and cultural expectations and this was done in Chapter Five. The next task was to examine the central motifs and themes that emerged and see if they were essential to health as the participants experienced it. Because all notions of the object to be described had been put aside, that object (health) should then have become unknown in the true sense of the word. In a way, it was a bit like being presented with a jigsaw puzzle of an unknown object. The picture to be deciphered represented the phenomenon of health and the data was the muddle created by the scattered pieces of the puzzle. The task of completing the jigsaw was twofold. Firstly, it was to determine which pieces represented the object in order to decipher what really was health as we sought to describe it. Secondly, it was to determine what pieces were just background 'noise' in the sense of them having been included by the manufacturers to make the puzzle more exciting. The background noise was, of course, the muddle of inherited
understanding which humans gather from their culture and life histories.

When discussing health, each of the participants revealed an individual motif of health; that is, each held to a dominant idea or central theme in their descriptions of health. However, even though the participants did not recognise it, there were few divisions in the way health was described. The themes are more a continuous description of health as an integrated notion than they are different aspects of a many-faceted notion. For this reason, a series of tables have been constructed to make clear to the reader how health presented itself in various ways, and how those ways coalesced and intersected to create themes for the analysis of commonalities which forms the latter part of this chapter. Some examples have been used in more than one category since the aspect of health described is multidimensional and could not be isolated to one theme only. Although headings have been used for the purposes of discussion in this chapter, it will be seen that there is continuity to the description that makes such headings artificial in some ways.

The first of these tables identifies critical words rather than phrases to show the concepts or ideas that were expressed by each of the participants. They are used to clarify the discussion of individual themes. The central motif of health described by each participant is starred (*) to indicate its special importance to the participant. Other elements of health for each of them were prioritised by the participant in terms of their importance to that person’s experience of health.
<table>
<thead>
<tr>
<th>Central motif</th>
<th>Anne</th>
<th>Sarah</th>
<th>Didi</th>
<th>April</th>
<th>Bill</th>
</tr>
</thead>
<tbody>
<tr>
<td>*balance</td>
<td>*feel good about self</td>
<td>*energy</td>
<td>*feeling rested</td>
<td>*happy</td>
<td></td>
</tr>
<tr>
<td>Other elements (prioritised by participants)</td>
<td>contentment</td>
<td>happiness</td>
<td>feeling rested</td>
<td>energy</td>
<td>relaxed</td>
</tr>
<tr>
<td>ease</td>
<td>contentment</td>
<td>being happy</td>
<td>enthusiasm</td>
<td>energy</td>
<td></td>
</tr>
<tr>
<td>self-esteem</td>
<td>feel positive</td>
<td>achieve more</td>
<td>achieve more</td>
<td>enthusiasm</td>
<td></td>
</tr>
<tr>
<td>get things done</td>
<td>confident</td>
<td>enthusiasm</td>
<td>happy</td>
<td>feeling accepted</td>
<td></td>
</tr>
<tr>
<td>feeling secure</td>
<td>sense of achievement</td>
<td>being organised</td>
<td>being organised</td>
<td>feeling at ease</td>
<td></td>
</tr>
<tr>
<td>being in control</td>
<td>more positive</td>
<td>coping</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>coping</td>
<td>more patient</td>
<td>feeling good about self</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>clear skin</td>
<td></td>
<td>feel connected to others</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>clear mind</td>
<td></td>
<td>have hope</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>energy</td>
<td></td>
<td>spiritual peace</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>concentration</td>
<td></td>
<td>ability to be available to</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>feeling happy</td>
<td></td>
<td>attractiveness comes through</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>improved relationship with family</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 1 (continued) - Individual themes

<table>
<thead>
<tr>
<th>Central motif</th>
<th>Holly</th>
<th>Sally</th>
<th>Rick</th>
<th>Charlotte</th>
</tr>
</thead>
<tbody>
<tr>
<td>*peace</td>
<td>*vitality</td>
<td>*feeling accepted</td>
<td>*emotional wellbeing</td>
<td></td>
</tr>
<tr>
<td>Other elements</td>
<td>completeness</td>
<td>refreshed / alert</td>
<td>social cohesion</td>
<td>wellness</td>
</tr>
<tr>
<td>(prioritised by participants)</td>
<td>spiritual peace</td>
<td>positive/life is good</td>
<td>life in balance</td>
<td>mental togetherness</td>
</tr>
<tr>
<td></td>
<td>mental soundness</td>
<td>motivation</td>
<td>feeling mentally motivated</td>
<td>quality of / in life</td>
</tr>
<tr>
<td></td>
<td>togetherness</td>
<td>energy</td>
<td>feeling wanted</td>
<td>feeling valued / wanted</td>
</tr>
<tr>
<td></td>
<td>being relaxed</td>
<td>clear thinking</td>
<td>accepting others</td>
<td>integrated</td>
</tr>
<tr>
<td></td>
<td>having energy</td>
<td>things are achievable</td>
<td>being comfortable with others</td>
<td>ability to live life energy</td>
</tr>
<tr>
<td></td>
<td>fitness</td>
<td>happiness</td>
<td>feel good about self</td>
<td>relaxed</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>confident/competent</td>
<td>‘you just glow’</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>having good relationships</td>
<td>feel good/skin glows</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>ability to put things in perspective</td>
<td>eyes light up</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>rested / relaxed</td>
<td>health shows in your smile</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>empowered</td>
<td>look/feel fresher</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>ability to let things go (e.g. friendships)</td>
<td>empowered</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>functioning well</td>
<td>at the steering wheel of own life</td>
</tr>
</tbody>
</table>
To give direction to the discussion and in order to clarify the way commonalities were identified, the second table synthesises the individual listings. The third table allocates them to shared themes that were examined and confirmed by a group of four researchers from the School of Nursing. Two of these researchers worked in the qualitative domain, one in the quantitative / qualitative arena and the fourth in purely quantitative research. This mixture of research approaches among the screening group was deliberately chosen to examine and confirm the assignment of themes. This was done because it was understood that, for the research to be comprehensible and coherent for researchers from any research domain, the thesis needed to use language that was cogent for all. The selection of persons with skills in a mixture of research approaches was therefore seen as a measure to enhance rigour in theme description.
<table>
<thead>
<tr>
<th>vitality / energy</th>
<th>refreshed, alert, ‘you just glow’, feel good, skin glows, eyes light up, health shows in your smile (Sally); energy (Sally, Charlotte, Anne, Didi, April and Bill); ability to live life (Charlotte)</th>
</tr>
</thead>
<tbody>
<tr>
<td>feeling good (positive about self)</td>
<td>(Charlotte, Sarah, April); life is good (Sally); self-esteem (Anne); feel accepted, accepting and wanted plus comfort with others (Rick); feel valued, integrated (i.e., not fragmented) (Charlotte), feeling connected (i.e., able to connect with friends) (April)</td>
</tr>
<tr>
<td>happiness</td>
<td>(Sally, Anne, Sarah, Didi, April, Bill)</td>
</tr>
<tr>
<td>enthusiasm</td>
<td>(Didi, April, Bill); ability to live life (Charlotte)</td>
</tr>
<tr>
<td>feeling relaxed</td>
<td>(Holly, Sally, Charlotte, Bill)</td>
</tr>
<tr>
<td>rested</td>
<td>(Charlotte, Didi, April); refreshed (Sally);</td>
</tr>
<tr>
<td>mental togetherness</td>
<td>(Holly, Charlotte); things are achievable (Sally); mental soundness (Holly); ability to put things in perspective, emotional wellbeing, ability to let things go (Charlotte); clear mind, concentration (Anne)</td>
</tr>
<tr>
<td>motivated</td>
<td>(Sally); mentally motivated (Rick); get things done (Anne); achieve more (Didi, April)</td>
</tr>
<tr>
<td>peace</td>
<td>(Holly), spiritual peace, completeness (Holly); spiritual peace, as in ‘relationship with God’ (April)</td>
</tr>
<tr>
<td>hope</td>
<td>(April); optimism (the ‘atmosphere’ of Anne’s description)</td>
</tr>
<tr>
<td>confidence</td>
<td>(Sarah, Charlotte)</td>
</tr>
<tr>
<td>feeling positive</td>
<td>(Sarah, Sally)</td>
</tr>
<tr>
<td>clear thinking</td>
<td>(Anne, Sally); ability to put things in perspective (Charlotte)</td>
</tr>
</tbody>
</table>
Table 2 - Synthesis *(continued from previous page)*

<table>
<thead>
<tr>
<th>contentment</th>
<th>(Anne, Sarah); completeness (Holly); life in balance (Rick).</th>
</tr>
</thead>
<tbody>
<tr>
<td>improved relationships</td>
<td>(Charlotte, Anne); feeling connected (April);</td>
</tr>
<tr>
<td>appearance</td>
<td>clear skin (Anne); attractiveness comes through (April);</td>
</tr>
<tr>
<td></td>
<td>you just glow, feel good - skin glows, eyes light up, health shows in smile, look and feel fresher (Sally).</td>
</tr>
<tr>
<td>balance</td>
<td>(Anne, Rick)</td>
</tr>
<tr>
<td>empowered</td>
<td>(Charlotte, Sally)</td>
</tr>
<tr>
<td>control</td>
<td>(Anne); at the steering wheel (Charlotte)</td>
</tr>
<tr>
<td>coping</td>
<td>(Anne, April)</td>
</tr>
<tr>
<td>being organised</td>
<td>(Didi, April)</td>
</tr>
<tr>
<td>quality of life</td>
<td>(Charlotte)</td>
</tr>
<tr>
<td>having a sense of achievement</td>
<td>(Sarah)</td>
</tr>
<tr>
<td>ease</td>
<td>(Anne)</td>
</tr>
<tr>
<td>feeling of security</td>
<td>(Anne)</td>
</tr>
<tr>
<td>wellness</td>
<td>(Charlotte)</td>
</tr>
<tr>
<td>functioning well</td>
<td>(Charlotte)</td>
</tr>
<tr>
<td>peace - mental and spiritual harmony</td>
<td>mental togetherness - (Holly, Charlotte)</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>mental motivation - (Rick)</td>
</tr>
<tr>
<td></td>
<td>things are achievable (Sally)</td>
</tr>
<tr>
<td></td>
<td>mental soundness (Holly)</td>
</tr>
<tr>
<td></td>
<td>ability to put things in perspective, emotional wellbeing, ability to let things go (Charlotte)</td>
</tr>
<tr>
<td></td>
<td>clear mind, concentration (Anne)</td>
</tr>
<tr>
<td></td>
<td>feel accepted, accepting and wanted plus comfort with others (Rick)</td>
</tr>
<tr>
<td></td>
<td>feeling valued - (Charlotte)</td>
</tr>
<tr>
<td></td>
<td>feeling connected (i.e., able to connect with friends) (April). ease - (Anne)</td>
</tr>
<tr>
<td></td>
<td>peace - (Holly)</td>
</tr>
<tr>
<td></td>
<td>spiritual peace (April, Holly)</td>
</tr>
<tr>
<td></td>
<td>completeness (Holly)</td>
</tr>
<tr>
<td></td>
<td>clear thinking - (Anne, Sally)</td>
</tr>
<tr>
<td></td>
<td>ability to put things in perspective - (Charlotte) hope - (April)</td>
</tr>
<tr>
<td></td>
<td>ability to be available to others - (April) empowered - (Charlotte, Sally)</td>
</tr>
<tr>
<td></td>
<td>feeling positive - (Sarah, Sally)</td>
</tr>
<tr>
<td></td>
<td>confidence - (Sarah, Charlotte)</td>
</tr>
</tbody>
</table>
Themes of health *(continued from previous page)*

<table>
<thead>
<tr>
<th>balance</th>
<th>balance - (Anne, Rick)</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>feeling good</em> (Charlotte, Sarah, April)</td>
<td></td>
</tr>
<tr>
<td><em>integrated</em> - (i.e., not fragmented) (Charlotte)</td>
<td></td>
</tr>
<tr>
<td><em>happiness</em> (Sally, Anne, Sarah, Didi, April, Bill)</td>
<td></td>
</tr>
<tr>
<td><em>contentment</em> - (Anne, Sarah)</td>
<td></td>
</tr>
<tr>
<td><em>completeness</em> - (Holly)</td>
<td></td>
</tr>
<tr>
<td><em>life in balance</em> - (Rick)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health presents as vitality / zest</th>
<th>alert, ‘you just glow’, feel good, skin glows, eyes light up, health shows in your smile (Sally)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em>energy</em> (Sally, Charlotte, Anne, Didi, April and Bill)</td>
</tr>
<tr>
<td></td>
<td><em>ability to ‘live’ life</em> - (Charlotte)</td>
</tr>
<tr>
<td></td>
<td><em>life is good</em> (Sally)</td>
</tr>
<tr>
<td></td>
<td><em>optimism</em> - (Anne)</td>
</tr>
<tr>
<td></td>
<td><em>enthusiasm</em> - (Didi, April, Bill)</td>
</tr>
<tr>
<td></td>
<td><em>motivation</em> - (Sally)</td>
</tr>
</tbody>
</table>
‘Themes of health’ (continued from previous two pages)

| energy and quality of life | wellness and functioning well - (Charlotte)  
|                           | skin is clear, mind is clear, have energy, ability to concentrate, feel happy, sense of humour is at its peak, good body comfort - (Anne)  
|                           | attractiveness comes through (April)  
|                           | you just glow, feel good - skin glows, eyes light up, health shows in smile, look and feel fresher (Sally)  
|                           | feeling relaxed - (Holly, Sally, Charlotte, Bill)  
|                           | rested - (Charlotte, Didi, April)  
|                           | refreshed - (Sally)  
| Health makes life more achievable | coping - (Anne, April)  
|                           | in control - (Anne)  
|                           | at the steering wheel (Charlotte)  
|                           | organised - (Didi, April)  
|                           | a sense of achievement - (Sarah)  
|                           | get things done - (Anne)  
|                           | achieve more - (Didi, April)  
|                           | ability to be available to others - (April)  
|                           | confidence - (Sarah, Charlotte)  
|                           | competence - (Charlotte)  
|                           | feeling of security - (Anne)  
|                           | quality of life - (Charlotte)  
|                           | improved relationships - (Charlotte, Anne)  

In common with the tables, although not necessarily in the same order, this chapter explores the primary themes or leitmotifs of health for the participants. It examines where and how these leitmotifs were reflected in the descriptions given by other participants.
LEITMOTIFS OF HEALTH

Health: A different encounter for each person

It is not only interesting but also critically important to note that until analyses were undertaken, I could see few commonalities in the way health presented to each of the participants. Set as they are in the midst of story, the participants’ descriptions of health were all fresh and original until I began the task of simplifying their descriptions (i.e., by reducing long descriptions to critical words) for thematic analysis and arranging them side by side to eliminate duplications. I think this is an important point because the observation may have passed unnoticed were I not engaging in the two different forms of analyses of the data.

It was also apparent that the participants only rarely described health as the others in the study depicted it. Indeed, during the final discussion with each participant to appraise individually and critically the essential elements of health, I introduced excerpts from the complete data set to little avail. Only in the two cases already included in Chapter Five were the descriptions of the other participants affirmed or even recognised as relevant to a participant’s own experience and the implications of this are discussed in more detail in Chapter 8. This is a point that has not been apparent in phenomenological studies of health to date and which endorses the need for dual analyses of the data. On one hand, the lack of recognition as a response to data provided by other persons appears to deny the appropriateness of thematic analyses since it shows the phenomenon of health as different for each person and perhaps unknowable to others as we ourselves know it. At the same time, however, it is clear that what is achieved by incorporating the two different approaches to phenomenology is a broader and deeper exploration of the data.

As indicated above, health was described in a different way by each of the participants and the central, dominant notion of the meaning of health for each of them was not replicated in others’ descriptions. The Heideggerian notion
described by Mehta (1976) that phenomenology is historical and sociocultural and is expressed through language became more evident as exploration progressed. Each participant described, in their own way, an encounter with health that was enmeshed in their own life history and, despite them trying to free it from that history, health was not seen in precisely the same way by any other person in the study. The multiple ways health was described nevertheless reappeared, although in different forms, in others’ descriptions. This was most apparent in the discussion of peace, a notion that no participant other than Holly had mentioned specifically.

**Health described as peace**

The notion of health bringing with it a feeling of peace to the extent that health is seen as synonymous with peace appears at first glance to be an unusual one. However, Holly stated that ‘health is peace’:

_I see health as being at peace ... I think peace is the greatest thing we can attain ... I think health involves other people as well; it needs to involve the people I care about as well, and I need to be at peace with them. That’s very important, so this peace is not just an inner thing, it’s also an interactive thing._

When Holly talks about health-as-peace, precisely what does she mean? As she described it, health-as-peace was spiritual in nature and was expressed as a feeling of completeness, as feeling mentally sound and in touch with her spirit. Further reflection on and discussion with Holly about this notion of health as peace showed that it relates to peacefulness of mind and peace as quiet and tranquillity. This peacefulness of mind could be present even when there were many things going on in Holly’s life. It encompassed busy times or times when there was a lot to think about and achieve, although it was dissipated by extended times of great demand. It was not related to being ‘peaceful’ in the sense of having little to do or little to be concerned about.
Still, I was faced with the question, ‘Health as peace, what would it mean?’ The meanings of peace that have relevance to an individual human state are, freedom from disquieting or oppressive thoughts or emotions, harmony in personal relations and a state of tranquillity or quiet (Webster’s Dictionary, 1983). The task of this inquiry was to determine if this was what health is.

