EXPERT PUBLIC HEALTH NURSING PRACTICE:

A COMPLEX TAPESTRY

A thesis presented in partial fulfilment of the requirements

for the degree

of Master of Arts in Nursing

at Massey University

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1997

ABSTRACT

Patricia Benner's seminal work, *From Novice to Expert* (1984), can be considered the starting point for ongoing nursing research that has sought to describe and understand expert nursing practice.

A review of the nursing literature revealed a gap in the research based knowledge relating to expert nursing practice from a New Zealand and community health nursing perspective.

This study used Heideggerian phenomenology, as this methodology has been interpreted and utilised by Benner, to examine the phenomenon of expert public health nursing practice within a particular New Zealand community health setting. Narrative interviews were conducted with eight identified expert practitioners who are currently practising in this specialty area. Data analysis led to the identification and description of themes which are presented as the research findings, supported by paradigm cases and exemplars.

Four key themes were identified. These seemed to capture the essence of the phenomenon of expert public health nursing practice as this was revealed in the practice of the research participants. The themes describe the finely tuned recognition and assessment skills demonstrated by these nurses; their ability to form, sustain and close relationships with clients over time; the skilful coaching undertaken with clients; and the way in which they coped with the dark side of their work with integrity and courage. It was recognised that neither the themes nor the various threads described within each theme exist in isolation from each other. Each theme is closely interrelated, and integrated into the complex tapestry of expert public health nursing practice that emerged in this study.

Although this research supports and elaborates upon many of the findings from published studies that have explored both expert and public health nursing practice, differences were apparent. This suggests that nurses should be cautious about using models or concepts developed in contexts that are often vastly different to the New Zealand nursing scene, without carefully evaluating their relevance.

ACKNOWLEDGEMENTS

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EXPLANATION OF TERMS

The following conventions have been used in the presentation of these research findings.

italics   the words used by the study participants themselves, including paradigm cases, exemplars and quotations longer than two lines

"   "   single words, or short phrases/sentences used by the research participants that appear in the body of the text.

'   '   words developed by the researcher or other authors.

...   intervening material within a paradigm case or exemplar that is omitted because it is not directly related to the issue being discussed.

(   )   this denotes a cultural group, language or place used in the paradigm or exemplar that, if used, would have had the potential to identify the research participants or their clients.

names   personal names of research participants or of the people whose stories the nurses used to describe their practice, have been changed, and pseudonyms used.

client   an individual person, family or school who are the focus of the interactions with the public health nurse in a particular situation. The text clarifies the meaning of the term.

gender   throughout the research report the feminine pronoun is used to refer to the research participants because all the participants were female.

CHAPTER ONE

Introduction and Overview

This is a study about expert public health nursing practice. Since the late 1980s, I have had an interest in the research programme of Patricia Benner, valuing the 'voice' she has given to the world of clinical nursing practice. In particular, her descriptions of expert nursing practice have supported my belief that an important way to enhance the quality of care clients receive is to recognise, support, develop and keep expert practitioners 'at the bedside'. In order to do this, however, we need to know who these nurses are, and what it is they do that truly 'makes a difference' to client outcomes.

The aim of this research is to describe and understand expert public health nursing practice within a New Zealand community health setting.

In addition to a personal interest in the concept of expert nursing practice, a review of the literature revealed that the majority of related research has been generated from acute care settings. It was also significant that the majority of the research reviewed had been conducted in settings where the organisation of health care, and the social and political environments, are quite different from the New Zealand context.

Only one research study was found that related Benner's work to nursing in New Zealand (Paterson, 1989). Although this study did not explore expert practice, the findings did highlight the relevance of aspects of Benner's (1984) original research to nursing in this country. Although Benner's research programme has gained international recognition, care must be taken not to assume that concepts developed in one socio-cultural environment can simply be transplanted into a different environment without some consideration of relevance occurring. The outcome of this study has the potential to validate, extend or challenge aspects of Benner's work within a particular New Zealand nursing context, and to continue the task of describing nursing practice from a New Zealand perspective.

My current work experience is in a community nursing context and I have become increasingly aware of how difficult it can be to clearly articulate the contribution that nursing makes within this sphere. In reviewing the literature on expert nursing practice, Zerwekh's (1991) research was the only study found that specifically

explored expert public health nursing practice. The present research therefore has the potential to expand the nursing knowledge base on expert public health nursing practice. It is also my hope that the findings will open to the public domain an area of specialty practice that appears to have been inadequately described, and, as a consequence, perhaps it has been poorly understood.

Through providing some initial description and understanding of expert public health nursing practice, other nurses working in this area may be inspired to continue the task of articulating their contribution to health care, and to aspire to personal excellence. Making a practice more visible can be considered one way to encourage a climate of professional growth and wisdom. As noted by Benner, Tanner and Chesla (1996), although it is impossible to completely formalise expertise, we must study and learn from expert practice in order for this to be highlighted and extended in practice. The findings from this study also have potential to increase the understanding of health care professionals about the contribution that expert nursing practice can make to the provision of quality, community-based, client care. As the nursing language around the concept of expert practice is extended, there is also the possibility that a greater sense of understanding and unity within the nursing profession will be encouraged.

Since its inception, the novice to expert framework for nursing practice that was described by Benner has been used to guide the development of a number of clinical career development programmes for nurses. These programmes have been adapted to meet the needs of diverse settings. For example, Silver (1986) described a five level structure adopted by nurses in South Australia, while the professional advancement programme described by Balasco and Black (1988) recognised three levels of practice. Levi, Montgomery and Hurd (1994) added another dimension in their discussion of the successful use of Benner's work in the development of a differentiated nursing practice model. This model recognised levels within each of the nursing professional groups.

From a New Zealand perspective, Ainge (1993) described the Cantabrian experience of developing a six step clinical career pathway, while Peach (1995) summarised the way Benner's work was utilised and integrated into the professional development programme of Auckland Healthcare. Many of the clinical career development programmes cited in the literature had the overt aim of encouraging, recognising and validating expert nursing practice. Maintaining expert practitioners in clinical practice was viewed as integral to quality care. The literature review undertaken did not however reveal examples of clinical career development programmes that have

been implemented for public health nursing. The findings from this research have the potential to provide a beginning point for exploring the relevance of such programmes for this area of specialty practice.