There was a sense of calm or acceptance in Holly’s description of health-as-peace. In this state of health as peace, the normal worries and concerns of life no longer pressed heavily upon Holly:

*When my body is fatigued and the mental resistance caused by stress is broken down, it takes away the tensions of my body and it allows my mind to be on another plane. It makes me feel more in touch with my spirit.*

(Holly)

Peace of this nature is then related to accepting the way things are in one’s life, with being in some sense content, or at least with ceasing to be troubled by them. Both Sarah and April alluded to this notion of health as peace-with-self when discussing their self-perception in relation to their experiences of health. April stated that attractiveness comes through when you’re healthy, even though she identified her size as the main problem that caused her to not feel healthy. Sarah, who identified ‘feeling good about oneself’ as the essential quality of health, shows in the following passage how peace with self or acceptance of self is required for that to occur:

*For me, my weight is quite an issue because I’ve always gone, up down, up down, up down like that. It’s not that I actually feel unfit when I’ve got an extra 5 kilos on, I don’t because I can still walk my three miles a day and that’s basically what I want to do. But even though I can still do what I want to do, it makes me unhappy when I go into a shop and I try and buy something for myself to fit in to, and nothing fits me! I go shopping and I can be feeling quite good about myself and I come out from these places and I feel quite revolting.*
For myself too, health presents as peace, although I would not previously have described it in these terms. In my life, health is characterised by a certain ease of the spirit. It is characterised also by equilibrium between the usual worries and concerns of my life and my feelings of hope or tranquillity, and by the ability to focus outside of my personal concerns and myself and see the beauty of the world around me. This also encompasses a lack of concern for the body and its functions and acceptance of the body and its changeful nature. Equally, acceptance of the circumstances of my life is part of the character of health in my life. Holly’s description of health-as-peace then, accords with my own recognition of the nature of healthful times in my life.

Reflecting on this representation of health-as-peace, I truly ‘see’ for the first time what Holly described to me; that health in this guise while embodied is inseparable from the emotions and from the spiritual. Thus, to say that health is embodied, emotional or spiritual is to do it an injustice, since in this guise it is simultaneously all three and, as such is complex and defies easy description.

Of course, when one suffers a physical ailment or disease, it may appear that the body is the only really decisive element in health. Like all nurses, however, I have worked with people who, despite severe pain or physical limitations, often with full knowledge that their life is close to ending, have described themselves as ‘very well’ and ‘healthy’. What I see when I look back in memory at such persons is not health as absence of disease or infirmity, for they had both, but persons who had health-as-peace.

That health-as-peace could not be achieved without some degree of physical or emotional integrity is undoubted, be that integrity ever so tenuous. It is hard to imagine a person suffering agonising pain or debilitating injury describing themself as ‘healthy’, just as it is hard to imagine a person suffering depression would do so. However, in some sense the phenomenon of health stands aside from occurrences of illness or disease. Such occurrences may preclude feelings of
health, in much the same way as the death of an intimate and much loved friend or relation precludes feelings of happiness. Although sadness may temporarily occlude feelings of happiness, it does not generally banish it completely. Similarly, it can be seen that while such occurrences or events as illness and disease may block feelings of health, they do not necessarily banish them completely.

Although the sense of health-as-peace did not clearly announce itself in the way the phenomenon presented to the others in the study, the notion of peace or harmony was reflected in many of the thought-full descriptions of the nature of health. Closer examination of the descriptions of health shows that the notion of peace is incorporated in Anne's concept of balance, in April's notion of health requiring harmony with God and in Holly's and Charlotte's notions of mental togetherness. For those reasons, it seems strange that the idea of health-as-peace has not taken a stronger place in the literature about health and I find myself asking, if health is enmeshed with peace, why this aspect of health has received so little recognition.

Perhaps, however, the idea of health-as-peace is present but unacknowledged in many views of health. For example, in the social view of health with its emphasis on social equality and self-determination, health-as-peace is intimated by the emphasis on reducing the stresses in peoples' lives. Even within the confining boundaries of the clinical or medical model of health, the notion of health-as-peace can be recognised. A vague sense of peace as lack of friction is conveyed by the notions of health as absence of illness and of health as the ability to perform normal social roles. There is also a sense of peacefulness, or at least freedom from care about one's physical state, about the notion of being 'hale' or 'whole' which was the initial meaning of the word health.

Can it be said then that peace is an essential quality of health; that 'freedom from disquieting or oppressive thoughts, harmony in personal relations and a state of
tranquility or quiet' are part of a healthful state? This question generates other questions. For example, would a person oppressed by disquieting thoughts describe himself or herself as healthy? Equally, would a person in disharmonious personal relationships or lacking in tranquility describe themselves so?

In pursuing this line of thought I engaged the image of a healthy person. What I saw in my mind's eye was a long catalogue of healthful persons I had known. In general, they have indeed presented as free from disquieting and oppressive thoughts with some ability to maintain harmonious relationships with others and who have been able to achieve a state of quiet, at times, in their lives.

**Health described as feeling good about oneself**

Health was thoughtfully defined by Sarah as happiness and as feeling good about herself, as contentment with where she was in her life and with knowing that she could do the things she really wanted to do. She described this as being characterised by feeling positive about herself (i.e., feeling confident), having a sense of achievement and being able to be involved in life. This latter feeling was connected with but not dependent upon being physically fit.

When asked to describe in pictorial fashion the way this presentation of health might look, Sarah replied that it would look like happiness. The notion of 'feeling good about yourself' being equated with health did not have broad appeal to me when Sarah first described this notion to me. Since I could envisage occasions when individuals would be able to feel the presence of health in their lives and not feel particularly good about themselves, it was relatively easy to approach this idea with suspicion and doubt about it being related to health. Again, I am acquainted with people who can describe the way health presents to them in their lives but who, as an ongoing factor in their lives, have poor self-esteem and consistently feel less than good about themselves in an emotional sense. Despite these reservations, I recognised that feeling good about myself is a feature of my own encounters with health. The attempt to 'see' it in my mind as Sarah depicted
it, resulted in a picture of a happy, albeit temporarily carefree individual who might easily depict the epitome of health in such terms.

Searching for an echo of this notion among the descriptions of health, it was apparent that although ‘feeling good about herself’ was not Sally’s dominant, inclusive picture of health, she described a picture of health that accorded with Sarah’s depiction. Sally’s glowing description of health (i.e., “You just glow...”) paints a clear picture of Sarah’s notion of health as feeling good, both with and about oneself.

This notion of health as feeling good about oneself carries with it an inference of acceptance of oneself and the conditions of one’s life that were discussed under ‘health as peace’. In this way, the notion of health as feeling good about yourself can be seen to be allied to health as peace and the aspects of health which are described as happiness or contentment are here described as ‘feeling good’. This does not, however, answer the question of whether ‘feeling good about yourself’ is an essential or necessary component of health. Certainly, it is the case that when describing their state of health, most people convey a sense of acceptance and good feeling about themselves that could easily be described as ‘feeling good about oneself’. The notion of ‘wellbeing’ so readily ascribed to health in so many places is also strongly reflected in the concept of ‘feeling good about oneself’.

Does that mean that ‘feeling good about oneself’ is an essential aspect of health? In pursuing this thought, I tried to imagine what it would be like to not feel good about myself and to simultaneously feel healthy. The two do not seem to be compatible somehow and yet my mind continually battles with what I have been taught in nursing; that one may have low self-esteem and still achieve health. As someone who has worked toward health for the many for much of my life, I am reluctant to acknowledge health as feeling good about yourself because it appears to leave so many of the victims of the modern world adrift, without any hope of achieving health. For example, if feeling good about oneself is an essential
component of health, could a person abused since childhood or a person suffering from anorexia nervosa experience health?

Such a notion as feeling good about oneself becoming recognised as an essential component of health poses gigantic problems for the health promotion movement. For without social change, it recognises that some people may never be able to achieve health. Although the place for such an exploration is not this thesis, it raises the question of what such a notion would mean to the health promotion movement whose most recent slogan was ‘Health for all by the year 2000’. So I baulk and am diverted each time I try to conclude that feeling good about oneself is an essential component of health.

**Health described as balance**

To Anne, health shows itself as balance, as ‘having the resources to meet challenges’ which results in a general feeling of ‘contentment’ and ‘ease’ with herself. This ease with herself leads to ease with what she is doing in life generally and with the way she works, to feeling comfortable in her job, to greater contentment in her relationship with her family and, therefore, to improved self esteem. The feeling of ease which characterises her encounters with health enables her to do things that otherwise frequently get left aside or not done, such as giving attention to relationships, keeping in touch with friends and keeping up with social commitments. This in turn leads to her feeling more secure and that she has a measure of control in her life which enables her to deal with stressors in her life and generally have a good self-concept. She described the physical encounter with health as having clear skin, a clear mind, energy, and the ability to concentrate and to feel happy. She described her sense of humour as ‘at its peak’ and her body comfort as ‘good’ when experiencing the phenomenon of health.

In discussing health as balance with Anne in order to try to ‘see’ it as it presented to her, I asked her to describe as nearly as she could what balance meant to her. She described it as a see saw, which goes up or down depending on the amount of
weight that is placed on either side. This notion of balance or equilibrium was not a new one in relation to the meaning of health (Dunn, 1959; Levine, 1973; Johnson, 1980). However, it was just that type of inherited or acquired notion that I was trying to ignore in order to try and see health as Anne saw it. For Anne, the meaning of balance equates with equipoise between contrasting, opposing or interacting elements (Webster’s Dictionary, 1983) and, in this light, has deep significance when discussed by Anne. The discussions made it clear that she sees health as contrasted but not opposite to unhealth, while needing to interact with it constantly. Even in unhealth, when she was sick with a migraine, Anne was constant in retaining her image of health as balance. The interaction between health and unhealth became clearer for her at that time and she could identify the ways in which health was still presenting to her and the areas where unhealth ‘outweighed’ health. The balance that she was able to achieve at that time represented health, as she experienced it then.

Used in such a way, balance is a pretty good synonym for health. Originally, the word ‘balance’, used by either the Babylonians or the Greeks around 500 BC to represent Libra, a Sign of the Zodiac, was depicted as a set of scales or a scale like symbol. This is precisely the way Anne depicts health. Among the various meanings of ‘balance’ are the following, taken from Webster’s Dictionary (1983): an instrument for weighing, a beam that is supported freely in the centre, a device that uses the elasticity of a spiral spring for measuring weight or force, a means of judging or deciding and equality between the total of the two sides of an account. As can be seen, these meanings do not literally and freely translate in relationship to health. Metaphorically speaking, however, they each have relevance and meaning when attempting to pictorially represent the breadth and scope of health and, in that sense, balance is a good metaphor for health.

**Health as energy**

The identification of energy as a central factor in health was discussed by Dixon, Dixon and Hickey (1993) and resulted from a study involving 310 nurses in the
USA. Because several of the participants and myself were familiar with the aforementioned study, I found this particular description of health one of the most difficult to put aside. It was hard to try to ‘see’ whether health as energy presented clearly in my own life and in the lives of Anne, April, Didi, Bill, Charlotte and Sally.

April sees health as energy that is dependent on being rested and which, in turn, is the result of having an established routine and making time for her relationship with God. Although she did not describe health in this way, April’s notion of energy is not so much expressive of vigour and vitality as it is enmeshed with peace, being organised and having a tranquil mind. When April is in a routine and feels rested and spiritually connected through prayer, she gets up early, exercises, breakfasts and gets started on her working day in good spirits and high energy. This energy stays with her through the working day and enables her to prepare nutritious meals and feel good about herself.

When I’m healthy like this, I feel like smiling. It definitely makes me happy.

Didi also saw health in the context of being rested, which is related to energy. For Didi, this restedness and energy are noticeable because she normally lives a very hectic lifestyle and these feelings are sometimes conspicuous by their absence. At those times, she feels less healthy. Having sufficient rest gives her energy which is the factor that Didi continually strives for, in order to maintain health in her life. For Bill, Charlotte and Sally, having energy was also a prominent aspect of health, although none of them described it in terms of being rested.

Although Anne linked energy directly to health only in the beginning of the following passage the latter part of the description is also indicative of energy:

I have energy; I have a great deal of concentration. I am very awake! ...

Health is also in the way I react. My reactions to things are different; I come across something unpleasant and I think ‘That’s unpleasant, I’ll get
\textit{this dealt with} rather than \textquoteleft Oh, my God, this is unpleasant, this means something terrible!' I feel as though I've got the capacity, the emotional capacity and resources to go \textquoteleft Huh (sound of optimism), this is a problem, let's deal with it', rather than think, \textquoteleft Oh my God, let's leave this one in the too-hard basket and let it fester there for a while (laughing).\' (Anne).

Reflecting on what it is like to feel healthy helped me to recognise that it is only when one has energy that one can address the problems and complexities of life in the way that Anne had described.

Energy comes from the Greek word \textit{energeia}, which means activity, which, in turn comes from the word \textit{ergon}, which means work (Webster's Dictionary, 1983). Since we do not only speak of health in terms of the ability to work, the meaning of energy in relation to health would surely be \textquoteleft that condition of body and mind which allows or promotes activity\'. The Webster Collegiate Dictionary (1983) provides several definitions for the word \textquoteleft energy\', all of which give clarity to the notion of energy in health. These are energy as vigorous exertion or power, the capacity of being active, a dynamic quality, useable power, the resources for producing power and the capacity for doing work. It can be seen that for both April and Didi, health-as-energy has meanings very similar to these. For them, the essence of health is energy - as power, as dynamism and as a resource to achieve the tasks they set for themselves. For Bill, Charlotte and Sally, the sense of energy as dynamism was vividly apparent in their descriptions of health. This dynamism is reflected in Bill's statement that health is:

\ldots a \textquoteleft Yeah, all right!' kind of feeling (Bill).

and in Charlotte's description:

\textit{It's like I've taken charge; I've grabbed hold of the steering wheel of my life and, for me, that has been an excellent thing. (Charlotte)}

For myself, what I discover in health is energy also, although I 'see' it more clearly in relation to the experience of mental energy as well as in its physical presentation. This is not to say that physical energy does not also present in my
life as part of health. The notion of dynamism or zest for life, which is an aspect of energy but is much more an aspect of vitality is, for me, one of the essential qualities of health.

**Health as vitality and zest**

Although the word ‘vitality’ does not appear in Sally’s narrative about the experience of health, later discussion with her to identify the essence of health showed this to be the most significant and essential component of health for her. For Sally, the essence of health is vitality or that which gives zest to life. Sally acknowledges that this feeling of vitality is related to energy but is not limited to it alone. She provides three highly descriptive accounts where she depicts the vitality that she sees as essential to health even though the word ‘vitality’ is not mentioned in the descriptions:

- **When I’m feeling really healthy, I feel alert, I feel alive; I’ve got energy and everything is good. It doesn’t matter what happens during the day, it doesn’t bother me.**
- **I feel refreshed and a lot more alert. Everything is so much better.**
- **When you feel really healthy you just feel so much better. You just glow, you go out and it’s nothing to do with being either fat or skinny, you still glow. Your skin glows and it shows in your smile and your eyes light up and you just look much better. Even if you wear the same clothes, your hair looks shinier and you look neater, fresher. When I’m feeling really healthy, I feel like I look good, so that when I go out it just comes out naturally, anyhow. I wouldn’t have to fake a smile or pretend I’m being happy because that just happens [naturally].**

Shortly after Sally described health in these ways, an incident occurred that showed me the nature of vitality as Sally had depicted it. I was driving past a neighbour’s house when he was in the act of getting into his car together with his seventeen-year-old daughter and several of her friends. The girls were laughing and joyous. They appeared to be embued with vitality and I recognised that there
before me was a pictorial representation of vitality as Sally had described it. It contained elements of exuberance, energy, enthusiasm, joyousness and a feeling of life being lived to the fullest. There was a quality of excitement and anticipation to this vitality; it posed the notion that life was more than work and day-to-day things, that it might present fortuitous opportunities at any moment.

An examination of the word 'vitality' does not, however, support the image of abundant zest for life that characterises health for Sally or the picture presented in the description above. Etymological examination of the word shows that although it has come to mean ‘physical or mental vigour’, the original meaning was ‘the peculiarity distinguishing the living from the nonliving’ (Webster’s Dictionary, 1983) which in no way expresses the verve and vigour of Sally’s view of health as vitality. The word vitality as used in nursing also infers living or nonliving, since to take a person’s pulse or blood pressure is to record their ‘vital’ signs. For this reason, while for some the word ‘vitality’ may bring to mind potent images of zest and vigour, for others it may carry images of life seeping away. Perhaps zest is a better word for vitality as Sally sees it. A review of the word ‘zest’ shows that it is used to refer to orange or lemon peel used as flavouring. In this context then, zest might mean ‘that which gives flavour to life’ and this is indeed the way that Sally uses the notion of vitality.

Vitality can be seen to be an ambiguous word; not a ‘weasel word’ as Crotty (1996a) denotes them, but one which perhaps does not clearly convey all that Sally means in relation to health. Nevertheless, focusing only on the idea of health as vitality, I consider the images that this word brings to mind and compare them with what I know of health. Vitality brings to mind images of the exuberance and enthusiasm for life that is commensurate with abounding health. Vital is the way one could describe the ‘picture of health’ that Sally relates above and, when picturing such a healthy young woman, the poet Byron’s phrase ‘a lovely, vital creature’ is not inappropriate. The words ‘vital’ and ‘vitality’ then convey something of the urgency of that rush of abounding good feeling that
comes with health in one’s life. This is not to be confused with those rare moments of elevated feelings, not to say elation almost, which many, if not most, individuals experience from time to time. Such moments are generally very fleeting and relate more to moments of beauty and / or tranquillity in one’s life than they do to an encounter with health. One may have such a moment in the midst of ill health or distress or during periods of great strain. This is not to say that such moments may not be more frequent in health than in unhealth; it is to be anticipated that they are, since health as balance or peace may enable one to be more open to the tranquil moments in one’s life. However, to my knowledge, such distinctions have not been studied and there is no empirical way of knowing whether health increases these fleeting moments of elevated feelings or not.

**Health described as happiness and/or contentment**

Several of the participants described ‘feeling happy’ as part of the way health presented to them. Bill described his encounter with health as feeling relaxed, happy, energetic and enthusiastic while April also linked health to happiness:

*When I’m healthy like this, I feel like smiling, it definitely makes me feel happy.*

In addition to Bill and April, Sally, Anne, Sarah and Didi all described happiness as an essential component of health while Anne and Sarah also used the word ‘contentment’ in relation to their descriptions of health.