There is a dearth of postgraduate nursing education available in New Zealand that has a community nursing orientation. The findings from this research could impact upon the development of educational opportunities for public health nurses. The literature revealed how educational strategies for encouraging, supporting and developing expert practice have been developed in different settings. For example, Fenton (1992) described how the findings from an ethnographic study of expert practice could be incorporated into educational content and learning strategies for graduate education. Gatley (1992) supported the theory/practice/education link in her description of a postgraduate district nursing course that used Benner's work as an organising framework. In describing a cardio-respiratory nursing curriculum that progressed from certificate to masters degree level, Shuldham (1993) acknowledged the reciprocal relationship existing between progression in practice from novice to expert, and increasing intellectual enquiry and research evaluation.

In order to develop educational programmes that will support the development of expert public health nursing practice, some understanding of the phenomenon is essential. The findings from this research could be used during the process of educational planning for this specialty area of practice, and could also impact upon the content, teaching methods and evaluative strategies. Nursing narratives have been used as the data collection method for this study, and some indication of the usefulness of this approach in capturing expert practice will become apparent. This understanding could impact upon how narratives are used in both clinical and educational settings.

As has been highlighted, the impetus for embarking on this particular research journey came from many sources. These included a personal interest in the topic, and the identification of a gap in the knowledge base surrounding expert nursing practice from both a community nursing and New Zealand perspective. A belief that the findings have potential to impact upon clinical practice and nursing education was also a driving force. There was also the challenge of attempting to articulate some aspects of a practice that does not appear to be clearly defined.

Although this study did not attempt to replicate Benner's work, her research has provided both the inspiration and a background framework. Heideggerian phenomenology, as interpreted and utilised by Benner, was the methodology used

to access and understand the practice world of the research participants. The focus of the research was clearly upon the phenomenon of expert public health nursing practice as conveyed through the narratives of identified expert practitioners. My clinical background has predominantly been in an acute care setting, and this work is therefore very much my interpretation of the phenomenon as identified in, and supported by, the work of these nurses. Heeding Van Manen's (1990) caution that lived life is always more complex than any explication of meaning can reveal, I did not expect, or seek, to identify all the nuances of expert public health nursing practice. The aim was to present key themes, not an exhaustive model that attempts to explain the totality of a phenomenon. Although there is some inevitable overlap in the chapters that describe the identified themes, I have endeavoured to minimise this in order to convey the characteristics of the phenomenon as clearly as possible.

As indicated in the title of this work, expert public health nursing practice is a complex tapestry that comprises many closely interrelated threads. The word 'tapestry' has been used to capture a sense of intricacy, of connecting patterns, of linkages formed, of harmony, and of balance. Viewing the threads in isolation from each other can dilute the richness, the coherence, and the understanding that is gained when the full picture is visualised. The reader is therefore asked to be mindful of the close relationships that exist between the identified themes. When viewed together, these themes make up the phenomenon of expert public health nursing practice as it was revealed in the present study.

Study overview

I will now present an overview of the chapters that make up this research report.

Chapter One has provided an introduction to the study topic, outlining how the focus for the study was identified. Tentative thoughts regarding possible implications of the study were articulated, and the scope of the research was clarified.

In **Chapter Two**, the literature that was selectively chosen as being most relevant to expert nursing practice and public health nursing practice, is reviewed. Main concepts that have emerged from Benner's research programme are described and published commentaries on Benner's work are discussed. Selected literature on

public health nursing practice is presented in order to provide some understanding of this specialty. Similarly, a selected exploration of expert nursing practice within diverse clinical settings gives a broad overview of this phenomenon. The role of nursing narratives in capturing aspects of expert practice is included and provides some of the rationale for selecting narrative interviewing as the research method for this study.

In **Chapter Three**, the selection of Heideggerian phenomenology as the methodology for this research is justified. Underlying assumptions are explicated, and the rationale for using Benner's interpretation of Heideggerian phenomenology is clarified. The study design is outlined, including a summary of the meaning of the terms paradigm case, exemplar and theme. These provided the basis for data analysis and the presentation of research findings. Ethical issues relating to the research are also discussed, including the measures taken to preserve anonymity and confidentiality of the research participants.

Chapters Four, Five, Six and Seven are a presentation of the major themes that emerged from the data. These themes seemed to capture the phenomenon of expert public health nursing practice as this was revealed in the practice of the nurses participating in this research. Each thematic chapter is divided into a number of sub-themes, and the presentation of findings is supported by paradigms and exemplars that were identified in the narratives of the participants. These provide the reader with textual evidence to support the interpretations being made. The details of some of the narratives have been slightly amended to preserve the anonymity of the people whose stories the nurses used to describe their practice. The discussion section at the end of each chapter relates the findings described within the theme to some of the concepts that have been described in Benner's research programme. As a part of each discussion relates to the domains and competencies described in Benner's (1984) original research, these have been appended to this research report (see Appendix 4).

In **Chapter Four**, the finely tuned recognition and assessment skills that emerged as a key component of expert public health nursing practice are addressed within the theme of **delving beneath the surface.** The chapter elaborates upon this theme using the sub-themes of recognising that it is seldom simple, and seeing the full picture.

Chapter Five describes the journey that the public health nurse and client undertake as relationships are developed over and through time. The theme of **watchful**

<u>journeying</u> is explored using the sub-themes of <u>forming relationships</u>, <u>sustaining relationships over time</u>, and <u>closing with care.</u>

Chapter Six encompasses the skilful coaching undertaken by the public health nurses who participated in this study. **Moving to the client's rhythm** is the theme used to describe this process that is addressed under the sub-themes of <u>coaching in harmony</u>, <u>focusing on the everyday</u>, and <u>valuing and supporting change.</u>

In **Chapter Seven** the theme of **coping with the dark side** is described. This emerged as integral to expert practice and is articulated within the sub-themes of <u>keeping the child at the centre of the web</u>, <u>maintaining personal safety</u>, and <u>walking along an ethical path.</u>

Chapter Eight is the discussion chapter. It provides a summary of the themes that are the outcome of this research. The research findings are discussed in relation to selected nursing literature, and implications for nursing practice, education and further research are explored. Limitations of the study are addressed and comments made regarding the value of the research for the researcher.

CHAPTER TWO

Literature Review

This chapter will summarise some of the current knowledge on expert nursing practice, and clarify where the present research fits within the wider picture. In the previous chapter, literature on clinical career development pathways and educational implications of expert practice, supported some of the rationale for undertaking the present study. In this chapter I will address other major themes that emerged from the literature. The first section is essentially a trail of Benner's research programme, her seminal work, *From Novice to Expert* (1984) providing a logical starting point. Commentaries on her research findings will be included, while a critique of the methodology used in her research programme will be included in Chapter Three. In order to provide further background information for this study the second section will highlight key findings from studies that have explored public health nursing practice and expert nursing practice in a variety of settings. The value and relevance of nursing narratives in capturing aspects of expert practice will also be discussed.

The research programme of Patricia Benner

Although various aspects of Benner's model were described by the author in previous work (Benner, 1982 and 1983), her book *From Novice to Expert* (1984) reiterated and expanded upon these earlier articles. This can therefore be seen as a seminal work to introduce the topic. Benner (1984) believed the Dreyfus model of skill acquisition, developed by professors H. L. Dreyfus and S. E. Dreyfus (1980, cited in Benner, 1984) could be applied to clinical nursing practice. This model was based upon the study of chess players and airline pilots, and takes into account the place of expertise and education in skilled performance. Briefly, the Dreyfus model posits that in the acquisition and development of a skill, one passes through five levels of proficiency: novice, advanced beginner, competent, proficient and expert. These different levels reflect changes in three general aspects of skilled performance. The first is a movement from reliance on abstract principles to the use of past, concrete experiences as paradigms; the second involves a change in the perception and understanding of a situation so it is seen less as a compilation of equally relevant bits, and more as a complete whole; and the third encompasses a passage from detached observer to involved performer.

In order to evaluate the practicality of applying the Dreyfus model to nursing, Benner (1984) conducted a systematic study that sought to identify the characteristics of nurse performance at the different stages. The methods included interviews with 21 pairs of nurses, one beginning and one expert, who were interviewed separately about patient care episodes they had in common, as well as interviews/participant observation with additional experienced and new nurses. Interpretation of the data was based upon Heideggerian phenomenology, the intent being to identify meanings and content. Through analysis of the situations as described by participants, and following the Dreyfus model, the researchers were able to describe performance characteristics at each level of development, and to identify in general terms, the teaching/learning needs at each level.

The novice or beginner nurse has no experience with the situations in which they are expected to perform tasks, and so must be taught context free rules to guide their actions. The advanced beginner can demonstrate marginally acceptable performance, having coped with enough real situations to note recurrent meaningful situational components that are termed 'aspects' of the situation. According to Benner (1984) these nurses "are only beginning to perceive recurrent meaningful patterns in their clinical practice" (p.25). Competency develops when the nurse begins to see actions in terms of long range goals or plans, which in turn dictate those attributes and aspects of current and future situations that will be considered important. This stage is characterised by a feeling of mastery and the ability to cope with and manage the many contingencies of clinical nursing. As the competent nurse moves to the proficient stage, situations are perceived as wholes. Performance is guided by maxims that reflect nuances of the situation, and provide direction as to what is important to take into consideration. At the expert level, the nurse no longer relies on analytic principles, but rather has an intuitive grasp of the situation that enables him/her to zero in on the accurate region of the problem. An important point to note is Benner's description of experience, which is not merely the passage of time or longevity, but results when preconceived notions and theory are challenged, refined or disconfirmed through encountering many actual practical situations.

Benner invited nurses to describe in narrative form patient care episodes that stood out in their minds, including as much detail as possible. Analysis of the field notes and transcripts yielded 31 competencies and these were then classified into seven domains on the basis of similarity of function and intent. These domains included: the helping role, the teaching/coaching function, the diagnostic and patient monitoring function, effective management of rapidly changing situations,

administering and monitoring therapeutic interventions and regimens, monitoring and ensuring the quality of health care practices, and organisational/work role competencies. Benner used exemplars, the majority of which focused on expert practice, to support the description of the competencies.

In this work Benner also began to articulate the perceived inter-relationship between power and caring. She identified and briefly described six different qualities of power including transformative, integrative, advocacy, healing, participative/affirmative, and problem solving. Benner also addressed the implications for teaching and learning at each level of development. She maintained, for example, that the novice needs to be taught about situations in terms of objective attributes and context free rules, while the expert benefits from describing critical incidents that illustrate expertise or a breakdown in performance.

Benner (1984) cited Thomas (1983) who described the nurse as "the glue that keeps the complicated system of hospital care together" (p.169), and maintained that more studies were needed to describe nurse/patient relationships in a variety of settings. Benner's research not only validated the applicability of the Dreyfus model to nursing, but it also began the process of describing levels of nursing practice, articulated domains of practice, and highlighted the power of caring. Through making the invisible visible in an academically respectable manner, Benner began the important task of describing how expert nurses do indeed make a difference to patient outcomes.

In a subsequent study, Benner and Tanner (1987) conducted a pilot project that attempted to identify the nature and role of intuition in expert clinical judgment. Intuition was defined as "understanding without rationale" (Benner and Tanner, 1987, p. 23), the authors describing intuitive judgment as the distinguishing factor between expert human judgment and decisions that might be made by a beginner or a machine. The authors stated that interviews and observations of expert nurses included examples of the six key aspects of intuitive judgment that were described by Dreyfus, H. and Dreyfus, S. (1985, cited in Benner and Tanner, 1987). These included pattern recognition, similarity recognition, commonsense understanding, skilled know-how, a sense of salience, and deliberative rationality. Benner and Tanner contrasted intuitive knowledge with analytic reasoning, noting that these are not necessarily in opposition, and also delineated some strategies to teach and evaluate intuitive levels of performance. This study attempted to bring into the public arena an aspect of clinical practice that is often difficult to articulate and

which can often be dismissed as un-scientific. Although the description was limited to the Dreyfus framework, the potential for further research on this aspect of expert clinical judgment was highlighted.

In their book *The Primacy of Caring* Benner and Wrubel (1989) extended the thesis begun in *From Novice to Expert*, that caring is central to human expertise, to curing, and to healing. These authors articulated that excellence is embodied in practice, that practice is a moral art and not merely an applied science, and that theory is derived from practice. Caring was described as the essential requisite for all coping, caring being used in the sense that persons, events and things matter to people. Through articulating their understandings of the phenomenological view of the person, stress and coping, and relating this to expert caring, Benner and Wrubel provided an alternative to the traditional Cartesian perspective. They highlighted the unique position of nursing in an era when care and caring are so often under-valued and poorly understood. Some of the caring behaviours described included understanding the lived experience, interpreting illness, using humour, the ability to presence oneself and the offering of hope. Through using paradigm cases and exemplars, the authors invited the reader to confirm interpretations being made, and to recognise the knowledge that is embedded in expert nursing practice.