Attempting to visualise health as happiness was quite difficult. In each of the final sessions, the participant and I attempted to reach beyond embedded meanings and cultural norms and try to ‘see’ precisely if and how health presented as happiness. However, the distinguishing characteristics of health as happiness could not be clearly articulated by any of the six participants who mentioned health in this form, although Sally’s descriptions given under ‘vitality’ served to give some sense of it. This overlap shows how the divisions used for this discussion are, in a sense, artificial. None of the participants were able to go beyond the description that ‘feeling happy’ was an essential part of health.
So what would health as happiness mean? The word ‘happiness’ means ‘a state of wellbeing or contentment’ as well as ‘favoured by luck or fortune’; ‘notably well-adapted’ and ‘a pleasurable satisfaction’ (Webster’s Dictionary, 1983), descriptions which could reasonably be applied to health as well. The first of these, ‘a state of wellbeing or contentment’ is easily recognisable in several of the descriptions of health given in Chapter Five. The second, ‘favoured by luck or fortune’, was specifically mentioned by Sarah in relation to health when she said:

\[
\text{Because I'm a nurse, [health is] also about feeling lucky since you go to work every day and see people who are sick, you think 'that could be me'; that puts a different slant on it.}
\]

Although none of the participants actually used the term ‘well-adapted’, Anne and Rick came close to it in their descriptions of health. Health as ‘a pleasurable satisfaction’ could also reasonably be seen in health as feeling good about oneself.

The similarities between the notions of ‘health’ and ‘happiness’ for these six nurses are then significant. It seems that in describing health as happiness, the participants in this study have indicated a notable move away from the bodily emphasis that was traditionally held to be central to the meaning of health in health care.

The word ‘contentment’ is not a difficult word to place in relation to health as it means that desires are appeased or that there is a feeling of satisfaction with one’s situation (Webster’s Dictionary, 1983). This accords well with what Anne, Charlotte and Sarah attempted to convey; that in health they found that nothing about their state of physical or emotional being required to be changed or amended. In this way the notion of health as happiness or contentment is related to health as peace and balance, since a feeling of satisfaction with a situation generally means that one feels balanced and at peace with the way things are.
Health described as quality of life

Charlotte described the presentation of health in her life as a feeling of wellness and ‘togetherness’, as feeling that all the threads of her life were connected and as feeling integrated and functioning well. This resulted in her feeling valued and good about herself, a notion that overlaps with Sarah’s notion of health as feeling good about oneself. In Charlotte’s case, however, she described feeling valued and good about herself as the things that enabled her to live life and take care of herself. Charlotte described health then as that which gave quality to her life and said that, for her, health is quality of life.

Rick described health as being ‘mentally motivated’. This motivation was characterised by a feeling of having all the components of his life in ‘balance’; a notion that displays again the overlap within the headings used. However, in the context of his description, the sense of what he was describing was that these were the aspects of health that made life worthwhile. He described health as feeling accepted by others as well as accepting of others, feeling wanted, and as comfort, all of which give him a quality of life that was only found in health.

While these two presentations of health as quality of life are different, what is similar about their descriptions is that health is seen as a composite mixture of feelings that lead to life being viewed as valuable and worthwhile. Health, then, for these two participants is that which makes life worthwhile; it is what gives quality to their lives and allows them to live life with gusto and enthusiasm.

The ‘picture of health’

In one form or another, most of the participants expressed an understanding of health as something that can be seen. This notion is represented also in the phrase ‘the picture of health’ which is commonly accepted in the English language. To say someone is the ‘picture of health’ conjures up images of a presumably healthful person. Examples of the visibility of health can be seen in the following
extracts from the narratives:

[Health] looks like happiness (Sarah)

“When I feel really healthy I just glow! I go out and I feel good. I mean, it’s not to do with being either fat or skinny; I still glow. My skin glows and it shows in my smile and my eyes light up and I just look much better even if I wear the same clothes. I don’t know. My hair looks shinier and I look neater, fresher! When I’m feeling really healthy, I feel that I look good so that, when I go out, it just comes out naturally anyhow. I don’t have to fake a smile or pretend I’m being happy because it happens naturally! I just feel happier; I feel alive and I really enjoy life.” (Sally)

[When you’re healthy], attractiveness comes through. (April)

When I’m healthy like this, I feel like smiling. It definitely makes me happy. (April)

When I’m healthy and balanced like now, my skin feels clear, I feel as though my mind is clear, I have energy, I have a great deal of concentration, I’m very awake! I’m very happy also. I’ve got a pretty sharp sense of humour and that’s at its peak when I’m healthy. (Anne)

However, looking at health as the fulfillment of an accepted norm or standard is against all the principles of phenomenology. Nor does the assumption of a picture of health merge well with all of the descriptions of health given by the participants in this study or with what I know from personal experience. Rather, what is required is to go back to the thing (health) itself to see if health is indeed something that can be seen.

In relation to this last point, a very persuasive example was given to me some years ago. I was caring for a woman who was the mother of four adult sons. The eldest son in this family was an extremely obese and unhealthy-looking man in his mid-forties whose health history was described as ‘poor’. In discussing her son, she told me this story. He was her first-born child and she knew almost nothing about the raising of children. The nurse at the child health clinic commented to
her that a chubby baby was a healthy baby ... and so she fed him ... and fed him until he was the epitome of 'the healthy baby' that had been described to her. She related that later, however, his weight had always been at least twice that of his school contemporaries and he had been precluded from many activities by his lifelong weight problem. Although the realities of this story may never be revealed, it is an ominous tale and one that has stayed with me over many years. For it says very clearly that the perception of something (in this case, health) may be mistaken, may be culturally constructed and thus open to different definitions and possible change and re-visioning. Consequently, while it may indeed be possible to paint a picture of health, such a picture may not always be reliable and therefore the visibility of health cannot be said to be essential to the state of health.

**Health described as dignity**

The notion of health as dignity was present in April’s discussion of health although she does not specifically mention the word ‘dignity’ in her description of her experience of health. However, dignity featured largely in her description of ‘health care’ and gave rise to the sense that, for April, dignity was an essential component of health. Despite the fact that she was resolute about its relationship to health, April was unable to give a clearer picture of what was meant by dignity.

Subsequent to April’s description and unable to understand fully the meaning of health as dignity, I expressed my inability to get this notion clear in my mind to a colleague. He immediately embarked on a discussion of the notion of health as dignity in his own life. For him, dignity implied that all of the aspects of health discussed in this thesis: balance, feeling good about yourself, energy, vitality, peace, contentment and quality of life are present. He described dignity as *the* most essential characteristic of health in his life.

Reflecting on this notion of health as dignity, I recalled clearly a man I had nursed many years ago. My patient, whom I shall call Mr. X, told me when he first came
into my care in the latter stages of a terminal illness that he intended to ‘die healthy’. Pursuing the meaning of ‘dying healthy’ with him showed that he also referred to the notion of health as dignity.

Mr. X explained that, for him, dying was not exclusive of health. To ‘die healthy’ meant that he would be able to maintain a balance between the demands of living and the demands of his illness. As I recall it, he expressed it thus ‘I do not want to spend all my time in the next few weeks concentrating on dying. I want to balance that out and concentrate on the living that I’ve got left to do’. He requested, indeed insisted, that we should enable him to nurture his energy for the things that were important to him. He wished us to find ways for him to take ‘time out’ from being a ‘patient’ so that he could achieve some ‘quality’ in his life, to allow him privacy and to treat him at all times with dignity. Despite the fact that breathing was difficult for him and he was in considerable pain at times, he managed to laugh often and be joyous (vitality). He managed to pray and to reflect on his life, to have ‘time out’ (peace), to dress while he still could in his own clothes and manage his routine so that his feelings of autonomy and dignity were maintained. In the weeks he was in our care, I recall only one time when he felt that his aim of ‘dying healthy’ was not achievable. That event resulted from an incident with a nurse who ordered him to behave ‘like he was in a hospital, not in some private hotel’.

The word picture above is expressive of dignity, but is it also expressive of health? Dignity is ‘the state or condition of being worthy, honoured or esteemed’ (Webster’s Dictionary, 1983). Extrapolating from that meaning, it can be seen that there are similarities between dignity and health. In its conventional form, dignity relates only to the way a person may be regarded by others, however, in the case of health it may also relate to the way one regards oneself. This way of viewing health appeared to carry a judgement or an assessment of the state of health that I found myself less than comfortable with.
Is the word 'dignity' expressive of the essential meaning of health for the participants in this study? I was only able to access an answer to that through an examination of what I now see health as being through the descriptions that are part of this study. If health is indeed composed of feelings of peacefulness or quietude, feeling good about yourself, balance, energy, vitality, happiness or contentment and that which gives quality to life, are all these, together, commensurate with dignity? While it may seem that they are, I am not convinced. Just as I witnessed the man described above, I have witnessed others who, while they certainly had dignity, were not healthy. For all of the ways that health has been identified in this thesis, the questions must be asked in reverse. For example, the question must be asked 'Is health balance?' but also 'Is balance health?' When viewed this way, it would seem that while health may imply dignity, dignity does not necessarily imply health.

Health as the unknown or the inexpressible

For several of the participants, in particular Bill, Rick and April, there was an unknown or inaccessible quality about health which meant that they found their experience of health very difficult to describe. While the majority of the participants said that they had rarely thought about the meaning of health before, both Bill and Rick indicated that there was an unknown or inexpressible quality about health. For them there were areas of deep significance that might lie in the perusal of the meaning of health that were beyond them. The nature of their descriptions, and the ways they searched for words to express what they assured me they had experienced, showed that, for some, the experience of health evades adequate description.

SUMMATION

Taken together, Chapter Five and the discussion here in Chapter Six show that health, while it is certainly a physical, embodied state expressed as vitality and energy, cannot be separated from the mental/emotional state of health. This
mental/emotional state is composed of optimism or hope and by a feeling of being able to cope with the potential vicissitudes of one’s immediate future. It includes a feeling of happiness or contentment with life as it is in the present moment and recognition of preparedness through rest and relaxation to be able to meet life’s challenges. Together, all of these qualities of health serve to make the tasks of life more achievable.

Prior to engaging on this section of the thesis, I had to some extent regarded statements like the need to ‘dwell in the data’ and ‘allow the sense to emerge from the data’ (Sandelowski, 1996) as poetic ways of referring to analysis. After working with the data for weeks and months, reading and re-reading, writing and rewriting, coaxing the data to tell their stories of meaningfulness in a clear way, the term ‘dwelling in the data’ has taken on new meaning. I have discovered that there is no other way to explain the way this analysis was completed than to say it was achieved by being engrossed in, absorbed and preoccupied by the data.

For all that the data have told a story of meaningfulness, however, I expect them to convey different things to the persons who read this work. This has been one of the primary lessons of phenomenological study. Participants’ stories frequently conveyed a breadth of meaning beyond what the participant themselves could see. At the same time that I saw, I was nevertheless also blind to the nature of health as revealed, and despite many readings, each time I read the narratives, a fresh aspect of the nature of health was disclosed to me.
CHAPTER 7

THE PHENOMENON OF HEALTH-FOCUSED CARE

This thesis had a twofold aim. The first of these was to describe the phenomenon of health for nurses who were educated about health promotion. The second aim was to explore the phenomenon of health-focused care via participants' descriptions of the experience of giving 'health' care.

As in Chapter Five, the narratives of experience mirror the contents of the interviews and the descriptive words and phrases are an exact reproduction of those used by the participants. In this case, however, what the participants have described is what health care means to them as they have learned about it, rather than what the experience of health-focused care is like in their immediate, primordial experience. The differences between the narratives of health and the narratives of health-focused care are considerable since the latter contain few, if any, descriptions of immediate experience. Despite considerable discussion and searching questioning of participants in an attempt to identify what health-focused care was like, the narratives of the experience of giving health directed care illustrate that such health care is, by its very nature, a learned phenomenon. Although this made exploration in the traditional phenomenological mode impracticable, description within the American continental mode appeared entirely feasible.

The narratives in this chapter, however, capture explicitly what it is like to give health directed care. For that reason, this chapter makes no attempt to describe what health-focused care is like within the parameters of traditional phenomenology since such description is dependent on recall of immediate experience. Analysis of the phenomenon of health-focused care is, however, conducted in the somewhat more subjective mode of the American continental approach. This is done through a thematic analysis, and analysis of exemplars.
and a search for paradigm cases among the data provided by the narratives of the experience of health-focused care.

THE NARRATIVES

Anne - the experience of giving health-focused care

I was caring for a patient who was admitted for a total hip replacement. She was very nervous about the surgery, as was her husband who accompanied her. He asked when she would come back to the ward after the operation and, when I replied that she would be going to the High-Dependency Unit (HDU), you could see from the look on his face that they knew nothing about the operation. So, I had to start from the beginning and tell them what would happen for her. I took them down to HDU and told her about it, that there's a doctor present all the time and a nurse who would look after her and one other patient. I explained that HDU was the post-operative care unit and all patients went there for twenty-four to forty-eight hours post-operatively, or until they were stabilised and in good shape to return to the ward.

HDU was empty, so it was quiet. I showed them around and explained where her bed would be and where the doctor sits and that her husband could come down and visit. He sounded relieved at that. We walked through the ward and suddenly she asked if the operation was very painful. I replied honestly, that, yes, it is a painful operation. Part of it was being honest and admitting that what she was to have done was a very painful operation, but also there's no point in kidding people and telling them that everything will be all right. So I explained to them that because she would be expected to have pain, she would be under the care of the Acute Pain Service Team - a group of experienced doctors and nurses who would manage her pain treatment. I told her that she would either have a PCA (Patient Controlled Analgesia), a morphine infusion or an epidural. I explained it as 'Something that will suit you, personally, to help the pain'. She discussed the fact that she didn't really want an epidural and we agreed that she could discuss that
and her pain management with her anaesthetist. I also gave her a booklet describing the surgery and arranged for her to watch an information film.

I showed her how we use the adduction pillow and the way we would roll her when we wanted to move her. I told her [that] she would be in bed for the best part of three days. We looked at the foam booties that are used and I explained what they're used for. I just gave her a general but detailed tour of all the paraphernalia, so that when the nurses produced a triangle shaped pillow or whatever, she'd know what it was and what it was for.

Pre-op education is the only way to go because after the event is after the event. That's damage control then! That's getting them better but this [pre-op education] is what health care is. If she had pain, she had to know that the only way we could help was if she told us [about it]. I explained to them that morphine is the post-operative drug of choice but that sometimes people have had an adverse reaction to it in the past and, if that was the case, they must tell us. I didn't go into a lot of detail about the medications used, except for morphine, because many people have a reaction to that. I told her exactly what she was going to have, [about] all the drips and drains and when they'd all be removed. When I told her about her bowel prep, she screwed up her nose. I pointed out that when you're not eating much or moving very much for the best part of two or three days and you haven't had your bowels opened for a couple of days beforehand, you end up constipated and very uncomfortable.

We established quite a good rapport and it seemed to take a bit of the fear away for her. They were a really nice couple who had been married for a long time and they doted on one another. For her, it seemed that the worst thing was that they were going to be apart and I really felt for both of them. That's partly why I took them both down to HDU, so they were both quite clear about what was going to happen. I wanted to make it as un-intimidating as possible, the least frightening I could make it, because she was worried about him as much as about herself.
I don't usually have any problems speaking and I don't find it hard to find things to say, so doing it was easy. I felt confident in the fact that I know I can prepare people properly and I can get everything in, you know, the hospital requirements and the admission procedures as well. She didn't talk a lot and neither did he, but I knew that they were listening. It seemed to me that she was more relaxed because I'd taken the trouble to explain everything while her husband was there to hear it as well, and he seemed to feel better about her having the operation, as well. They didn't say very much because they were very quiet people, but at the end when I walked away, I had a feeling of having done well.

April - the experience of giving health-focused care

Example 1: Some years ago I was caring for a newly retired schoolteacher who had come in to hospital for removal of kidney stones. One of the stones had a very sharp edge and it couldn't be removed without doing damage; it stripped the lining of the ureter. They had to do a surgical repair of the damage that was quite a big job, so he came out of surgery in pretty horrendous shape. I had to care for him, work through it with him and help him to get back to normal. He was in such agony, and in such a ... he was in a mess, there's no other way to describe it.

When I look at someone who's not clean and not fresh and not rested and all that goes with that, what I see is a mess. So I spent a lot of time with him, a lot of slow time, working through transfers, showers, positions. I'm not sure how he was eating, or what he was eating or even whether he was eating ... but it took a long time; it was a fairly long haul, to get him better. I can remember I wanted him to be presentable. I wanted him to be like he would want to be when he had people coming in to see him. I wanted him to be fresh and clean so that he need not feel embarrassed about this thing and that thing, so he could project that he was okay and that he felt reasonably okay about himself.

I don't think I saw him discharged and I'm not sure how long he was in hospital. But while he was there, helping to restore his dignity was the main thing in his
care, for me. Men, especially, find it hard to be so dependent and so out of control. Helping to restore his independence and to feel back in control was the whole objective for me. I was trying to hand it over to him, trying to allow him to do things all the time. Other than that, the details of his care are not really clear in my memory.

*Extracts from Example 2:* Last Thursday was my first delivery and it was very much a learning experience. My clinical instructor made me feel so confident and the actual delivery was very neat and tidy; that's the only way I can explain it. It was controlled! The next day, I used the skills I'd gained with a less experienced instructor but I'd gained from the experience of the day before. Caring for the woman mainly involved trying to maintain her dignity while she was in labour and talking to her and trying to help her feel confident enough to keep going - supporting her. [Everything was going well] then she had to move onto her back for a vaginal examination ... that was horrendous. It just happened so quickly and her dignity was down to zero when he was doing the examination on her; she had this look on her face of just total horror!

When she was sitting up she could make eye contact with people but when the doctor came in, she had to lie on her back. The doctor didn't even speak to her. He didn't come in and talk to her, he just stood back and talked at her, and that didn't permit her any dignity at all. Then we had to take away her independence and put her flat on her back and it was almost as if her head was downhill. She was just lying there and suddenly we'd ripped away all the good things that we were trying to do for her, like maintaining her privacy, maintaining pain relief with gas and getting her up and helping gravity to work for the baby. All of those things were just suddenly yanked away. It was like all of a sudden her dignity was just stripped away, and there she was flat on her back. She didn't move from that position until after she'd had the baby.