In a series of studies that explored the practical knowledge of nurses, Benner (1991) described how she and her colleagues examined narrative accounts for notions of the good and the knowledge that is embedded in the practice of nursing. These stories provided texts for interpretive phenomenological studies of ethical comportment, practical moral reasoning, and ethical distinctions. Benner described the dominant ethic as one of care and responsibility, noting that an ethic of care must be learned experientially. The development of skilful ethical comportment that occurs in practice was emphasised, the term comportment referring to "the embodied, skilled know-how of relating to others in ways that are respectful and support their concerns" (Benner, 1991, p. 2). Comportment essentially refers to thoughts and feelings, together with physical presence and action.

Benner (1991) presented two major types of commonly occurring narrative themes, constitutive, or sustaining, and narratives of learning. The former depict situations that constitute the person's understanding of what it means to be a nurse, while narratives of learning include features such as being open to experience and learning the skill of involvement. An important aspect of this work was the presentation of an alternative to traditional quandary and rights-based procedural

ethics, with narratives being used to explicate ethical concerns in relation to particular persons and situations.

Tanner, Benner, Chesla, and Gordon (1993) elaborated upon nurses' discourse about knowing the patient that emerged as a recurring theme in an interpretive phenomenological study of the development of expertise in critical care nursing. The authors presented two broad categories of knowing the patient, in-depth knowledge of the patient's pattern of response, and knowing the patient as a person. Tanner et al maintained that knowing the patient was central to nursing practice, describing it as a primary caring practice that is always situated and influenced by time constraints, clinical situations, and the nature of the nurse-patient-family relationship. They stressed that it is the discourse of the particular that is so essential to clinical knowledge, acknowledging that organisational and economic constraints can certainly impact on the possibility of nurses truly knowing their patients.

In their most recent work, Benner, Tanner, and Chesla (1996) provided what they described as a much "thicker description" (p. xiii) of the acquisition of clinical expertise and a more detailed examination of the nature of clinical knowledge, inquiry, judgment and ethical comportment. This work was based upon a six year study of 130 hospital nurses, most of them critical care nurses. The four key aims of the study were: to delineate the practical knowledge embedded in expert practice; to describe the nature of skill acquisition in critical care nursing practice; to identify institutional impediments and resources for the development of expertise; and to begin to identify educational strategies that encourage the development of expertise. Interpretive phenomenology was used to access the everyday practice and skill of critical care nurses in order to explain particular and distinct patterns of meaning and action, while taking context, history and concerns into account.

Many themes emerged throughout the course of this study, and can be only briefly alluded to in this literature review. The authors discovered new aspects of each stage of skill acquisition, and came to see the competent stage as particularly pivotal in clinical learning, with the proficiency stage being a transition into expertise. The nature of the nurse's sense of agency, distinctions between engagement with a problem and the skills of involvement, links between clinical and ethical decision making, and further exploration of expert clinical judgment were described. Interesting discussions focused on the nature of the nurse-physician relationship and the social embeddedness of knowledge. The comment was made

that skill acquisition and the development of clinical expertise are dependent on the social ecology of the environment that includes aspects such as pooled expertise, role modelling and a shared vision of excellence. These authors also identified nurses whose practice falls out-side the 'normal' trajectory of novice to expert.

Of particular relevance to my research was the discussion on expert nursing practice. This was characterised by increasing intuitive links between seeing the salient issues in the situation and ways of responding to them. The practice of the expert was seen as encompassing engaged practical reasoning, a perceptual grasp of distinctions and commonalities, emotional involvement with patients and their families, knowing the patient, and a strong moral agency. Key aspects of their clinical world included gaining a clinical grasp and response-based practice, embodied know-how, seeing the big picture and the unexpected, the skill of involvement, managing technology, and working with and through others. At the expert level, moral agency also becomes more socially embedded. Benner et al. noted that although the clinical and moral world of the expert can in fact never be spelt out entirely, we can certainly study and learn from expert practice. These authors also made the point that through this study the role of sharing narratives in understanding a practice came into sharper focus, with narratives capturing clinical reasoning as it occurs in transition.

Benner's research programme has provided a broad framework for my study. As described, various concepts have been developed and refined over the past twelve years. In their latest work in particular, Benner, Tanner and Chesla (1996) have included a more detailed analysis of aspects of expert practice such as ethical comportment and a sense of agency. Issues impacting upon the development of, and support for, expert practice have also been increasingly addressed and the usefulness of narratives as a method for describing, analysing and validating expert practice has been reinforced. This lends support to the method I decided to use in this research. However, Benner's research programme has had a North American, acute in-patient focus, and a gap seems to exist in relation to providing a broader description of the phenomenon of expert nursing practice that encompasses a community nursing perspective. Care must also be taken not to assume that concepts developed in one setting can be used in a vastly different environment without some modification or perhaps re-framing. My research will explore expert practice within a particular New Zealand context. Although I am not replicating Benner's research, her work provided a catalyst for recognising and understanding the clinical knowledge that is embedded within nursing practice. She has also legitimised and encouraged research that attempts to describe the very 'being' of

nursing, and to articulate what nurses have to offer patients and families within their care. It is my hope that this research will in turn go some way to giving a descriptive voice to expert public health nursing practice in this country.

Commentaries on the work of Patricia Benner

In exploring expert, tacit knowledge, Meerabeau (1992) validated the existence of what Benner (1984, 1996) has termed intuitive knowledge. Meerabeau concurred that expertise can only be captured by qualitative, context dependent methods, and stressed the importance of an integration between theory and practice. This author made the comment that observation of practice is difficult in a community setting as the nurse-patient dyad becomes a triad, therefore lending credence to the use of narrative interviews for data collection in the present study. By discussing intuition within a wider sociological and educational framework Meerabeau also supported the existence and researchability of intuitive knowledge.

In an attempt to investigate if the concepts of expertise and intuition have anything to offer nursing, English (1993) provided some interesting arguments. In seeking clarification of what is entailed in gaining expertise, and suitable measurement criteria, this author claimed that the expert nurse as presented by Benner (1984) is some "blessed practitioner, initiated into the protected knowledge of some secret society" (English, 1993, p. 389). English denigrated Benner's description of the expert's intuitive grasp of the situation as a fanciful concept, and redefined intuition in terms of cognitive models. He did not seem to appreciate the interpretive approach taken by Benner, and also seems to have mis-read some of her original text. For example, Benner (1984) stated quite categorically that perceptual awareness (intuition) must be followed by confirming evidence, with the context dependent nature of expertise clarifying her stance that the expert is not omnipotent.

English questions how nurses who seek to achieve excellence can in fact succeed if criteria are not made explicit. I would comment that the writing and sharing of narratives is one way of identifying expert nursing practice, with my research having the potential to support this proposition. Darbyshire (1994a) responded strongly to English's critique, and stated that, by using the tenets of positivism, English had mis-understood not only Benner's work but its philosophical base. Darbyshire countered many of English's claims by contrasting Benner's interpretive approach to understanding the complexity of nursing practice, with the deductive,

logical, predictive, scientific paradigm from which English viewed Benner's work. The value of such debate must not be underestimated, as it is important that ideas are discussed if nursing's knowledge base is to develop. Darbyshire does state his concern that Benner's ideas might become flavour of the month, a concern I share when considering the dearth of research that has sought to explore Benner's work from a New Zealand perspective. The potential value of the findings from my research to begin such local debate is therefore important.

Cash (1995) also described the concept of expertise as being arbitrary and questioned if it is only the expert who thinks intuitively, taking the stance that intuition does not give power in the nurse-doctor relationship. The strong comment was made that Benner's emphasis on intuition "fossilises a nursing practice distorted by unequal power relations" (Cash, 1995, p. 534), and that her method ultimately validates practice through authority and tradition. This author has focused primarily on intuition without acknowledging the increasingly complex descriptions of expert practice that have emerged in Benner's research. I would also argue that the use of narratives enables the reader to judge whether interpretations do in fact emerge from the text. As Benner, Tanner, and Chesla (1996) highlighted, their presentation of interpretations was guided by a concern to provide the clearest textual evidence for the interpretations offered.

Price (1995) provided an analysis of Benner's work as it relates to the New Zealand nursing world, and supported the point I have raised regarding the potential problems in adopting ideas uncritically, and without thought to the social, political and cultural influences on the context of practice. Price commented that although Benner's work has been used as the basis for various clinical career programmes, and has been influential in some clinical and educational environments, it remains difficult to ascertain the impact of her work on nursing practice in New Zealand. This author also noted the dearth of research that has explored any aspects of Benner's work within this country. My research, with its focus on expert public health nursing practice will begin to articulate a New Zealand community perspective and add to the body of knowledge on this subject. It may also encourage further research to explore this phenomenon in diverse in-patient and community settings.

Paterson's (1989) research was one study that did support the relevance of Benner's (1984) findings in a New Zealand setting. The aim of her study was to explore the practice world of a group of nurses working in medical and surgical wards in an acute general hospital. A phenomenological approach was used to

describe the context in which these nurses worked, to identify areas where they made a difference, and the types of experiences that change nurses' practice. Paterson stated that the work of Benner (1984) guided her research and four of Benner's identified domains of practice emerged strongly in the findings. Coaching through a situation bit by bit, and advising and supporting other nurses were additional competencies that were identified. The importance of gaining practical knowledge for the subsequent development of clinical expertise and the intuitive understanding of experienced nurses were also confirmed. Although the aims of Paterson's study were different from the present research, studies that chart the practical knowledge of nurses working in diverse practice settings begin to build a composite picture of nursing within a New Zealand context.

Public health nursing practice

The work of public health nurses has been described in studies concerning the content of the work and decision making processes. For example, Pearson (1991) studied clients' perceptions of health visiting and noted the importance of the nurses' communication and interpersonal skills. This author recommended that health visitors look carefully at achieving joint definitions of planned and intended help with clients, and that they must be prepared for alternative methods of practice. Vehvilainen-Julkunen (1992) used a grounded theory method to describe client/public health nurse relationships in child health care. The relationship between the nurse and child was described as one of persuasion and entertainment, while that between the mother and nurse was described as one that supported self confidence. Although expert practice was not the focus of these studies, research that describes various dimensions of public health nursing practice provide a framework that enhances understanding, and the findings from my research can further develop this.

As part of an international research project Lauri, Salantera, Bild, Chalmers, Duffy and Kim (1997) described the decision making processes of public health nurses in Canada, Finland, Norway and the United States. These authors identified five different decision making models, the statistically significant differences between countries being ascribed to differences in health care systems and the nature of the nursing role. These results support the contextual nature of nursing practice and the importance of not presuming congruence of findings across diverse settings. From a New Zealand perspective, Pybus's (1993) in-depth description of the work of three public health nurses with 15 stressed families gave an insight into public

health nursing practice in this country. The aims of this study were to describe the public health nurse/client relationship as viewed by the nurses, and to describe the clients' views on health and social services, and the features of relationships that are effective in helping families manage stress.

Families are complex, and the findings from Pybus's study demonstrated that this complexity was paralleled in the conceptual framework used by the public health nurses. Major nursing goals were identified and described, including enforcing minimum standards of child care, in-depth treatment of particular health problems, and helping families achieve activities of everyday healthy living. The goals of the nurses were broad as were the ways in which they worked towards these goals. Some of their strategies included assessment, teaching and learning, use of interpersonal relationships, and acting as intermediaries. The important perspective of the client was explored in this study. There was a high level of agreement between mothers and nurses about the contribution nurses make to families, with factors such as decision making, providing stability, and identifying and assessing options being described. Although this work did not examine expert practice, it provides a foundation from which to build an understanding of public health nursing practice in New Zealand, the findings from the present research extending this knowledge base.

Expert nursing practice

The phenomenon of expert nursing practice has been explored by various authors in diverse settings and using a range of methods. Fenton (1985), for example, conducted an ethnographic study to determine the areas of skilled performance demonstrated by the master's prepared nurse in a large health centre. The interviews and observations of practice demonstrated activities in all of Benner's (1984) areas of skilled performance, with additional themes of instituting change and consulting. Orme and Maggs (1993) examined clinical decision making through a literature review and conducted a series of workshops with expert nurses, midwives and health visitors. The findings indicated that the decision making process of expert practitioners was based on sound knowledge, informed by research, may involve risk taking, and can only flourish in a supportive environment. The importance of intuition was endorsed, with the group arguing that, before intuition can be of value, there must be a pre-existing knowledge base that fosters the appropriate and relevant interpretation of information.