When I talk about her dignity, cleanliness wasn't the issue. It was that she had all
her support, her regime and her sense of control taken away from her. The things she was doing to try and maintain her function in labour were all taken away from her. I think the things we do to maintain ourselves, and having the ability to do those things, makes us feel dignified. It was like she was isolated. She couldn't maintain herself. She couldn't even give herself some pain relief because she couldn't access anything.

I think the delivery position made a big difference to the two experiences. She was in that position because she'd just had a vaginal examination. Once she'd had the examination, she became transitional and it was like she couldn't move from that position; there seemed to be no way she could be moved. She was in such a position that we had the whole bed between the baby and us. She wasn't just half way over the bed; she seemed to be up on the furthest third of the bed, away from us.

It was very different to the day before, which had been very controlled. On that day, the girl had an epidural and she only had one top-up before she delivered. She didn't have to have her membranes ruptured and the instructor did the vaginal examination when I was out of the room. The instructor was very well prepared and the girl was focused on us and on what we were telling her. She responded well and worked with us. She was in a good position on the bed and that was because we were so well prepared.

Bill - the experience of giving health-focused care

Basically everything I do at work is related to ‘health’ care. I mean, for me, fooling around with the kids and making them feel better is all part of it - just making them more relaxed is health care. There could be nothing worse than being a kid in hospital, but to have someone who will play around with you just makes it so much easier to stay there. They're in hospital to get better most of the time, so anything that helps them to do that is good. That's a big part of care for me and I think that's why I act like a kid when I'm at work. Firstly, I love doing it;
it's just me anyway. But also, if I was a kid in hospital, the last thing I'd want would be a starched-up sort of nurse ordering me around; you know 'Get back to bed!' that kind of thing.

Kids just want to hang loose! I go to work and they'll say 'Oh yeah! (said gleefully) Can you look after us today Bill?' That's if they can talk; a lot of them can't because we have a lot of children with cerebral palsy on the ward but they show that they like it in other ways. That's a good feeling for me when I know that they can enjoy being in hospital. I mean, I know they don't love it, but if it's better for them to be in hospital than not, it's good that they enjoy it because having fun is helping them to get better. It makes them more compliant too.

When I say 'playing around', I'm just loud and I joke around a lot. I make fun of the kids to get a laugh out of them. They love it when people make jokes and they say 'Oh, you're such a wuss, aren't you?' It's hard to describe, because it's just what I do. It's just me, being myself. I just act the way they want me to act, so I play up to them; they'll ask me to do something stupid and I will! I throw things at them or sing. I go in there doing stupid voices or I squirt them with water, you know, get the syringes out and just run amuck! The clean-up work after it is the worst part of my day other than notes, but it's worth it. Of course, if they're not interested in clowning around, I don't force it on to them; I just leave it. A lot of times when parents are around the kids don't join in, but as soon as the parents go you notice a change in them. It's like they have to inhibit all this energy.

One particular case I remember was a twelve-year-old girl; she came in with a neurological disorder and her symptoms included peculiar skin sensations. She was scared at first, very anxious and scared because at her age she knew what hospitals were about. Because she was so scared, I just started joking around with her. She was the same age as my niece so I sort of knew exactly how to act around that age. I got her relaxed, got her into it, you know, to be able to have a good joke. Then she could tell me when she was having the funny feelings under
her skin. Eventually, a brain lesion was diagnosed and she had to keep coming back to be treated. But it was quite devastating, for her and for the family before they knew what was happening to her.

I was just there kidding around and being stupid during all that time, partly because I'm not all that good with that kind of thing. When people start crying, which they don't do very often, but if they do, I'm not much good with that. I just sort of have to look away and ... just leave it. I get annoyed with myself because I don't know what to do. I don't walk away, I try my best to comfort them, but I just know I'm not doing a good job. I can only go back to my kidding around kind of behaviour and I don't do that because it's not appropriate at the time. I mean, I don't try and pretend that everything's going to be okay, because that's just a lie most of the time. I just try my best, but most of the time it doesn't seem good enough when people are really upset.

This girl did get upset and she didn't want to see anyone, but I kept coming in to her room and I forced myself on her, basically. I just kept coming in and annoying her, kidding around with her. I find that's helpful, it annoys them so much that it breaks them out of it a bit. She used to say 'Just leave me alone!' But I just kept coming around and I'd say 'Oh, yeah! Well I'll go out, but I'm coming back in again.' Basically, I was saying 'You're not getting rid of me!' She was in a room by herself so me arguing with her didn't matter. I don't know if it helped or not that I was so persistent in giving her the message 'I'm not letting you get away with feeling sorry for yourself.' Of course, we gave her all her medications and did all the task-oriented stuff, all the chore stuff as well.

Her mother was with her all during her first hospital stay, and I just acted in a similar way with her as I did with the girl. We joked around, the girl, her mother and me. She was pretty easy-going, sort of country and easy to get along with - really nice. It was the joking around that helped us all I think; we're not grief-stricken kind of people. She knew that if she had any questions she just needed to
ask, but we all ganged-up and clowned around and I think she appreciated that. We'd just chat and joke and she knew that her daughter was being well looked after and that she was having a good time. I think all that helps.

Now, she comes in every month for infusions and it helps her to know that the same staff is going to be there, looking after her. She knows exactly what to expect from me. She knows that she's going to get a hard time from me as soon as she walks in the door, but she's okay. I don't want this to sound stupid, but all the young girls make a big thing of me because I'm the only male nurse on the ward. I get hassled a lot about this. She loves having me looking after her; she jokes around with all the staff that she knows well, but as soon as she sees me, she shrieks and runs off. She's told me that she loves the teasing and joking and I think it's really helpful for her because she's got to keep coming back [into hospital]. Just to know that Bill is going to be there is helpful for her. She said to me 'I actually look forward to coming in; I count down the days.' I mean, we're good mates, sort of like Spot and Tom.

Being in hospital is not like being at home. The kids wouldn't get away with what they do with me if they were at home, so I'm spoiling them I suppose. We encourage them to bring in their music and videos and whatever they like but it's hard to make it homelike when they're in a room with six other kids, especially when we've got doctors coming in constantly and treatments to do. We try and stick to their routine if they've got one but they have a school at the hospital, so it's not like being at home; for half of the day it's more like being at school. The other thing is that you don't get sick at home, generally.

**Charlotte - the experience of giving health-focused care**

To me, nursing occurs when you can relate to someone. I have a lot of difficulty, even now, understanding the concept of perioperative care. So I'd like to relate the question to looking after someone in recovery room rather than the operating room. I'll take it from the time that this particular patient was emerging from the
procedure, right after spitting out the airway up to the time that he was discharged from recovery room.

You asked me what was it was like. Well, apart from airway assessment and things like that, I was thinking about what I'd set out to do. I try to do pre-operative visits so I can meet the patient, introduce myself and let them see who I am and that I'm the one they're going to see when they wake up. I tell them about pain! I used the word 'pain' when I was talking to this man and I told him he probably would have pain and that if he did he must let me know. I told him to talk to me, communicate with me, that I could do something [about his pain] if I knew [about it]. I explained a little bit about positions [and] that he might be lying on his side or whatever. I tried to establish a rapport with him so that when he woke up [in recovery room] and opened his eyes, he'd sort of look at me and think 'Oh, yeah, she's the person I saw before'. I like to think that that gives people a sense of reassurance because I think there's a lot of reassurance needed after surgery. I like to reassure patients that it's okay, that I'm going to be with them, that I'm not leaving them and they're not going to be alone.

This particular man had a lot of pain and I was trying to get him to relax a bit so he could communicate with me. He was frightened and I don't know whether he was disoriented or whether it was a combination of that and the fact that he had a lot of pain. He'd had a major bowel procedure with minimal analgesia on the table. He was also extremely cold for obvious reasons after a bowel resection where his bowel was exposed during surgery; so not only was he frightened, he was in a lot of pain and he was shivering with cold. I was just trying to fix all those things. I was feeling very sympathetic towards him. Not empathetic, sympathetic! I was sort of thinking 'You poor wretch!' and I was talking to him, trying to make eye-contact with him, trying to look him in the eye and reassure him that he would be okay. I was trying to communicate to him that he could trust me, have faith in me, that I could make him feel better. I wanted to say to him 'I can make you feel better, I can make you more comfortable if you just give
me a chance; just let me do this, this, and this.’

I talked to him; I like to think that talking to a patient helps. You can talk them through a lot of things in recovery room, or that’s my personal belief. I think if you can establish some sort of rapport through eye-contact, establish a relationship, although it’s minimal and only for a short period of time, you can do a lot for patients in recovery room. I really worked hard at eye contact and establishing rapport. I said ‘Look, you saw me before and it’s okay; remember, I told you this was how it would be’, I wanted him to feel better, to feel safe. I knew I couldn’t take away all his pain because I couldn’t give him the amount of narcotic or analgesia to do that completely, but I could start that. I wanted him to be warm, to stop shivering so that his oxygen saturation could be maintained above 90; that would have been really nice.

When I have a patient like this, I become a bit single-minded because that’s my patient. I feel like I own that patient for the time being, if you want. I feel I have ownership of that patient in the sense that I’m responsible and it’s up to me to discharge him out of recovery room when I have done absolutely everything I can for him in the time that he’s in my care. I tend to feel a little bit irritated and a little bit stressed if there are interruptions to me doing that for that patient. When I have a patient like this in recovery room, I refuse to accept any other patient because I think that these patients need one-on-one care.

That’s what it was like with this man and it took me two hours to get him settled enough to send him back to the ward. Normally, I would have expected him to be discharged from recovery room within an hour, one hour maximum! It took me over two hours and I started to feel really stressed. I was asking myself ‘What am I missing?’ ‘Is he bleeding?’ ‘Is he doing something that I’m not identifying?’ ‘What is going on here?’ For obvious reasons, he took a long time to be able to focus and hear what I was saying; he had pain and he was frightened and he was just emerging from anaesthesia. But I knew that if I could really get in early and
get him to listen, I could get him settled and he’d be more comfortable. But he
couldn’t and I couldn’t get him comfortable; it took me two hours! I was
surprised because, when I did the pre-op visit on the ward, he was very open and
had a bit of a laugh and made good eye contact, so I wasn’t expecting him to have
such a hard time in recovery room.

He had as much narcotic on board as I could give him. He was wrapped in space
blankets to warm him up and I held his hand to try and reassure him. In the end, I
got his wife down. I thought ‘I’m not winning here; perhaps someone else can get
through to him’ and I got his wife to come and sit and just hold his hand. That
seemed to help. I think he could identify her and I think that was reassuring. She
was someone from family, someone he really knew, not just this funny person
with the hat on. I wanted to make him as pain-free as possible for him to
commence his first twenty-four-hour period on the ward. That’s the type of nurse
I am; I work in an operating theatre and we’re very blinkered. I know I don’t look
at care long-term, other than perhaps making the patient as pain-free and as
comfortable as I can for the next twenty-four-hour period on the ward. So, when I
sent him back to the ward he was in as good condition as anyone could have got
him in recovery room.

I believe that patients get out of hospital quicker if they have good post-op care.
At the moment, that’s only my own experiential belief. Although I don’t always
get time, I endeavour to go back afterward and check on a patient’s progress.
After I’ve worked in recovery room, I go back the next day and see the patients
I’ve cared for who are still in hospital. I tend to be a bit nosy and have a look
through their charts to see how the first twenty-four-hour period has gone. I want
to know, specifically, whether they’re feeling comfortable, how much pain
they’ve had, how much narcotic they’ve needed and whether they’ve been
vomiting.

I firmly believe if those things, pain, warmth and nausea, are under control before
their discharge from the recovery room, that sets the tone for the next twenty-four hours and possibly for the speed of their recovery. That’s just my own anecdotal belief; I did a sort of survey although it wasn’t documented. For a period of time I went and did both pre-op and post-op visits and checked on patients’ progress personally. Then, I deliberately let a week go by where I didn’t do the pre-op visits; I didn’t try to establish rapport with patients coming through recovery room. There was a marked difference in pain levels and in how patients coped in the first twenty-four hour post-op period between the two groups, so I know why I do it the way I do. It gets back to what I said previously about ownership and responsibility. I take ownership of those patients in recovery room and I feel very responsible for them because they have no control. They have no control and I take responsibility; in a way, I reflect what I would like if someone were looking after me.

Didi - the experience of giving health-focused care

I was nursing a new mother with her first baby and she was extremely unsure and nervous. It was just all so new for her that she gave me the impression that she could hardly touch her baby, she was so nervous.

She had a very short labour. It was funny, no one really thought she was in labour and she ended up having the baby about 40 minutes later. She asked me ‘Was that the way I was supposed to do it?’ (said very hesitantly). She had been hospitalised for hypertension and said she was uncomfortable when she was walking around. This is the way she told me and I can see her face as she was telling me this. ‘I was walking around Didi, and ohhh, I was really feeling uncomfortable. I thought that I wanted my husband to come in, so I got the nurse to ring him up and he came in. Then they took me round to labour ward and I was feeling really uncomfortable’ and an hour later she delivered the baby. And she said to me ‘So, do you really think that I was in labour? It must have been that I was in labour, Didi, wasn’t it?’ So, I said (laughing) ‘Oh, I think so, yes!’ ‘Yes, because I was really feeling uncomfortable.’ she said ‘I really was, and they kept
saying 'Oh, no, you're not!' but gee, I was feeling uncomfortable and it wasn't really like what you read, you know.' I told her that people often say that it's not like what you read and to remember that everything is individual, even labour; that the most important thing is to listen to what you feel, to listen to your body, tune in to your body.

She just looked at me with these big wide eyes, just looking and making an amazed face, and then she said, 'Well, was it really a labour do you think?' I thought 'Does this woman know what's going on?' But then I realised that she did, but that this was nothing like she thought it was going to be. [I could see] she wanted somebody to legitimise her labour, so I said to her 'That was your labour! That's what your labour was like, that's how it was for you' and I told her that her next labour might be the same or it might not. She needed to feel good with herself that she'd done it. No one did it for her; she delivered her baby; she went through the labour. She looked surprised; she was very unsure. So I said to her 'You've got to realise that you did it.' because I think sometimes we don't say that. We say things like 'I delivered the baby.' I've fallen into that trap of saying, 'I delivered the baby'. We don't deliver the baby; we just stand there!

She was up and about from the first morning, asking me 'Should I stay in bed? Didi, should I stay in bed?' I told her she could get up and do whatever she felt comfortable doing, and go back to bed and sleep whenever she felt tired. I try to make sure the mothers have a sleep during the day; it's important to tell them it's time for them to rest.

Her family lives overseas, so she didn't have her mother with her. They'd only been here for three years so she had few visitors except for her husband, although she does have a sister here. But her sister had a ten-day-old baby so she was pretty much alone while she was in hospital. Her baby was only small and she was worried about that. I asked her to tell me a bit about herself and whether she had ever had any contact with babies, to find out what she knew. She knew very
little! One of her nipples was flat which made it difficult for her to breast feed, although she was keen to do so. You could see that she needed a lot of reassurance and a lot of time spent with her. That was the most important thing, that I actually took time. I really had to recall all of my knowledge and try to anticipate her needs and really, really listen to what she was saying to me. I had to really watch what I was saying as well because she took things quite literally; we had quite a lot of education to get through with her. It was quite intensive care and I had another client across from her who had the same sort of needs but was a little more confident than she was. The other one was just that little bit more confident that she was going to do a good job.

She was so unsure; just watching her and asking her a few questions, not challenging questions, but watching her as she communicated with me, you could see how unsure she was. Each day, I could see how well she was progressing and how, after a while, it was no problem for her to pick the baby up and be able to put it to the breast herself. Before, I had to support her in that. At first, she used to wait until I was there before she’d start to do things. After I’d taught her things, I’d give her little quizzes. I’d say, ‘Now, can you remember ...?’ because I felt that she needed to hear it from herself, not from me telling her what to do all the time. When I’d ask her a question, she’d give me the answer and then she’d say ‘How am I doing?’ and I’d tell her she was going well. Then I’d see the look of achievement, like ‘Oh, yeah. I do know how to do that.’ and I could see she’d feel better. I believe that you can’t do things for people, but you can’t stand there and watch someone almost lose it either, when all you need to do is just give them a little bit of reassurance and spend time to talk to them.

One particular incident that happened during the first days was when the baby was due to be fed. She was using a nipple shield, and she picked up the baby and got her ready, but she had forgotten that the nipple shield was out of reach. She had to stretch across a long way to get it and she was so unsure, she couldn’t work out if she was doing it the right way. On top of that, because the baby was only little,
she couldn't open the baby's mouth, so she was really struggling. Trying to put all the motor actions together was very difficult for her, so I spent time to explain to her how to hold the baby and about positioning the baby's mouth for feeding and then asked her to demonstrate it to me. I guess you draw on your own experience. I told her that when babies are little, you think they're going to break, but really, if you handle them this way, they're okay and I'd demonstrate it to her. [It was] just validating with her, I suppose, that this was all a bit scary and at first you don't really know how much you can toss the baby around. [I was] using humour and things like that but including the basics of caring for a baby like telling her not to turn her back on the baby when she put her on the bed.

Sometimes I thought, 'Oh, God, am I doing the right thing? I hope it's not too much; I hope I'm not overloading her.' because I didn't want to take over. Nurses tend to be control freaks at times, so I wanted to avoid that but sometimes there is a fine line between doing that and letting someone's confidence go down the plughole. So I just watched her all the time to see how she was managing.

There was an issue about the baby's weight because it was a small baby. She was quite anxious about her getting enough milk with each feed, so that she wouldn't lose weight. While one of her nipples was all right and we could attach the baby on that side, the baby was having difficulty attaching to the other one and, of course, as her breast filled up it was harder to attach. So we'd express on that side and make the breast nice and soft so the baby could get on, and sometimes the baby would get on and sometimes she wouldn't and she'd get quite anxious.

I got a little bit more involved in her care than is normal, I suppose, because I was there and I saw how important it was that she had someone to offer support and also that she had someone who could spend the time to teach her. I think it was on the fourth day that she said to me 'I'm glad that you're here because you're easy to talk to.' I think clients build up relationships with some nurses because other nurses, for whatever reasons, sometimes aren't meeting their expectations or
their needs. But because they have built up this rapport with you, it's as if no one else can help them as you can.