Other studies have focussed upon Benner's (1984) novice to expert framework, one example being Bostrom and Newton Suter's (1992) study to determine and assess the importance of factors that nurses considered in making patient assignments. Data analysis indicated that the level of complexity of the patient assignment process was greater among experienced nurses who considered multiple factors and relied less on the hospital acuity system than did novice charge nurses. Although the findings supported the novice to expert framework, the use of a questionnaire format could be seen as restricting the emergence of the full complexity of expert decision making. In an interesting discussion on the development of clinical research skills, Summers (1994) described how Benner's novice to expert framework can be used to describe and explain this aspect of practice. This author proposed using research preceptors to assist nurses in developing research knowledge and skills, demonstrating the potential practical applications of Benner's work.

Some studies have addressed expert nursing practice from a community perspective. Zerwekh (1991b) interviewed 30 experienced public health nurses and asked them to tell anecdotes about those instances when they believed their home visiting made a difference to maternal/child outcomes. Using a qualitative constant comparative method, the author identified sixteen family care-giving competencies which were then organised into a Family Care-giving Model. The central focus of this model was the encouragement of family self-help. This author used the analogy of Hercule Poirot to elaborate upon the detecting function of expert public health nurses who must "solve the mysteries of families who may need more than meets the eye" (Zerwekh, 1991c, p. 30). Detecting encompassed sensory images and critical thinking, with the nurses articulating how seeing families in their own environment will often allow early detection. Zerwekh (1991a) discussed the nurse preserving sphere as an unanticipated finding which included how nurses struggled with adversity, confronted the threat of violence, and preserved their well-being. She highlighted that agency policies and strategies for self preservation must be carefully developed to make it possible for public health nurses to demonstrate their expertise. My research has potential to build on the work of Zerwekh who illustrated the wealth of knowledge within the practice world of expert public health nurses.

McMurray's (1992) study had as its aim the development of a model of expertise in community health nursing. This author noted that, although the last decade has seen heightened interest in researching nursing's practice base from a qualitative perspective, community health nursing practice has certainly been under

represented. The data from this study identified the expert as someone in whom a variety of characteristics operate synchronously, including knowledge, empathy, communication, holistic understanding, an ability to get right to the problem, and self confidence. The findings also suggested that a combination of educational, personal and experiential factors influence the development of expertise.

Along similar lines, Butterworth and Bishop (1995) used the Delphi approach to identify the characteristics of optimum practice from a survey of expert practitioners in nursing, midwifery and health visiting. Respondents were asked to consider various aspects of optimum practice and to comment on factors that encouraged those in practice to deliver care of the highest quality. Key characteristics of these expert nurses were that they demonstrated leadership, expertise, and innovation, with commitment, a positive attitude and well developed communication skills being integral components. Requirements for optimum practice included a supportive environment, involvement in education and research, and political awareness. Although the present study focuses on expert nursing practice and does not seek to produce a set of characteristics describing the expert public health nurse, the findings from different studies provide multiple perspectives that enhance one's understanding.

Nursing narratives and expert nursing practice

Nursing narratives have been used in research, education and clinical environments to describe and understand expert nursing practice. In their recent work, Benner, Tanner and Chesla (1996) discussed how the role of sharing narratives, or story telling, came into sharper focus as a means of understanding a practice, and communicating meanings, intentions and concerns. They noted that narrative accounts of actual clinical experiences reveal the everyday clinical and caring knowledge central to the practice of nursing, and better capture both forward and retrospective thinking. These authors used exemplars as one of the interpretive approaches in their analysis of the narratives, noting that it is through the thoughtful taking up of example after example, that the story gets filled in and understanding is deepened. Darbyshire (1991) promoted the telling and interpretation of nurses' stories, narratives, or paradigm cases as one way of uncovering the excellence and creativity embedded within nursing practice. He described how narratives can highlight nursing knowledge and caring practices, encourage a deeper self understanding, and assist nurses to discover and understand the tacit knowledge that so often remains hidden.

Anastasio and Foldy (1995) shared exemplars from expert perioperative paediatric nurses and described how these were used as a means of peer review and formal evaluation. These authors acknowledged that exemplars are a particularly useful means for experts to communicate their unique knowledge, and that they are also an effective way to influence the practice of others. They made the comment that exemplars are not presented to describe extraordinary situations, but to expose the extraordinary skills that lie within the everyday practices of expert nurses. Many examples of nursing narratives can be found in the literature. Since 1987 for example, the *American Journal of Nursing* has published a series in which expert nurses describe situations in which they made a difference to patient care. Aspects described have included expert coaching (Cucci, 1987), acting as an early warning signal (Marculescu, 1987), trusting one's judgment (Ball, 1989), caring (Magnan, 1989 and Dyck, 1989), pattern recognition (Gruber, 1989), and the skill of involvement (Mottley, 1992). Similarly, Smith, Skewes and Darnell (1992) shared personal experiences in which they demonstrated excellence in practice. These encompassed pain management in an elderly patient, a drug reaction in a rehabilitation centre, and resourcefulness in dealing with a terminally ill patient. The exemplars cited above highlight some of the diversity within expert practice and also demonstrate the usefulness of the narrative approach in articulating the essence of expertise in nursing.

Bradshaw (1994) provided a counter argument to the usefulness of nursing narratives, stating that the glaring problem is that such stories are always from the nurse's viewpoint. She also asked how the expert can be judged if objective principles and practices are denied. This author appears to have not fully appreciated Benner's philosophical position and approach. For example, Benner (1984) clearly stated that her work did not advocate a "chaotic or anarchical position that would claim there are no rules" (Benner, 1984, p. xix). Rather, she acknowledged the importance of advanced understanding that responds to a given situation rather than being rigidly rule driven. In their latest work, Benner, Tanner, and Chesla (1996) included various narratives of learning that described situations where the nurse often learnt an important lesson from getting it right and getting it wrong, there being no attempt to cover up practice that is less than perfect. Darbyshire (1994b), in responding to Bradshaw's (1994) assertions, highlighted that Benner has sought to question the reliance on context free, prescriptive objectivity, not to overlook it completely. He also made the point that narratives have provided a counter to the deficit mode of thinking that has characterised much of the nursing literature.