I walked in early one morning and they were both pretty upset, partly because they were tired of course, like all new mums. They hadn't got much sleep during the night and they had asked if the babies could be taken back to the nursery for a couple of hours so they could get some sleep. Apparently one of the nurses had said 'This isn't a hotel!' so they were quite upset and angry because it had made them feel as though she thought they didn't want their babies. So I explained to them that there was a legal requirement that somebody had to be in the nursery whenever there were babies there. But I also explained that even though the staff may have been too busy to be able to spend time in the nursery just then, the nurse should not have spoken to them like that.

I enjoyed seeing her go from hardly being able to touch her baby because she was so frightened, to seeing her changing her and caring for her. When I first met her, she would look at me with her mouth open and her eyes wide open, and I would speak to her and know that she was not getting the message because it was all too overwhelming. The overriding thing was that she hadn't any confidence. I tried to make her see that she could do it, would do it and do it well - and she did! Toward the end it was 'Ohh, hi Didi, how are you?' (said in a casual tone of voice) and we'd talk about the weather or talk of something other than the baby. So, it wouldn't be 'Ohh!' (said like a cry) it was just casual. It wasn't 'Help me, I'm drowning!' any more. She had time to talk about other things and she would hold the baby more. In the beginning she would feed her and put her straight down, as if that was all she could cope with just then. Later, as she got more confident, she'd feed the baby and have a cup of tea or watch TV with the baby sleeping in her arms.

**Holly - the experience of giving health-focused care**

Just recently, I nursed a woman who was having her first baby and who knew
nothing about childbirth. She hadn't been to any antenatal class at all and she hadn't read anything. As it was her first baby, she didn't know what was going to happen and she didn't seem to care. I stayed with her for the whole of her labour, right through to delivery and it was all a rude shock to her. She thought something must have gone terribly wrong because she didn't think childbirth could possibly feel this bad; it just couldn't be this bad! So, my task involved constant reassurance that she was working through it well and that she was progressing in her labour. I had to tell her that contractions hurt, they do! I had to reassure her constantly that this was normal and that she was doing okay.

She seemed very apathetic; she wouldn't look me in the eye and was kind of pretending she didn't care what was going on. In a way it was funny, really. She came in and said, "I uh ... think my water's broken" but she was looking the other way as if she didn't really care anyway. Where you'd have someone else panicking or getting very excited, she sort of gave the impression that she had just come into hospital because her waters had broken, as if that was all that was the problem. It was quite strange, right from the beginning.

She didn't seem to mind anything we did; she seemed so closed to us that nothing appeared to permeate her isolation. It was as if she was there, she was going to have a baby and that was it - it was just it! I told her that labour could be painful and that she might want painkillers to help the pain but I also explained the different positions that might make the pain easier and I explained exactly what was going to happen. I had to keep asking her if she minded if I stayed with her because I think it's important that they have control over that. I tried to talk about her baby; like for example, had she thought of a name - but she hadn't, or, if she had, she didn't tell me. She didn't want to talk about names. When I asked her, she said "I don't know yet. Wait and see if it's a boy or a girl!"

She wasn't very interested in how the baby was doing and she wasn't prepared at all, so I was teaching her there and then what was going to happen. I had to teach
her there and then the physiology of what was happening in such a way as to provide reassurance to her. It wasn’t that she was self-focused, it was more a deliberate ‘not-focusing’ on the baby and it appeared as if she didn’t want to have a baby. She just came into hospital and said ‘Oh, I think my waters have broken.’ Because she was in a private hospital, she was about 30 and she seemed to have quite a supportive husband, the only explanation I could think of for her not having read anything (about childbirth) was a kind of denial that she was having a child.

I was alone with her for most of her labour and then, right at the end, one of the other midwives was with us. Her husband wasn’t there for the delivery, he was in the country and she didn’t want him to be there. At first I had to work out why she didn’t seem interested in the baby. I think you’ve got to be very careful; you’ve got to assess the situation to see where she’s at and that involved me recognising that she had a knowledge deficit about labour and delivery. Because she wasn’t really interested in the baby, I had to focus on her and not on the baby. She just didn’t seem to be interested in hearing how the baby was. She had to be guided through the contractions. At first I thought, “How could she not be concerned about the baby?” and then I realised that maybe she was more afraid of the baby than of the labour.

I think once you realise what is going on for people and try and see their point of view, you can work out a tactful way of helping them. In this situation, I think that helped. Once I was able to identify her fears and her isolation from the baby, we worked quite well and it ended up really well. She went through her labour really well. She coped with it better than many women do, actually.

During her delivery she was almost panicking. I mean, it’s painful for everyone but she did okay, although she was still very removed from the baby. Even when it was born, she didn’t display any interest in seeing it. It was a few days before she actually had a name for the baby. She had told me she didn’t want to breast
feed and you have to respect that as well. Because I had already realised that this was the way she was feeling about the baby, it was important not to thrust the baby onto her but to do it gradually; not tossing the baby onto her chest when it was born. We didn't do that; we certainly gave her the opportunity to look at the baby but tried not to give the appearance of insisting on her responding to it. She just seemed closed to it and we may have made the situation even worse if we had done that. By identifying her needs, we were able help her, although it was very different from the way another person's delivery might be.

She was in a private hospital and, if the mothers don't want their babies with them at night, they just put them into the nursery. The hospital is trying to encourage rooming-in, but she didn't really have to interact much with her baby while she was in hospital. The baby was bathed for her and she went home quite early, back to the country, which was a worry. Because the baby was bottle-fed, it was just zonked-out between feeds so she didn't really have much to do for or with her baby. I'm sure she wouldn't have learned a lot until she went home. I think it's wrong that she went home all unprepared. She didn't have to face the reality of being woken several times a night while she was in hospital. It may seem like we're doing them a favour at the time when we take care of their babies for them, but it's not at all, it's quite an injustice.

During my nursing education, we were always told to really look at the person and that's something I really value from my education; that you really look at them and their needs and let them make decisions about their care. I feel that I respect the people I give care to. I look for what people want and to see what their individual needs are and then try to work towards a positive outcome for them. I try hard to see them as human beings because nursing is about following-through with people.

**Rick - the experience of giving health-focused care**

I was looking after an older woman who suffered from dwarfism. She was in
hospital because she wasn't coping any longer at home and because she had begun to suffer intermittent paralysis of the legs. She would just fall down for no identifiable reason and I was caring for her while she was being investigated. I first met her when I did her admission and she joked and laughed and I sort of surmised that she was using humour to cover up some sort of hurt or concern. That was fine for the moment, so I went along with it and jollied her along. By that, I mean that my approach was to use humour in response to hers to make her feel comfortable and just let her relax.

There wasn't a great deal of nursing care involved in her care. Basically, it was just attending to her psychological needs, listening to her, attending, counselling and building rapport. I felt really concerned because there were no obvious reasons for her condition. Her tests didn't reveal any stenotic changes or anything so there was no obvious physical reason for the paralysis. The family couldn't manage her at home and we anticipated that she would have to go to a nursing home. That was hard, because she was a very independent woman. It was very sad for her and I wished there had been another alternative available.

I knew a long time before she was aware of it that there weren't many alternatives for her. She may have had an inkling of the way things would turn out, but she wasn't really aware of what might be the outcome. Because she covered everything up with humour, I wanted to be able to provide an avenue of release for her, some way for her to explore the issues and [to] understand when she was told that the nursing home was the only avenue open. Part of that was to involve myself, so I sat and listened to the family talk about all the different aspects of her condition. I wanted her to feel more relaxed and to have someone to whom she could vent her feelings, [to] have someone to talk to and feel comfortable with. I didn't want her to have to use humour to cover up the way she was feeling so people wouldn't need to address the feelings.

She gave the impression that she was a 'happy chappie' when, underneath, she
was upset about lots of things; my perception was that she had no one to talk to. So I just wanted to befriend her. I liked her and I thought she needed someone to listen to her. After a while, she’d ask for me on my days off. I mean, sometimes you have patients who ask where you are when you’re not around and they can be a bit of a pain, but this seemed different. When you make a real connection with somebody, it’s really quite special. She seemed to feel more emotional pain because she was unable to do the things she normally did to look after her family than she felt in trying to walk. The pain of walking didn’t appear to be the problem to her; not being able to look after her family and her sister’s kids whom she was rearing was what was painful for her.

People are what are really important. Procedures are important but I’m a ‘quick study’ person and it doesn’t take me long to pick up on the ‘doing’ things, but understanding where people are coming from is a lot harder than doing; to really help them out, that is. Don’t get me wrong, I know I also need to pay attention to the details like helping someone walk or doing procedures. I think about that too, but I’m most concerned about how people are feeling, what they’re going through ... and I actually do listen. If I do anything, I listen.

**Sally- the experience of giving health-focused care**

A couple of weeks ago we had a patient [admitted], who had been involved in an accident. He came in to the Emergency Department and then went to a different department for tests and back to Emergency, then back to another department; you know, going backwards and forwards. The family had been with him since he came in and, although everyone was quite concerned, neither they nor we knew how severely he was injured. Although the scans and tests didn’t show it, he had unstable injuries and he deteriorated quite suddenly while he was having the tests done, so he was transferred to ICU immediately. In less than half an hour we had completed a full fluid resuscitation on him but he was in a very bad way, so we intubated him and sent him to theatre, still not knowing why he had deteriorated so swiftly.
The next thing I had to do was to see the family and I found that they were angry and upset that his condition had deteriorated while he was having the tests done. It was understandable that they were angry because he was their loved one and he wasn’t in a very good state, but from our point of view, everyone had done as much as they could for him. I had to explain to them what was happening. It was very hard because when he first came into ICU he was talking, he was conscious and had quite a bit to say, although he was in a lot of pain. When he came back from theatre, it was obvious that his condition was very serious. Although we poured blood into him all during the night, he died before I went off duty the next morning.

As soon as he came back from theatre and we realised what his injuries were and that he was in such a bad way, we brought the family in to be with him. A lot of the time when people are dying, I think nurses take charge of situations and the family feels helpless and irrelevant. I know that we have to do everything we can for a person, but at the same time, we’ve got to remember that we don’t own the people we care for; we are only there to care for them. So in this case we brought them in while we were working with him, they just sort of sat with him all during the night. They were on one side of the bed and we sort of worked around them. When he came back from theatre we had that feeling, you know that feeling that you get, that he wasn’t going to survive. Of course the family weren’t aware of that and we weren’t able to tell them until it became absolutely clear to us that we were fighting a losing battle.

When we told them he was unlikely to survive, they came to the decision by themselves that it was time for them to withdraw. What made the difference and relieved their anger was allowing them to see exactly what we were doing and how hard we were working to save him. Initially, it helped them to grieve and then later to make the decision that we just couldn’t keep giving him more and more blood because it was clear that it was not doing any good.
This case really sticks in my mind because he’d come in and he was talking and then ... he wasn’t talking ... and he just got worse and worse. It’s just not normal (emphasised) for someone to deal with death and dying every day of their life and certainly not for young people. I’m in my mid-twenties now but when I started in ICU, I was 22. There are young people [working] there who’ve had only two or three years nursing experience and they’re dealing with death every day of their life. It’s not normal! This case sticks in my mind also because the relatives were very angry at the start of the night and we were able to turn that around so that they were actually quite ... um ... ‘Content’ is not really the right word, but [they were] more accepting of the whole situation. Having them there throughout the care is something that’s not normally done, but I did it anyhow. I know what it’s like to be on the other side because I’ve had friends who have been in ICU. So I like to get the relatives in to be with people as soon as I can. In this case, I put it to the shift coordinator and we decided we should allow them to be with him. It would have been wrong to leave them sitting in the waiting room and two hours later to have to go and say he’d passed away; that would be terrible for them and it would make them even more angry.

As it was, they were able to begin to talk things through; they talked about people’s birthdays and about their life together - not with him because by this time he wasn’t conscious, but between themselves. That often seems to make it better for people and it was like that for them; they spoke about this and that and talked about their life and the things they used to do together and it seemed to help them accept what was happening. It’s a lot warmer; in a way, it’s sort of a nice death, given the circumstances.

When we realised that he wasn’t going to survive, I think I was relieved because although there wasn’t anything more we could do for him, we had been able to make it better for his family during the brief time we had with them. It was very clear that time was short and that we couldn’t do any more for him. In the end,
the family was really thankful for everything that we had done and because they were with him the whole time, they could see all that had happened. Them knowing his condition also made life easier for us, even though there was blood everywhere; the bed was soaked.

Because they were there the whole time, they weren’t as shocked by the news that he wasn’t going to survive; they’d seen him get progressively worse and worse after he came back from the theatre. Because they’d been there from the beginning when he got back from theatre, as he got so much worse, they could see and comprehend what was happening. Although we covered him up and they couldn’t really see a lot of the blood loss, it was clear even to them that we were fighting a losing battle.

When he actually died, I felt sorry for him of course, but I felt really sorry for his family. He was young and he had a wife and a couple of young kids and they weren’t originally from Australia. Although they’d been living in this country for a while, they were from a long way away. There were only two relatives with him when he died; they were the only two living here. All the rest of the family, the parents and such, were back where they came from. I arranged through the switchboard for them to be able to make long distance phone calls. They were concerned that it was going to cost a lot of money and I told them not to worry about it, that I had organised it through the switchboard as a hospital call. I had to explain that, in emergencies, we were allowed to do this so it was all right for them to call their people. That’s something that is really important. There could be few things worse than not having enough money to let your loved ones know that someone is dying or has died. There’s so little that we can offer them in times like this, so I felt good that I was able to help them in some way and they were really appreciative.

What I wanted most for his people was that they understand. I think that if the relatives understand what’s happening, within a certain level, they’re a lot more
accepting of the outcome, whether there's a positive prognosis or not. If they understand what's going on, they feel better! When they first came in, all they wanted to know was that he was going to be okay or that his condition could at least be stabilised. That's all they really wanted to know then and there's no point in explaining everything at that stage. The only way you can relieve their anxiety is by their understanding what is wrong and that everything that can be done is being done.

As far as I could, I tried to give them little things to do for him. When a sick person is at home the family can cook for them or make a cup of tea for them and relatives have got some independence in amongst life as a family. And then all of a sudden that loved person gets hurt or sick and comes in to hospital and gets taken away from them and they don't have anything that they can do for them. They can't do anything for them because it's out of their control. So I get them to do things for the sick person, like giving them a foot massage or doing their mouth care or filing their nails. Any of those sort of things, things that they can do to make them feel like they're doing something. When they feel that they're helping, it makes the situation a lot easier for them and the things they do are time-consuming as well, so there are two gains. They're not sitting around feeling helpless and they're helping me as well; I'm a smart nurse. If it was my husband or relative who was the patient, I'd want to do things for them. When they're doing something, relatives feel like they're contributing to the person's care, that in some way they're helping to make them better.

When the relatives understand what's wrong and what's happening and they're involved, it's better for the patient too. Often the patient is sort of awake even though they don't appear to be conscious. If the family is talking to them constantly or carrying on, telling them to do this and do that, it really stresses the patient. They get very anxious and it shows, and the family gets more upset. If I can help the family to see that the person is doing all they can do to get well and that they need to rest, it relaxes them and the patient gets better a lot quicker.
because they haven’t got these people at them all the time. Even with dying patients, when the family understand, they ... I don’t know, they just sort of ... accept it better. If they understand exactly what has happened and they know the reasons why it’s happened, they can accept it easier. But if they don’t know why and how, they don’t accept it and that’s worse for them.

Sarah - experience of giving health-focused care

At the moment, I’m caring for a patient in hospital who basically has two problems, he drinks excessive amounts of alcohol and he’s a smoker. He’s a very nice guy and has his feet fairly firmly on the ground, which is perhaps a bit unusual for an alcoholic. Generally, they’ve got reasons why they drink and that makes them a bit more difficult to work with. This guy was just out of control and was drinking very heavily, so I’m trying to tell him to slow down a bit rather than nagging him to stop completely.

The doctor came in one day and said to him ‘You know you’ve got to give up drinking altogether’ and then walked away. The man’s response was ‘What a load of crap. It’s all right for him to say that, he hasn’t got the problems that I’ve got!’ So, I started off by sort of agreeing with him to a certain extent to get him on my side and, in a roundabout way, said to him ‘Yeah, I agree with you.’ Then I talked about people that I know. I always talk about things that I know and people that I know to patients I’m trying to work with; it makes people feel that they know you better, I think, so then they’re more willing to listen to what you’re saying. No one wants to be told by another person [that] they don’t know how to live their life! So, I talked about my father, how he’d given up smoking and taken it back up again, and highlighted how human it is to do that, and how human it was for all people to do things they ought not do. For instance, even though I know I shouldn’t eat chocolate bars and greasy chips, I still do it. I talked about the fact that everyone has got to try and cut down on the unhealthy things they do. My intention was to make both him and me seem more human and the people around us more human so that he could see it as a general type of problem and to
take away the sting of a comment like ‘You should just stop it!’

You do the talking about change over a period of time. You can’t go up and give someone an ‘ear bashing’ about things because no one wants to know you when you do that. I use the time that I’m backwards and forwards with them, like when I’ve taken them to the shower or downstairs for a smoke or whatever. You walk back together and I say, casually, ‘How many cigarettes have you had today?’ that type of thing. Just small comments that are made without turning them into a lecture, because I know that I don’t like being ordered to do things. I like to use indirect comments that come across to the person and point out that they’re only human and so am I.

I talked to him about his drinking in terms of the serious things that could happen to him; the ones that people think are never going to happen to them, but they do. I talked to him about things like pleural hypertension and oesophageal varices and ascites and this and that. Then, he asked ‘Is that what that guy over there has got?’ (The man across from him in the ward) and I said, ‘Well, more or less...’. He said, ‘Oh, I don’t want that to happen to me!’ and I said, ‘Well, you know you had better start thinking about it, then!’ It doesn’t work if you leap in and say that immediately, before you know them. You’ve just got to do it subtly and you’ve got to do things with them, like go down with them for their smoke and sit there not smoking and then they have one instead of having six. Eventually it may work or it might not but there’s no point in getting ‘hepped-up’ about it because no one can force them to make a decision to change.