Summary

This review of the literature has provided a summary of the background understandings that were brought to this study of expert public health nursing practice. The research programme of Patricia Benner provided the focal point, her work, *From Novice to Expert* (1984) having brought the concept of expert nursing practice into the academic and public arenas. Further research has extended the knowledge base while her work has certainly provoked academic debate. The literature on nursing narratives supported the usefulness of this approach in uncovering and understanding expert nursing practice. The literature review revealed a dearth of research that has examined expert nursing practice from a New Zealand or community health context and the findings from this research have the potential to fill a perceived knowledge gap. As has been highlighted, it is also important that presumptions are not made regarding the portability of concepts developed in one context to areas where the social, political and cultural influences are quite different.

In considering the utilisation of Benner's research findings in nursing education and clinical career programme development, it is surprising that the body of research that has tested or elaborated upon her work in different settings is not more extensive. Part of the reason for this may be the ease with which many nurses in clinical practice have identified with Benner's work, the frequency of the adaptation of her model legitimising it to a certain extent. In order to further develop professional and academic credibility however, developments must be based upon a sound research foundation. The present research is an attempt to contribute to this.

CHAPTER THREE

The Research Process

I have selected Heideggerian phenomenology as the research methodology for this work, supporting Walters (1994) contention that phenomenology offers nurses a valuable way to understand the life world of nursing. This chapter is divided into two sections. In the first section I will briefly address the history and underlying assumptions of Heideggerian phenomenology. Benner's work provided a framework for this research and it is therefore relevant to discuss her interpretation and utilisation of Heideggerian phenomenology. The viewpoints of authors who have critiqued her approach will also be acknowledged. Finally, the rationale for selecting this approach to explore expert nursing practice will be clarified. The second section will describe the research method in terms of participant selection, data collection, data analysis, ethical concerns, and strategies used to address issues of rigour.

Research Methodology

History and underlying assumptions of Heideggerian phenomenology

As discussed by Walters (1994), Edmund Husserl is recognised as the founder of phenomenology. Husserl regarded the method he developed as the only way to elevate philosophy to the status of a rigorous science. Under Husserl's influence, phenomenology came to mean the study of phenomena, as phenomena appear through consciousness. Martin Heidegger was a student of Husserl, and his significant work, *Being and Time* (1962), was a major reinterpretation of phenomenology and its method. The transcendental phenomenology of Husserl had as its focus the description of the lived world from the viewpoint of a detached observer. In contrast, the phenomenology of Heidegger was based upon an existential perspective which considered that the observer cannot separate themselves from the world. Heidegger shifted the philosophical debate from epistemology (how we know what we know), to ontology (what it means to be a person). In his commentary on Heidegger's *Being and Time*, Dreyfus (1991) noted that Heidegger aims to deepen our understanding of what it means for something to be, and attempts to get beyond the subject/object distinction in all domains.

Underlying assumptions of the Heideggerian phenomenological view of the person as summarised by Leonard (1994) include the following:

The person as having a world.

World is the meaningful set of relationships, practices and language that we have by virtue of being born into a culture. According to Heidegger, world is 'a priori' and given in our cultural and linguistic practices, and in our history. Language in particular sets up a world. It both articulates and makes things show up for us, and creates the possibility for ways of feeling and relating that make sense within a culture. World is regarded as being both constituted by and constitutive of the self, the latter meaning that the self is raised up in the world and shaped by it. Heidegger uses the term 'thrownness' to express his view of the person as always already situated, as being-in-the-world. We are all 'thrown' into a particular cultural, historical and familial world, and freedom in the Heideggerian view is situated freedom. Heidegger also differentiates between taken for granted skills and practices (the ready-to-hand mode) and theoretical knowing (the present-at-hand-mode).

The person as a being for whom things have significance and value.

Each one of us is considered to be what she/he pursues and cares for, with people having qualitatively different concerns based on their culture, language, and individual situations. As there can be no significance-free account of desires, feelings and emotions, our understanding of these terms moves in the hermeneutical circle in which actions, feelings and purpose all refer to each other. To understand a person's behaviour or expressions, one therefore has to study the person in context, for it is only in context that what a person values and finds significant shows up.

The person as self-interpreting.

This view of the person as self-interpreting is seen in a nontheoretical, noncognitive way, in which every encounter is an interpretation based upon our background.

The person as embodied.

In the phenomenological view, rather than having a body, we are embodied. It is

the body that first grasps the world and moves with intention in that meaningful world.

The person in time.

Temporality is the term used by Heidegger to describe a notion of time that is directional, relational, and applies only to being, not to physical objects. Being-in-time cannot be studied except within the context of its past and future, by which it is constituted. Related to Heidegger's notion of temporality is his account of the essential structure of human being that he describes as care. Care, in Heidegger's sense, is having our being be an issue for us. In other words, we exist existentially in terms of the things that we care about.

Based upon these assumptions Leonard (1994) described some of the implications of the Heideggerian phenomenological view of the person for research. These included an understanding that:

* There is no Archimedean point or privileged position for objective knowing that is atemporal and ahistorical. Both the researcher and research participant have a world and exist in historical time.

* All knowledge emanates from persons who are already in the world, seeking to understand persons who are also already in the world. Based on common background meanings it is therefore assumed that the researcher has a preliminary understanding of the human action being studied.

* One is always within the hermeneutical circle of interpretation. The interpretive process is necessarily circular, moving back and forth between part and whole. The researcher has a mandate to stay true to the text and to honour the lived experience of the participants.

* All knowledge is temporal.

* Understanding human action always involves an interpretation by the researcher, of interpretations made by those being studied - this interpretive approach is called hermeneutics. Hermeneutics seeks to develop explanations and understandings that are based on concerns, commitments, practices and meanings. It is a method for studying human beings that flows out of the Heideggerian view of the person and is consistent with it.

Van Manen (1990), in answering the question, what is a hermeneutic phenomenological human science, notes that phenomenological research is:

1. The study of lived experience
2. The explication of phenomena as they present themselves to consciousness
3. The study of essences
4. The description of the experiential meanings we live as we live them
5. The human scientific study of phenomena
6. The attentive practice of thoughtfulness
7. A search for what it means to be human
8. A poetizing activity, or a thinking on original experience.

Heideggerian phenomenology as interpreted and utilised by Patricia Benner

Although I am not replicating her research, the work of Patricia Benner has provided a framework for this study, and it is therefore pertinent to consider how Heideggerian phenomenology has been articulated within her research programme and writings.