People are very much in a mood to listen when they’re in hospital. You can tell someone, when they’re physically fit and feeling fine, that they should stop smoking and they find it easy to ignore you. But when they’re in hospital and they’ve got bronchitis, it’s a different story altogether, they’re more willing to listen to you then. Advising people has got to be done in a human way though; people don’t want to feel as though they are sitting in a lecture theatre! Always
being there in the background with odd comments gets to people far more than a
lecture does; small comments every now and then can be very effective.

Sometimes they might need a bit of bit of shock therapy and then I tell them about
the really awful things that can happen, but I have to know the person a bit and
they have to know me before I can do that. I would never just go up to someone
and tell him or her they’ve got to give up smoking if I didn’t know that person. I
think people have to know you a little bit before they will even listen.

What I ultimately wanted for this particular man was for him to try and get off the
alcohol to the extent of making himself healthier and happier. He had been in
hospital about five times in the last year with melaena, oesophageal varices, with
bleeds and to have his ascites tapped. He’s given up drinking now but it’s a bit
late, there’s been some serious damage done. He’s about fifty years old but he
looks seventy because of his medical problems. He’s told me a lot of the reasons
why he drinks but people don't always come out completely with those, although
I'm sure they often would if nurses had more time. Patients do come up to me and
tell me very personal things and if you could have long conversations with them,
you could counsel them. You could try and work through their problems if you
could sit down and go through some points for change. That would allow nurses
to be able to design individualised health teaching for people. It’s very frustrating.
Every day that you go to work, as you go off duty you’re thinking "I would have
liked to sit down and have a chat with so-and-so about that" but you don't get the
time and that’s that.

It’s actually very sad that a lot of the time nurses don’t have the time to talk to
their patients in an educative way; what they do is a five-minute thing mostly.
Like today, an eighty year old man was told he’s got cancer and that he’s only got
about three or four months to live. He only had a five-minute conversation with
the doctor about it! Then I was only able to spare fifteen minutes for a
conversation with him because I didn’t have the time to sit there for an hour.
That's what I really needed to do to tell him what was going to happen and listen to all the questions that would be in his mind. So, although I do talk with patients, I do it for a lot shorter amount of time than I want to. I can be just getting into a conversation like that and somebody comes up to ask me to check a drug, or ask me a question or to say someone's going off to theatre. It's very, very difficult to do what needs to be done!

If I really want to talk to a patient and I don't want to be interrupted to get to the drug cupboard or something else that the nursing staff might want, I try to take the person off the ward. Partly that's because, in nursing, there is still the feeling that if you're sitting down and talking with someone, you're not busy. So I tend to try and go out for fifteen minutes, to get off the ward for fifteen minutes. I took this man, the one we've been talking about down for his smoke today and then I could talk to him.

Obviously, every patient is not the same. With some patients I wouldn't even attempt to talk about serious issues. I mean, sometimes, I can't even get a conversation going with some of them about their kids or something easy, much less something serious or deep. But people in hospital generally want nurses' company and they like any attention that they can get from the nurses, so I think that if I spend a little bit of time, I have a base to start health teaching from. One of the problems is that people come into hospital and expect to be cured and it doesn't work like that. It's up to you really. But if you've had a few people explain to you why and how things happen to you, and they do it to you on a human level rather than talking at you like a textbook, you may be more inclined to listen. People who bother ... to find out that [the reason] you can't test your blood sugar in the morning [is] because you've got screaming kids or you work night shift and you're too tired ... and who treat you like an individual, are more successful at health care.
WHAT IT IS LIKE TO GIVE HEALTH-FOCUSED CARE

In phase one of the research, when describing their experiences of health, most of the participants identified great difficulty either in recalling the immediacy of the experience or in finding language with which to describe what they recalled. Describing health-focused care was quite different, however, and all of the participants gave such spontaneous and lengthy descriptions that the narratives could have run to many more pages than are given here. This was despite the fact that at the beginning of this second phase of the research with each participant, we sedulously sought for descriptions of the *immediate* experience of giving health care. My requests for descriptions of what it was *like* to give health-focused care aroused puzzlement or, in a couple of cases, extreme perplexity. In several cases it provoked the statement that they did not understand *how* to describe it any differently than in the thoughtful, interpreting ways in which they had begun.

Reflection on and discussion with participants indicated that this was because the phenomenon of health-focused care is a learned, cultural phenomenon. Such a learned phenomenon can not be accessed in an *immediately experienced* way since what occurs is the giving of thoughtful, planned care. In giving health-focused care, participants first think about what they are going to do prior to doing it, and care is planned according to the nurse’s knowledge of the patient and the patient’s needs prior to its implementation. For this reason, the narratives of health care are quite different to the narratives of health.

As a participant in this study myself, the experience of gathering the data for this segment of the research was quite different to the experience of gathering the data for the first part. When they were describing health, participants were extraordinarily hesitant. The phenomenon frequently eluded clear description, whereas the descriptions of health-focused care that the questions of phase two elicited were freely given, articulate and varied. The care each chose to describe recalled other stories of care from their experience of giving health care. This contributed to lengthy interviews and an attempt to bring participants back to the
central story was frequently met with the response that what they were recounting was related in some way. Thus, the narratives of health-focused care have been written many times and each editing has reduced them still further to the essentials of what health care was like for each of the participants. Despite these descriptions of health-focused care, however, there is much that is still hidden or inexplicable about the nature of such care. As well as describing what health-focused care is like then, this chapter also describes what is missing from the descriptions of health-focused care.

Caring and health-focused care

Among the data for this study lie other data provided by these nine participants that are not immediately relevant to the questions of this thesis. These other data are about nursing and health-focused care in general, rather than the experience of giving ‘health’ care, which was the focus of the exploration. They are taken from a variety of experiences and include a wide variety of impressions described by the participants. At first, it was my intention to disregard these segments of the data since they did not describe directly the experience of giving health care. Ultimately, I found that it was impossible to be true to the data of this study without them, since these segments in and of themselves convey something that the stories do not directly impart. That something is a sense, an ‘atmosphere’ as Merleau-Ponty (1962) described it, of what it is like to give health-focused care for these nurses.

In telling their stories of health care, the participants recounted much that was personal about their own lives in nursing. They also related much that was opinion about the nature of working in hospitals and the nature of the health care system in Australia. In addition, they gave descriptions and explanations that contained their considered judgements about what should be done to make nursing more effective. From all, there was regret and concern at the extent of the funding cuts to health care in Australia and the effect these have had on the way they are able to offer health care to those in their care. In these ways as well as
throughout the interviews, a pervasive atmosphere of caring permeated the discussions of health care. Although the word ‘caring’ in the sense it is meant here was not specifically mentioned by any participant, it showed in the descriptions as devoted attention to doing the best for and with patients who were in the care of the nurses in the study.

The reader might well ask how this conclusion was reached when indeed it came unexpectedly to me, the writer. If I am honest, it came also as an unwelcome recognition, for I have discovered that laying aside one’s assumptions and presuppositions is not an easy task and requires that one lay aside one’s prejudices as well. Although Leininger (1984) asserted that caring is the essence of nursing, this notion had always seemed somewhat vague and indistinct when placed within the context of nursing; it is after all a notion that is difficult to validate. Watson’s (1985) description of the ‘caritive factors’ in nursing also seemed to me to be too ephemeral a notion to be applied to the pragmatic practice of nursing in Australia. Perhaps it was also that I found caring as described by Leininger and Watson too much a call to the emotions, too personal and too much like the devotedness one expects from a person with a vocation. I thought of it as a word and a state that many women have tried very hard to ignore or reject. Yet every time I read the narratives of health care, I was left with a memory of the participants’ ardent ways of describing the phenomenon. The thought recurred persistently that I could not do justice to an exploration of health-focused care without a description of the enthusiasm and commitment to such care that was displayed by the participants.

What is it about these interviews then that gave such an overwhelming sense of caring? When participants had completed the interviews about the phenomenon of health in their lives, although unspoken, there was a sense of relief that each interview was completed; like the sense one receives from another when a difficult job is over and done with. The interviews about health-focused care were quite different. Participants spoke with fervour about giving health-focused care - they were passionate and involved and there was a sense that they had so
much to say that they didn’t know where to start or what to include. Frequently, they continued speaking long after the audiotape was turned off (generally because we had run out of tape) and often accompanied me to my car and talked for long periods of time afterward about the issues they had raised in the interviews. Although much of it was repetitive, it would have been easy to conduct interviews that were two hours long or longer!

Illustrations of caring appeared in many different forms in the narratives; for example, when Charlotte stated that she ‘owned’ the responsibility for the patient. It was not what Charlotte said, however, but how she conveyed to me her dedication to caring in the form of devoted attention, as well as caring for and taking care of the persons in her care. In the sense that Charlotte meant it then, caring implied an almost total involvement, even if only for a limited period of time. It implied also a considerable investment of self in the tasks presented by the demand that she care for the patient, so much so that she did not feel comfortable with herself if she did not fulfil her ‘responsibility’. When Charlotte stated that she felt a bit stressed if she was unable to care for the patient in the way she needed to, she confirmed the personal involvement in the task that the notion of caring as attachment or cherishing implies.

Again, although Anne’s description that she:

wanted to make it as un-intimidating as possible, the least frightening I could make it because she (the patient) was worried about him as much as about herself,

does not convey the sense of caring described above, her observations of the relationship between the couple and her concern that she reassure both of them was indicative of a more than superficial involvement. Anne went to considerable lengths to reassure and prepare both her patient and the patient’s husband for the surgery that lay ahead. In doing so, she demonstrated that she had taken their wellbeing temporarily into her domain. Rick also described the involvement of self and being ‘touched’ by his interaction with the woman to whom he was
offering health care.

Didi and Holly both spoke about their experiences of giving health-focused care with intensity and an attention to detail that called to mind the absorption of a parent describing the doings of a child. Each displayed empathy and understanding for the situation of the other person. While neither of these qualities, empathy or understanding, inevitably imply caring, each of these attributes is connected to the type of deeper feeling that caring calls forth. During the interviews with Didi and Holly and on re-reading the narratives, I was left with the sense that these were interactions that called forth the devoted attention of the participants and that, for this reason, for each of them, offering 'health' care involved caring.

Encountering this unanticipated aspect of the nature of health-focused care required that I find out more about caring in nursing. Gaut (1983) analysed the components of such caring and stated that respect for self and others are necessary conditions for caring. She also stated that knowledge of the need for care and the intention to take action towards positive change are part of caring. As can be seen, each of the stories in this chapter fulfils these criteria. However, a considerable number of other researchers (Bevis, 1981; Gadow, 1985; Roach, 1987; Swanson-Kauffman, 1988, Watson, 1988; Fry, 1989) have also described caring in nursing. In a comparative analysis of such conceptualisations of caring, Morse, Bottoroff, Neander and Solberg (1991) analysed the diverse descriptions of caring in nursing. They concluded that there are five ways caring is apparent in nursing. These include caring as a human trait, caring as a moral imperative, caring as an affect, caring as an interpersonal interaction and caring as a therapeutic intervention.

In this study, the forms that health care as caring took were varied. Viewing them from the perspective of knowledge about 'caring' in nursing gained after 'the thing itself' had shown itself to me as part of the phenomenon of health-focused
care allowed me to identify them more clearly. Sometimes caring showed as therapeutic interventions (Gadow, 1985; Watson, 1988) as in the narratives of Anne, Sarah and Charlotte; sometimes it showed as interpersonal interactions (Bevis, 1981; Swanson-Kaufman, 1988) as in the examples in the narratives of Didi, Holly, Bill and Rick. At times it appeared as a human state (Fry, 1989) which is particularly shown in Sally's narrative of health-focused care and her feeling for the family of the injured man. At others, it had the tone of a moral imperative (Gadow, 1985; Roach, 1987) as when Charlotte referred to 'owning' the responsibility for the patient.

**Rapport and health-focused care**

The word 'rapport' indicates communication, relationship or connection (Webster's Dictionary, 1983). It also translates as concord, affinity, harmony or compatibility, all of which help to explain the meaning of rapport in health-focused care as it was described in this study. At each reading of the narratives of health-focused care I was struck anew by the dominant theme of rapport building that is so clearly evident in all of the nurses' stories. While there were several elements to rapport building, Anne, Charlotte, Didi and Rick explicitly mentioned 'rapport'. Bill's descriptions of getting to know the children in his care in general and the twelve year old girl in particular provide exemplars of the manner in which rapport in health-focused care is built. Bill's description shows the beginning of rapport building:

*This girl did get upset and she didn't want to see anyone, but I kept coming in to her room and I forced myself on her, basically. I just kept coming in and annoying her, kidding around with her. I find that's helpful, it annoys them so much that it breaks them out of it a bit. She used to say 'Just leave me alone!' But I just kept coming around and I'd say 'Oh, yeah! Well I'll go out, but I'm coming back in again.' Basically, I'm saying 'You're not getting rid of me!'*

When taken in the context of his later description, the result is described:

*She loves having me looking after her; she jokes around with all the staff*
that she knows well, but as soon as she sees me, she shrieks and runs off. She’s told me that she loves the teasing and joking and I think it’s really helpful for her because she’s got to keep coming back [into hospital]. Just to know that Bill is going to be there is helpful for her. She said to me ‘I actually look forward to coming in, I count down the days’. I mean, we’re good mates, sort of like Spot and Tom.

Charlotte described explicitly the ‘building’ of rapport when she recounted going on pre-operative visits to the persons who would come into her care the next day. Sarah also showed that rapport is constructed with patients when she gave detailed descriptions of getting to know the people in her care. Together, the descriptions show that rapport doesn’t just happen but is something that is deliberately worked towards by the nurse in order to provide health-focused care.

**The social relationship in health-focused care**

In the narratives above, it can be seen that the establishment of rapport in the relationship with the person in care was of importance to each of the participants to enable them to offer health care. Indeed Anne and Sarah each gave examples of other incidents that showed how health care was inhibited when they were unable, for whatever reason, to form a good social relationship with a patient. In discussing health education, Sarah made this explicit when she said:

*Obviously, every patient is not the same. With some patients I wouldn’t even attempt to talk about serious issues. I mean, sometimes, I can’t even get a conversation going with some of them about their kids or something easy, much less something serious or deep.*

During the interviews, Anne also discussed incidents in her nursing experience that showed the ways the nurses’ ability to give health-focused care was inhibited when they were unable to develop a favourable social relationship with a patient.

In general, there has been scant exploration undertaken of the effect of social relationships on nursing practice. Purkis (1994) identifies ‘the social’ as a missing
ingredient in 'the body of literature which accounts for the way nursing practice is produced and reproduced' (p 315). She points out that, in a practice-based discipline such as nursing, the work of nursing is accomplished between social actors. An exploration of the relationships between these social actors is then necessary to fully understand the nature of nursing. Such an exploration of relevant social relationships accords also with the purpose of hermeneutics which is to clarify the conditions in which understanding takes place (Gadamer, 1976).

In this study, the nature of the social relationships that developed between each nurse and the individuals in their care was clearly important to the giving of health care. Didi made this explicit when she said:

Because they have built up this rapport with you, it's as if no one else can help them as you can.

The relationships described in this study were based on honesty (Anne, Bill, Charlotte, Holly), empathy (Charlotte) and support (Anne, Bill, Charlotte, Didi, Holly, Rick and Sally). In all of the examples given, it was clear that the ability to build rapport between patient and nurse was dependent on the nature of the social relationship between nurse and patient. Thus, a favorable social relationship between nurse and patient would appear to be critical to the success of truly health-focused care.

Support and health-focused care
Support was seen to be an important element in the giving of health-focused care for many of the participants. Again, it was not so much what was said, as the way the nurses described health care. Support was evident in the way Anne interpreted the unease of her patient and the patient's husband and set out to allay their anxieties. Its importance was clear in April's comparison of two examples of care in midwifery, one that failed to be 'health'-focused because the woman's support was blocked, compared with a successful health-focused event where support was the keynote.
While Didi specifically mentions support, the full breadth of meaning of support to her is only gained through reading the whole narrative. It seemed that Didi’s whole focus in health care was to provide support for the new mother in her care so that she could learn - about her baby and to trust her own ability to care for it. To offer support means to carry for a time, to stop from falling, to give strength to, to encourage (Webster’s Dictionary, 1983) and all of these actions were described by Didi in her description of giving health care.

April accorded particular importance to the role of dignity in health-focused care. To April, dignity includes support but is far more than that; it includes the notion of respect as well:

When I talk about her dignity, cleanliness wasn’t the issue. It was that she had all her support, her regime and her sense of control taken away from her. The things she was doing to try and maintain her function in labour were all taken away from her. I think the things we do to maintain ourselves, and having the ability to do those things, makes us feel dignified (April).

This notion of respect was also apparent in Sarah’s description of not offering health advice to someone whom she didn’t know at least slightly and also when she described the way she got to know patients by sharing something of her own life with them. In this way, Sarah also demonstrated that support for the feelings of others was inherent to her practice of health-focused care.

SUMMATION

The intention of this chapter was to describe health-focused care in nursing in such a way that the relationship between the meanings of health for nurses and the way they practise health care could be distinguished. When this was established, relationships between the way nurses understand health and the practice of health-directed care could be drawn. However, clear relationships between the meanings of health for these nurses and the way they give health care have not been
elucidated in this study. These relationships have not been identified because of the individualistic nature of health-focused care as these nurses have described it. Several aspects of health-focused care related to health promotion are, nevertheless, clearer. These are the way nurses understand health and the meanings of health-focused care for them.

If nursing care is focused on the achievement of health, by its very nature, it is health directed and therefore falls within some of the described categories of health promotion. However, health promotion is dependent on positive notions of health (Nutbeam, 1986) and, in particular, certain notions of health produce certain types of health promotion (see Chapter Two for a discussion of this). For that reason, health-focused care could reasonably be expected to contain many of the basic elements of health promotion derived from positive notions of health and introduced to nurses during their nursing education. In the case of this research, notions of caring, of support and notions guiding the development or building of rapport with the persons in their care can be seen to underlie health-focused care for these nurses. While these notions may be connected to the social view of health with its emphasis on respect for individuals, the nurses in the study did not make such connections. Thus, the connections between the way the participants understood health and the way they gave health-focused care were unstated and could not be discerned from the descriptions given by the participants. In other words, the notions of health that guide health-focused care could not be detected from the nature of the care that was described in this study.
CHAPTER 8

LINKING HEALTH AND HEALTH PROMOTION: POSSIBILITIES FOR NURSING PRACTICE

INTRODUCTION

This study was a search for the meanings of health and the way such meanings are translated into nursing practice, but it was not only that. Although it was by no means the intention at the beginning of this study, what has emerged during the span of the research has been as much a methodological journey as one which was focused on health. The study was conceived in 1994 and the approach was chosen (it seems now with extreme naivete), purely as a research methodology. Yet a philosophical approach can never be merely a research approach alone and the immersion in phenomenology that followed directed me on a path that was unforeseen and certainly unintended at the beginning.

As a student of the type of research question that characterises phenomenological research, namely ‘What is life like?’ (Olson, 1986: 104), the student seeks not to master the question but to live it with understanding (van Manen, 1990). In order to understand the research question, paradoxically, I needed to step away from it and doubt that it existed in any form but that created by my culture and learning. And so I stepped away - into reflection - to search for the structures that would show me what this thing called health was like in my own life and in the lives of the participants in this study. In revealing itself to me through my own experiences and the experiences of the participants in this study, the phenomenon of health has shown its structures and the themes that characterise it. It has been for me to learn to reflect phenomenologically and put into language the understanding that came, and continues to come, from that reflection.
To be able to reflect on health-focused care in nursing, I needed to begin with what it means to be a nurse. It is clear that being a nurse is not only a matter of fulfilling nursing tasks, nor is it only a matter of ‘doing’. It is also a matter of recognition and acceptance that one is constructed by and constructs one’s environment according to the meanings in one’s life. For these reasons, health as it relates to others cannot be separated from health as we experience it ourselves, since individuals do not live in a vacuum but take their meanings with them into their interactions with others. The intimate relationship that exists between questions of meaning and understanding, between manifestation and concealment, comprises the hermeneutic experience in its true dimension (Gadamer, 1976). Consequently, the answers to the questions of this thesis have revealed many aspects of nurses’ lives in tracing their transformation from persons who experience health to ‘health’ care providers. Some clear answers have been achieved; still, what may be essential to that transformation may yet remain concealed. The ultimate questions of this thesis are ‘What is health?’ and ‘What does it mean to give ‘health’-focused care?’ According to Bergum (1986), these questions demonstrate the open-endedness of phenomenological research and indicate that, in a sense, it is not finished; it cannot ever be finished since meaning is re-constructed constantly by humans.

The giving of care that is directed towards the achievement of health is synonymous with health promotion since health promotion is loosely defined as any action which is directed towards the achievement of positive health gains (Canadian Journal of Public Health, 1986). The mode of being a health-promoting nurse is, however, not only a matter of adopting a specific nursing role or of merely taking care of others. Health promotion requires that nurses have positive notions of health toward which practice can be directed. It also requires nurses to be active in promoting healthy ways of living and being for the people whom they care for. ‘Taking care of’ a patient, as in physical or emotional care is a very different thing to actively asking oneself ‘How can I help this person to be more healthy?’ The concrete ways such questions may be answered are a matter
for the discipline of nursing to resolve. In order that nursing might do so, understanding is required of what nurses take with them from their own experience to their work as health care providers. This study explored the nature of health in nurses’ lives in order to comprehend the meaning of health-focused care to nurses as they offer such care to others.

The study was proposed for the purposes of augmenting the effectiveness of nursing education in health and health promotion by seeking to understand the nature of the connection between the way health is experienced by nurses and the practice of health-focused care in nursing. In doing so, the intention was to add to the knowledge that informs nursing. As can be seen from the preceding chapters, the study has clarified the ways these nine Australian nurses understand health to be present in their lives and has illustrated some of the meanings of health-focused care for them. The intention of this chapter is to briefly review the questions of health and health promotion in nursing in light of what has been revealed by the work of this thesis. Some conclusions and possible future directions for health teaching and health-focused care in nursing will be offered for the reader’s consideration.

The question of health for nursing
Definitions and descriptions of the meaning of health abound in nursing. Indeed, it would be understandable if, out of the confusion of meanings offered to nurses, health emerged as inextricably garbled and indefinable. As this study has shown, health reveals itself in the lives of nurses in ways that are unmistakably positive. However, the meanings of health for these nurses are only poorly discerned by the nurses themselves and Merleau-Ponty’s (1962) statement that ‘nothing is more difficult to know than precisely what we see’ (p. 58) has also been manifest in this study.

In the experience of the nine nurses in this study, the essential elements of health were quite similar. Nevertheless, participants rarely acknowledged that the
meanings of health were shared. Indeed, several expressed the belief that the meanings of health described during the study were diverse and that the major themes were not shared by other participants. This raises both an interesting observation and a question about the nature of health understanding in nursing. Firstly, the data suggest that health as it is understood in nursing has few acknowledged shared elements since the nurses in this study did not recognise that they had described the same thing when they listened to others’ descriptions of health. For example, the notion of health as peace that was introduced by Holly received little recognition by other participants in the study and none could relate to health the way Holly had described it. Analysis showed, however, that health as peace was included in various ways in the descriptions of health of the others in the study. The question remains however: ‘Before these nurses started to explore the meanings of health and were exposed to the immediate experience of others, were they under the illusion that there were no differences in the way nurses understand the meaning of health?’ If that were the case, a priority issue before the dimensions of health to guide nursing could be developed would be to make nurses aware of the ways in which they share meanings of health.

The lack of recognition and acknowledgment of shared meanings is a problem for nursing because it means that when nurses speak of health or health care they do not always perceive themselves to speak of the same things. In addition to this, in this study the meanings of health were not clear to the nurses themselves. Indeed, most of them expressed the sentiment that they had rarely or never thought about the meaning of health until asked to describe their experience of health for this study. If nurses do not recognise that they share an understanding of the meanings of health, how can they share an understanding of the meaning of health-focused care that is the keystone of health promotion? If clearly shared meanings of health are lacking; there can be no clearly shared meanings of health promotion.

The question of the meaning of health is a significant and challenging one for nursing given that nursing practice in Australia requires that nurses be health-
promoting practitioners. Despite the introduction of health promotion into nursing practice, the question remains ‘What is this health that nurses are to promote?’ To say that it espouses positive concepts of health is too vague a notion and offers scant guidance to nurses in the pragmatic practice of nursing where such practice is required to be coherent and systematised. Certainly, as Seedhouse (1996) indicates, the development of a philosophy of health to guide nursing practice would be desirable. However, the lack of such a philosophy would not appear to be as constraining a problem as the lack of clearly defined connections between the way health is viewed and the practice of health promotion. However, neither philosophy nor connections can realistically exist in the absence of clearly acknowledged shared understandings of the meanings of health for nursing. Some beginning work with nursing students to assist in the development of shared understandings of the meaning of health for nursing practice has already been undertaken (Caelli, in press). Replication of that project would, however, be advisable to examine whether the positive results that were achieved could be replicated or improved upon.

**The question of health promotion for nursing**

Reading again the insightful work of Bergum (1989a), I am aware for the first time that becoming a health-promoting practitioner perhaps implies a question rather than a statement. Does it perhaps involve not just a change in what nurses do (i.e., a change in role) but a change in what nurses are (i.e., a change in the nature of nursing)? Indeed, I wonder if more is being revealed in the words ‘health promotion’ than has previously been contemplated.

Although health promotion has been viewed as merely an extension of the role and function of nurses, in fact it has changed the focus of nursing itself. Health promotion implies that nursing must be patient, family and community centred, rather than episode of care centred as was previously the case. Because health has been shown to be an experience that is significant for nurses, the manner in which nurses understand the meanings of health influences the way they understand the
meaning(s) of health care. Thus, what they understand health to be both constructs their practice of health-focused care while their practice is simultaneously constructed by the individual relationships they develop with those to whom they offer care.

It is here, at this point in the discussion, that a major problem for nursing becomes apparent. For at the present time, it would seem that the notions of health which construct nursing practice for the nurses in this study have been only vaguely recognised by the nurses themselves. As well, these nurses report that they have rarely or never before been asked to think about their own understandings of health which will ultimately guide their practice. In this final chapter then, it is timely to reiterate that health promotion has little chance of coherent implementation in nursing without the identification of clearly acknowledged shared meanings of health used to guide nursing practice.

Health promotion theory holds that positive concepts of health are essential to the effective practice of health promotion (Nutbeam, 1986). At the beginning of the study, little was known about the nature of the health concepts of Australian nurses since there had not been any research done in this area of nursing in this country. All of the nurses in the study described the meaning of health in positive ways. In this way, they have shown through their lived experience of health that the foundations on which to build effective health promotion practice are present in their lives. However, the connections between the ways these nurses understand health and the ways they practise health-focused care are still indistinct.

In addition to the indistinct nature of health that is to be included in health-focused care, several other issues related to health promotion in nursing practice appear to warrant further exploration and examination. The first matter that requires scrutiny is the effect on health-focused care of the lack of a clearly defined ‘theory of purpose’ (Seedhouse, 1996) for health promotion. This lack
was evident in the discussions with the nurses who participated in this study for the following two reasons. Firstly, despite the absence of research evidence to show that nurses are health-promoting practitioners, these data reveal that the nurses in the study do indeed practise health promotion, albeit in a limited way. Secondly, that practice appears to be directed by the participants’ individual understandings of health-focused care as rapport, support and caring rather than by any acknowledged and shared idea of the meaning of health care. These issues were evidenced by the fact that each nurse discussed their experience of giving health care in ways that illustrate that they give such care in an individualistic fashion, rather than adhering to any unified purpose or design for health promotion or health-focused care.

Additionally, several participants explicitly discussed the impact on health-focused care of the social relationship that develops between each individual patient and their nurse carer. These discussions indicated that this relationship affects the nurses' attitude toward facilitating health directed care with that patient. In cases where the social relationship was favourable, both Anne and Sarah described readily undertaking such health promotion tasks as were related to illness prevention and preventative health behaviours. Even when the social relationships were not favourable to such exchanges, Anne described attempts at health teaching but stated that they were significantly hindered by the nature of the relationship. From this, it can be seen that there needs to be further exploration of the effect of social relationships on nursing practice and the commensurate effects that these may have on health-focused care or health promotion needs to be described and assessed.

**Missing elements in the descriptions of health-focused care**

Although the descriptions of health-focused care have conveyed something of what it is like to give such care, there are worrisome missing elements in the descriptions. This study was initiated to explore two things; (1) what are the meanings of health for nurses and (2) how those meanings are translated into
nursing practice. As has been seen, the study has resulted in clear descriptions of the meanings of health for the nurses in the study. What it has not done, however, is show how, or even if, those meanings are actually used in any way in nursing practice.

Phenomenology requires that one go back ‘to the things themselves’ to seek understanding. For that reason, it is not possible to construct a link between the meanings of health for these nurses and the meanings of health-focused care unless they themselves describe that connection. None of these nurses have done so. Indeed, although I gave them every opportunity to do so (in phenomenology, questions that require analytical answers are not utilised), none described any connection between the way they understood health and the way they practised health-focused care. When asked why they practised health care in the way that they did in the final (non-phenomenological) segment of the final interview, none could answer the question in any coherent way. For that reason, this study indicates that two problems exist in nursing to hinder health-focused care and thus health promotion practice. The first is, as previously stated, the lack of clearly acknowledged shared understandings of the meanings of health among nurses to guide the practice of nursing. The second is that nurses do not appear to understand their health-focused care to be linked to identifiable meanings of health. While it was clear that in some instances (e.g. in the narratives of Charlotte and Bill) the participants saw their actions in health care to be directed towards promoting health, the ‘health’ towards which their actions were directed remained generalised and indistinct.

SUMMARY

The nurses in this study have consistently attempted to incorporate into their health-focused care aspects of health promotion. This occurred in a situation where there was little clarity about the nature of health itself, a lack of acknowledged unified understanding of the meanings of health among nurses, and
no clearly defined role for health-focused care. Indeed health-focused care was offered as caring and support via the development of rapport between the nurse and the person cared for, rather than being specifically ‘health’ directed. The aspects of health which were ‘promoted’ therefore appeared to be only in a very general way related to health, rather than ones that had been identified by the recipient of care or by the discipline of nursing.

In light of the exploration that has taken place in this study, the question of whether nurses are being adequately prepared and supported by the education sector toward health promotion practice is pertinent. It would appear that nurses are not adequately prepared for the practice of health-focused care in that they do not have clearly acknowledged, shared understandings of the meanings of health. Nor are there any indications that nurses derive meaning from health-focused care in any but personal ways. In reality, then, this means that nurses fail to recognise a structural link between guiding notions of health offered in nursing education and health-focused care as implemented in practice. Such a situation cannot be allowed to continue if nursing is to fulfil the recommendations of the Better Health Commission (1986) to foster and develop nurses as health-promoting practitioners.

On the question of whether nurses do or do not practise health promotion, some answers would appear to be clearer from this exploration. In the experience of this researcher, nurses working in hospitals have consistently replied in the negative when asked specifically whether they practise health promotion. However, in this study, when asked to describe the giving of health-focused care, the nurses have included descriptions of activities that are recognisable as health promotion. It would appear, therefore, that there is work ahead for nursing to clarify and define the parameters of health promotion for nurses.

In addition to clearly acknowledged and shared meanings of health for nursing, it would also appear to be imperative that nurse educators work toward achieving
clarity about various types of strategies of health promotion. If nurses are to practise health promotion in a variety of arenas, they need to understand clearly the connections between the meanings of health and health promotion, as well as the application of different types of health promotion strategies to the various different nursing situations in which nursing is to be carried out. A deeper understanding of the effect of the social relationship that develops between the social actors engaged in health promotion (i.e., nurse and patient) also needs to be pursued. Since it appears that such relationships may have a significant impact on practice, they need to be explored in both the research arena and during the education of nurses.

**Concluding thoughts**

While thoughts about the meaning of health in nursing and nursing theory can be helpful, there remains the matter of ‘living the question’ which is inherent in the work of phenomenology. That means that one must keep open the search for understanding and constantly question that which has previously been held to be securely known, accepting always that there is more to learn. Living the question means that the search for another view of the manifold reality of living continues, opening one continually to further depths of questioning and understanding. By its very nature, living the question implies that the conversations with nurses about the meaning of health in their own lives and in nursing are kept open. This must be done so that the groups who have the potential to develop different perspectives on nursing issues (such as nursing theorists and nursing researchers) are sustained as well as challenged as they engage with others in open communication, so that discourse may continue. It means also keeping open the conversations between nurses, health researchers, doctors and health workers of all kinds. This must be done to explore forms of knowledge appropriate to the situations that confront them and so that the meanings of health in health care remain constantly challenged, constantly renewed and appropriate for the effective practice of health care in the current context.
To change health care in nursing to accord with the directive towards health promotion and so that nurses may become more effective as health-promoting practitioners, conversations and discussion about the significance, possibilities and consequences of applying differing meanings to health are needed. Such conversations are what will eventually change attitudes and practice and will serve to make clear the connections between meaning and action. Simplistic solutions can serve no purpose and nursing is already stumbling under the burden of an excess of information about health. For these reasons, this thesis was intended not as a re-visioning of the meaning of health for nursing, but rather as a way of clarifying what are the critical issues if health promotion in nursing is to ultimately succeed. For that reason, in the following section I present theses derived from this study with the aim of continuing the dialogue about knowledge to be used in health promotion practice in nursing.

THESES

To be a nurse does not mean that one has a coherent understanding of the meaning of health. One cannot offer effective health-focused care, however, without clearly comprehending the meaning of health.

Teaching for health in nursing must encompass ways for nursing students and graduate nurses to share dialogue about the meaning of health for them so that they may come to recognise and comprehend the meanings and the role of health in both their lives and their work.

Nurses need to be encouraged to contemplate and discuss the connections between health, as they understand it, and the way they approach and practise health care.

As a discipline, nursing must resolve the meanings of health that are to be used to guide nursing practice so that the meaning of health promotion in
nursing may be universally understood.

*For nurses, understanding of the meaning of health in one’s own life does not mean that one knows how to link those meanings to health promotion in nursing.*

The connections between the meanings of health and health promotion require continued dialogue and resolution for the effective practice of health promotion.

*The implementation of health promotion in nursing practice depends on more than the nurse’s ability to understand the meanings of health and their connections to health promotion.*

Health promotion is not just a strategy or series of strategies which need to be implemented. Dialogue to develop coherent, articulated health promotion strategies needs to be engaged in, so that the relationships between the various meanings of health and practice can be readily understood in the context of health promotion.

Health promotion is more than mere problem solving; it is a human interaction and, as such, is constructed anew by each pair of individuals who engage in such dialogue. Such human interactions require to be explored further so that the relationship between them and health promotion may be articulated.
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APPENDICES

Appendix 1

INFORMATION FOR RESEARCH PARTICIPANTS

The intent of this research is to explore recently graduated nurses’ experiences of health and their experiences of giving health-focused care to someone in their care.

Each participant in the study will take part in two stages; firstly, through the development of a concept map of health as they experienced it, and secondly, by participating in between three and six interviews over a period of several months. The interviews will be:

- informal and semi-structured by the participant’s concept map of their experience of health
- held at a venue suited to the participant
- approximately 45 to 60 minutes in length
- audiotaped

The first meeting will be used to explain the process of concept mapping to the participant and to demonstrate and discuss the way a concept map may be developed. The interviews subsequent to this will be guided by the concept map thus developed. The first interview will begin the process of exploring the way the participant experienced health. The second and subsequent interviews will provide opportunity for discussion and validation of the researcher’s preliminary interpretation of the previous interview(s) while further interviews will focus on the way participants experience giving health care.

Audiotapes resulting from the interviews together with the researcher’s notes will be stored securely in a locked filing cabinet, as will transcripts of the tapes.
Transcripts will be accessible only to the researcher, Kate Caelli, and her principal supervisor, Professor Robin Watts. Transcripts of the tapes and the resulting narratives will not include any identifying names of persons or their places of work and all participants will be referred to only by a pseudonym. The narratives and excerpts from the audiotapes may be used in the research report and in any resultant published work, but no identifying phrases, names or labels will be used. Audiotapes, notes and transcripts will be retained securely as detailed above for five years following completion of the research, after which they will be destroyed. Information obtained from the concept maps and the interviews will be regarded as confidential between the researcher and the participant at all times and participants will have the opportunity to screen all material that is to be included in the thesis.

CONSENT

- I have read the information provided and understand the conditions under which the data resulting from the interviews will be utilised.
- I have been given the opportunity to ask questions relating to the research, concept mapping and the recording of the interviews and the narratives. I am satisfied that my questions have been adequately answered.
- I understand that I may withdraw from my participation in this study at any stage, or withdraw my consent for the use of all or part of the information obtained through my participation.
- I therefore consent to participate in this study subject to the above conditions

Signature: ......................................................... Date: ..............................

Witness: ................................................................. Date: ..............................
EXEMPLARY FROM INTERVIEW WITH ‘ANNE’, FRIDAY, APRIL 28, 1995

Res: I'm interested in knowing what health is like for you. I want you to think of a time when you felt truly healthy, and describe it to me, as it occurred.

Anne: The last time I felt truly healthy it was just a general feeling of contentment ... and ease ... with myself, with what I was doing and with how I was working, with ... my environment. I'd taken up a new job ... and I felt very comfortable in the job that I was doing; I felt that I was achieving good things in the job. I was very content where I was living and ... had a good relationship with my family. I was in a relationship that was very comfortable and very happy ... and... um ... I felt like I was keeping in touch with people and I was doing all the right things. I was financially secure and emotionally secure and I was living in a very pleasant environment. In my job, I felt [that] even though it was busy, it was achievable, although there were a lot of tasks to do and things to do. My employer's expectations went with my capabilities. So, while it was a challenge, it wasn't - I didn't feel as though I was ... um ... doing something that I might have felt ... or been ... unsafe doing, or been uncomfortable doing. I was giving good care and I could feel that. I got that ... um ... reaction from my patients. I was learning and I reckon I'm at my happiest when I'm learning. At home, I'd decided that I might as well clear out of my room all the things I didn't want or need around me ... and I managed to um ... give myself more space - just to make it a very aesthetic room. It's my own bedroom and it's quite large and light and I just had things that I wanted in it. You know, I hung pictures on the wall and finally got my room very balanced and very aesthetic... [long pause].

Res: When did the feeling of healthiness occur?

Anne: Umm I'd say in the last two months. I uh ... was in a relationship that I could - needed to get out of. So it's a relief ... from it. It's very sad. It was a two-year commitment that we had, but [we] didn't work it out, or it didn't work out
and ... I was just so damn relieved to not have that worry in my life. That's when I started to ... um everything kind of got ... My work was lagging and my personal life and my home environment ... was lagging to a certain degree. I couldn't see my desk [laugh]. I had things to do ... and I wasn't getting ... I had things to do in life, just regular bills and general stuff that everyone else has to do, that I just wasn't getting done. I thought, I can't, I can't, I can't exist like this! I'm just not ... I'm stale! So I started to achieve what I wanted to do. I went away and achieved some personal goals. [I] came back and house sat and thought 'Right! This is what I need to do - I need to move out [of home], I need my space and I need to be more of an individual.' [After that] I came home on excellent terms with my ... and I am on excellent terms with my parents. The most comfortable I've been at home - ever - and it's been wonderful. It's just balance! Life is [like] that; you've got to achieve a balance in everything you do. I'd lost the plot in a very big way. I felt I'd ... there were ... between my boyfriend at the time and my family, there were ... bad vibes. They just did not get along, which was hard, because I was the person in the middle, trying to pacify this one and care about that one. And I couldn't do it; I did it very poorly. I was having ... the previous place that I'd worked; I was having a lot of problems with management there. They weren't small problems. They were considerable and I had to ... address an appeal to certain comments and ... things that had happened there ... very high up ... in management. I had to stick up for myself and ... say, 'Hey, look, I don't believe I'm being treated correctly. I'd like an explanation.' So I had to uh ... deal with a lot of stress at the time ... and that'd been going on for several months. It was an accumulation of things. One-by-one, as one thing resolved, I came down to the relationship which was still ... I felt ...that was the last thing that needed to be dealt with ... to find a balance. And I have! I have!

Res: Can you describe what health was like when you started to feel healthy?
Anne: When I feel healthy, I feel as though my skin is clear. I feel as though my mind is clear. I have energy! I have ... a great deal of concentration. I very ... awake! I'm very happy. I've got a pretty sharp sense of humour and that's at its peak. Um ... I don't feel bloated - like, you-know how you can feel bloated if you
have a lot of salt in your diet or eat certain [foods] or um ... when your hormones are going crazy. It's ... [that] you don't feel like you're carrying that ... extra fluid. You don't feel like you're carrying that extra weight. My shoulders weren't tense and things like that.

Res: And your emotions ... when you were feeling really healthy?

Anne: It's the way I react! So you come across something and you say "Oh, that unpleasant ... let's deal with that" rather than "Oh, my God, this is unpleasant, this means something ... terrible!" and [you wonder] how are you gonna deal with it and you just, you just react differently. You feel as though you've got the capacity, the emotional capacity and resources to go "Huh" [sound of optimism], this is a problem, let's deal with it. Rather than go 'Oh my God ... let's leave this one in the too-hard basket ... let it fester there for a while.' [laugh]

Res: How did you recognise this health?

Anne: It's just not that when I can ... Depending on my diet, I can tell you exactly what makes me feel ... like ... bloated, like you've eaten something that you really shouldn't have and it's just sitting there. It's just feeling like you can eat a meal ... and feel very comfortable after eating it. It's not seeing a huge bowl of pasta and eating the whole lot! You know you're restrained! You're content! You know, you think "Oh, that was more than enough". Let's enjoy [that] rather than ... Sometimes you can enjoy food and feel fine and sometimes you eat it and think, "I should have enjoyed that but I didn't!" Sometimes I [can] feel quite bloated and weighed down by it. It's [health is] being able to deal with things that restore balance ... and ... You know you can have stress, but as long as you can deal with it, you can achieve a balance. I felt compromised in the sense that ... the personal relationship, the family and myself ... didn't mix. There was a compromise [involved] there that I didn't appreciate. I found it very hard to be part of a family unit, be a part of a relationship and be myself. And I compromised my family relations and I compromised myself for the relationship.
EXEMPLARY FROM FIRST INTERVIEW WITH ‘SALLY’, APRIL 29TH, 1996

*Res:* Sally, I want you to describe a time in your life when you felt really healthy. It need not be the most recent as long as you can remember it clearly and describe what it was like.

*Sally:* I guess I dream about it [health][laughing]. One morning I woke up and thought 'I've got to get really healthy' and I went down to the Superdrome and organised a membership there. I guess the times that I feel most healthy are when I’ve done some form of exercise to get my day under way. But, I think I feel really healthy when I’ve got a routine in my life. When I’m doing shift work, I don’t have any routine, but when I’m doing night duty ... It sounds back to front, but when I do night duty, I actually feel more healthy than when I’m doing day duty because I have a routine. I sleep all day and then I get up and I have to do some sort of exercise that'll wake me up. I go swimming or go for a run or a walk. I do quite a bit of exercise, but it's the routine that keeps me feeling healthy. I always get a good sleep on night duty. I make my room dark and I have a fan that's not too noisy and I'm young and I can ... sort of cope with night duty. So it's the routine factor that makes me feel healthy ... because I eat better too. I eat better on night duty as well, because there are no shops open so you need to make your meals and things like that. I always have a big meal in the middle of the night and a small one when I get home and breakfast is when I get up in the afternoon.

*Res:* So it's the routine plus the exercise ... together?

*Sally:* Mmm ... it's a healthy diet as well. About two years ago, I was feeling extremely unhealthy. I felt that I was overweight and I'd sort of let the exercise go a little bit and things like that. So I thought 'Right, I'll make a concerted effort to get over this.' and I went and saw a dietician for a while. It was good. They basically just talked about food facts and healthy foods and all that sort of thing. I actually lost about 10 kilos but over a period of about four to six months I made a
real effort to eat healthily and a real effort to exercise three or four times a week. It paid off, and ever since then I've sort of kept up with that, so I feel good. But some times, I go through weeks when I ... smoke a lot and drink copious amounts of alcohol [laughing] and ... not exercise. But that's all because you get out of a routine and it's all a catch 22! If you have more of this, then you do less of that. The more you don't do any exercise, the more you feel lethargic. It's like a circle. You think 'Oh, what should I do? Oh, I'm bored, I'll have something to eat.' Then you eat and then you feel fat and then you think 'Oh, what should I do?' and then you smoke. Then, when you start smoking and you have more cigarettes, you think 'Oh, I think I must have smoked too much! Oh, I've got no energy to exercise!' It just goes round and round in circles!

Res: When you feel really healthy, how does it feel?

Sally: I feel like I've got more energy. I feel refreshed and just a lot more alert. Everything's so much better. Like you'll go to work and you won't feel depressed about going to work. It'll be like um ... Instead of complaining about having to go to work you'll be like ... you look at the positive aspects of it. Like, I'll think 'Oh, I'm not really going to work. I'm going to go and socialise with my friends but work happens to be there at the same time.' That's mostly the way I think. I'm a fairly positive person. I always think positively and even with things that have the worst possible outcomes, I sort of try to have them as positive experiences, even though they might be bad. But yeah, when I'm healthy, when I feel really healthy, I feel alert, I feel alive! I've got energy and everything's good. It doesn't matter what happens in that day, it wouldn't bother me. But on other days when you feel less healthy, or you're feeling a bit sad or a bit depressed, someone can just say something really ... insignificant, ... just be making a comment or a sarcastic joke or something like that, and it'll just get to you. You just feel really "off" about it and upset because you start the day off in a bad frame of mind, like an unhealthy frame of mind. It's not necessarily physical, health; it's mental. I think that's more of a problem in nursing and [the] stress-related occupations than actual physical health. Physical health is subservient, I think, to mental health. If I'm feeling mentally healthy, I'll be physically healthy because my mind is telling
me 'I'm feeling good.' I'm not ... feeling upset about something that might have happened at work. I'm not upset about anything; I'm feeling good! When I'm feeling positive, I eat well and I ... exercise and I feel all the physical things. But if I'm feeling lousy mentally and ... because I've had a bad day at work, or someone has died or they've ... switched someone off a ventilator or something like that, I feel ... a bit down and out about that. Then I think ... then I tend to sort of slump around or smoke more or I won't exercise or I won't sleep well and all those sort of things.

Res: Tell me about it [feeling healthy] from when it started, the way you were when it started and then now.

Sally: I'd actually been up north working and had a great time. I came back and I don't know what happened, I just woke up in the morning and thought 'That's it!' I think just sort of suddenly thought 'Gosh, I'm not doing anything like I used to!' I wanted a new life. Just suddenly, I felt 'Ooh, I'm sick of all this. I just want a change.' I didn't have as much energy. Like, you just tend to get into ... [a rut]. I mean, you start wearing baggy clothes and ... You go out, and you might have a really big night out and then you flake out all day the next day because you've ... [feeling awful] [laughing]. Now it doesn't appeal to me to go out and have a really big night because I think 'Oh, I just couldn't stand to be lying around all day with a dreadful headache, feeling sick and nauseous and having diarrhoea or whatever.' I just think to myself 'It's such a waste of an entire day!' and I could go out and have an equally good time without having to suffer the effects the next day. The last time it happened, I looked at all the people that were around, going running and doing things like that and I thought 'Ooh, I wish I had the energy to do that, but I just don't!' and then
my head was back on the pillow! That was a couple of years ago and I'm just starting to feel how I felt before I went out and changed it all last time. Even though I've kept the weight off and I've increased my exercise and stuff, it's sort of like I was healthy here [drawing a diagram on the table in front of her] and gradually, over two years, I've come down to here. So I've started playing hockey again but that's training twice a week. That's a winter [sport], that's good, and you play on the weekends. But, I really need to get back into swimming and um ... I feel that I'm eating healthy but I've just started to ... because I'm really busy at the moment; I'm busy studying and working and I've got no time to exercise, unless it's forced exercise. By playing hockey, it's forced; I have to train and I have to play. At least then I know I'm getting four hours a week of exercise. I'm also going back on night duty so I'll get back into that routine that I've been missing. When you feel really healthy ... you just ... you just feel much [better]. When you feel really healthy, you just glow! You go out, you feel ... I mean it's not to do with being ... [that] you're fat or skinny but you still glow. Your skin glows and it shows in your smile and you light ... your eyes light up ... You just look much better and even if you wear the same clothes ... I don't know, your hair looks shinier and you look neater ... or fresher! That's how, when I'm feeling really healthy, I feel like I look good. So when I go out it just comes out naturally anyhow. I wouldn't have to fake a smile or pretend I'm being happy because it would just happen! You just feel happier, like you just feel ... alive and ... you really enjoy life. I mean, you do that when you're feeling lousy as well but you ... it's ... you've just got much more energy! And even ... when you're feeling healthy, you've got ... you think 'Oh, I wonder what I'll have for dinner?' and you've actually got energy to go down to the shop and buy fresh veggies and come home and cook them because you're feeling really good. But if you weren't feeling that way, ... I know I'm guilty, like when I went through a period when I was feeling really unhealthy, I'd just stop at McDonald's on the way to work and at Kentucky Fried Chicken on the way home. Then I was getting all this weight building on, because I was feeling really unhealthy ... and I'd eat unhealthily and do no exercise at all. It's [health] all about having energy and feeling good! Some
days you’re at work and the person next to you doesn’t talk to you. It doesn’t help you. It doesn’t create a team approach and that makes you feel lousy. But when we’ve had a really good day … Nothing beats you when you’re having a good day. Nothing beats you, you just feel really good about everything. I mean, you’ll be driving along and you’ll get caught in a traffic jam and you look out of the window and think ‘Oh, that’s a nice tree’ or ‘What’s going on around here?’ I was driving to … a couple of weeks ago and [there were] huge roadwork [going on] you know, like on a main highway and you’re just stuck there for 20 minutes in the middle of nowhere. But [I thought] ‘Oh well!’ and I was feeling really good. I thought ‘Well, I’m not in a hurry, I’ve got nothing to do; I’m not being impatient about anything.’ I thought ‘I’ll have a look around the bush,’ and talk to the people that hold the ‘Stop’ and ‘Go’ signs and … I had a look at what they were doing and it wasn’t stressful. I was actually enjoying the scenery and feeling relaxed being where I was and enjoying the drive. The fact that I had to wait in the middle of a dusty road … you know, for 20 minutes, was incidental. It didn’t bother me … Yet if I was feeling unhealthy and stressed and in a hurry to get to wherever I had to go, it would’ve … I would have been sitting there getting all worked up and feeling impatient and wanting to just drive through. That’s the difference!

Res: So are you saying health is being relaxed about the way things are?

Sally: Yeah, like you just don’t feel this stress! It’s like, you go to work and you’re not in a hurry to go to work, so you just sort of get to work. I think ‘Well, if I’m five minutes late for work, who cares?’ [It’s a feeling like] the whole world’s not going to stop, yeah. If I’m feeling healthy about things I will … usually I will have got up earlier in the morning because I wouldn’t have set the snooze button three times back to sleep. [I’d have] got up … sprung up out of bed, you know, had a shower, felt really good and you get in the car and off you go. But when you’re feeling really tired and unhealthy and lousy you do set the snooze button.

Res: It sounds like you’re saying that it helps you put things in perspective.

Sally: Oh yeah, definitely! You think straighter, you think more clearly and you
... you don't get so ... You actually think more logically about things as well. I think basically health relates to ... you know, feeling good. Then once you feel good you're so much more in control and you've got much more direction and you're able to achieve things that you want to achieve. Whereas when you're feeling lousy or unhealthy you um ... your mind's clouded with emotions and you're not thinking straight. You just get into a rut where you just go around in circles. And it's really hard to snap out of when you're in it!
Appendix 4

PUBLICATIONS AND PAPERS ARISING FROM THIS THESIS

Publications


Caelli, K. 1996, Health to health promotion: Transforming health experience into nursing practice, Proceedings: Qualitative Research Methods Asia-Pacific Workshop, Monash University, Melbourne, December 3-6, 134-137.

Abstracts and conference presentations


Caelli, K. 1997, Doing phenomenology: Gaining the edge. Paper presented at


Caelli, K 1996, Shared Understandings: Negotiating the meanings of health via concept mapping, Paper presented at First International Conference of the Nursing Education Unit of the School of Nursing, McMaster University, 'Create the Future, Celebrate the Past: Global Connections in Nursing Education', Hamilton, Sheraton Hotel, Hamilton, June 17 - 20.

Dimensions Conference, University of Ballarat, Ballarat, Victoria, February 4-7.

**Invited presentations**

Caelli, K. 1998, Phenomenology and health research, School of Nursing, University of Technology, Sydney, August 11.

Caelli, K. 1997, The Image of Nursing - perception and belief, to Royal College of Nursing, Australia, WA Chapter; Professional Network Forum Number 4, July 23.

Caelli, K. 1997, Health to Health Promotion: Transforming health experience into nursing practice, to the Primary Health Care Special Interest Group, School of Nursing, Curtin University of Technology, Perth, April 16.

Caelli, K. 1997, Health to Health Promotion: A phenomenological study of the meanings of health, to the Faculty of Nursing, Ohio State University, Columbus, April 3.

Caelli, K. 1997, Phenomenology and research in nursing, to the Faculty of Nursing, Newcastle University, Ourimbah Campus, February 7.

Caelli, K. 1995, Phenomenology and health research, to the Department of Nursing, The Chinese University of Hong Kong, Shatin, September 5.

Caelli, K. 1995, Phenomenology, to the School of Nursing, Curtin University of Technology, Perth, August 23.

Caelli, K. 1995, Primary health care curricula, to the Primary Health Care Special Interest Group, School of Nursing, Curtin University of Technology, Perth, February 18.

Conference reports