Beginning with her original work, Benner (1984) described how the interpretive strategy used was based upon Heideggerian phenomenology, with the intent being to identify meanings and content. She noted that with this situation-based interpretive approach, synthesis rather than analysis was used, this allowing a "manageable yet rich description of actual nursing practice" (Benner, 1984, p.39). In a subsequent discussion that took a phenomenological perspective on quality of life, Benner (1985) described the essential tenets of Heideggerian phenomenology. These included the notion that human beings are self-interpreting, that a person takes a stand on the kind of being he/she is, and that the self is not a radically free arbiter of meaning because of the limitations of language, culture and history. Hermeneutics was described as a systematic approach to interpreting a text that involved shifting between parts and wholes, with paradigm cases, exemplars and thematic analysis being useful interpretive and presentational strategies.

In their book *The Primacy of Caring*, Benner and Wrubel (1989) described how the phenomenological view of the person, as proposed by Heidegger, formed the basis for this work on stress and coping. These authors articulated the key concepts of their view of the person as embodied intelligence, background meaning, concern and the role of the situation. A phenomenological view of stress and coping was

developed using these concepts, one example being how coping options available to the person will vary, depending on how the person is involved in the situation. More recently, Benner (1994) noted that, by engaging in the interpretive process, the researcher seeks to understand human concerns, meanings, experiential learning, and everyday comportment. The researcher is constrained by the demands of the text, and the interpretive account is seen as illuminating the world of participants while making visible and challenging aspects of the researcher's preunderstandings.

Finally, in their latest research, Benner, Tanner and Chesla (1996) articulated that hermeneutical phenomenology was their approach to understanding the practice of nurses, the particular tradition within which they worked deriving from the work of Heidegger and Kierkegaard. They pointed out their preunderstandings of human action and engagement, noting that these totally directed their approach. These included an understanding that human beings are situated in their worlds, that the basic way humans live is in engaged practical activity, and that the way humans are engaged in their worlds is set up and bounded by what matters to them. These assumptions structured their study. For example, it was assumed that nurses are situated within their practice, this situatedness being captured in narratives and observation. These approaches were also a means of accessing involved activity and arriving at an interpretation of the concerns orienting the nurse within the situation.

This brief exploration of the philosophical and methodological underpinnings of Benner's work demonstrates her approach to understanding nursing practice. Concepts which have been more clearly articulated in her recent work, such as situated meaning, embodiment and concern, have their basis in the work of Heidegger. The link between underlying assumptions and research methods has also been made more explicit. As Benner (1994) noted, the aim of the data collection and interpretive strategies is to portray the "practices, meanings, concerns and practical knowledge of the world it interprets" (p. xvii).

Critiques of Benner's approach

In reflecting upon the work of Benner, Thompson (1990) noted that, in both the design of her research programme and in the theoretical influence apparent in her work, Benner clearly demonstrates the application of hermeneutic thought in nursing. Thompson recognised the importance of Benner's work in affirming the

knowledge and wisdom within nursing practice, describing her work as an "important post-modern voice in nursing" (Thompson, 1990, p. 275). However, Thompson concluded that the cultural frame of reference is muted or missing in Benner's research programme. From the perspective of critical social theory, this author argues that Benner's work needs to show how the social and political contexts in which nurses practise inhibit dialogue and impact upon practice. A similar theme is taken up by Rudge (1992) who utilised an evaluative framework, based upon a critical perspective, to illuminate the interpretive strengths of Benner's work and to offer some grounds on which to extend her analysis. Rudge described how Benner's research has acted as a positive affirmation of nursing's worth, but that her analysis has failed to adequately explain the structural and power relationships engendered by social structures.

While both these authors raise a valid point in terms of extending Benner's research programme to encompass a critical approach, this would require the researcher to ask questions from a different perspective. Benner's primary aim has been to describe and understand nursing practice, and in keeping with an interpretive stance, she has not set out to explicitly explore issues of power and domination. In responding to Thompson's critique, Benner (1990) commented that hermeneutics can augment critical theory by describing the notions of good that one wishes to conserve or preserve, and that expert practice in itself can be a source of liberation. She maintained that the narratives of excellence and nurses' own critiques of constraints, are used in her work to critique dominant cultural and organisational constraints.

In recent work Michael Crotty (1996) contrasted the 'new' phenomenology which he believes encompasses the approach taken by most nurse researchers, with the traditional form stemming from Husserl. According to Crotty a major difference is that the 'new' phenomenology seeks to establish the subjective experiences of the people studied, while mainstream phenomenology is the study of actual phenomena, or the objects of human experience. In relation to Benner's research programme, Crotty spoke of the wide gap he perceives as existing between Heidegger and Benner, one example being that even when the same words are used the meanings and perspectives conveyed are quite different. Crotty described Benner's orientation as highly humanistic and characterised by a positive attitude towards human beings. He contrasted this with Heidegger's more forbidding accounts of destiny and authenticity. Although conceding that the value of nursing phenomenology needs no defending, Crotty does raise the question to what extent, if any, the research conducted by Benner and others is indeed phenomenological

research. When one considers the many perspectives that have emerged within phenomenology, it is anticipated and desirable that debate, critique and analysis will occur, and Crotty's work contributes to this. For the purpose of the present research, it is important to acknowledge this debate concerning the relationship between nursing research and phenomenology.

Rationale in selecting Heideggerian phenomenology

Based upon my current understandings, I believe that Heideggerian phenomenology as interpreted and utilised by Benner in her research programme, is an appropriate methodology to use in the present research for the following reasons:

* The focus of this research is the phenomenon of expert public health nursing practice as conveyed through the narratives of identified expert practitioners – the ontological question therefore takes precedence over the epistemological one. In other words, I am concerned with the question of being or experiencing the world, rather than with the question of knowing.

* Benner's approach, encompassing as it does both the knowledge found in skilled bodily activity and the wisdom and ethics of nursing practice, is applicable to this study which seeks to understand the essence of expert public health nursing practice. According to Van Manen (1990), the term essence can be understood as a linguistic construction, a description of a phenomenon. He likens phenomenological inquiry to an artistic endeavour, describing it as "a creative attempt to somehow capture a certain phenomenon of life in a linguistic description that is both holistic and analytical, evocative and precise, unique and universal, powerful and sensitive" (Van Manen, 1990, p. 39).

* Benner's emphasis on the primacy of being situated is reflected in this research. The focus is the context specific nursing practice which is captured in the narratives of nurses' who are working in an area of specialty practice.

* I acknowledge that I am seeking to construct a possible interpretation of the nature of expert public health nursing practice. It is important to be aware of Van Manen's (1990) caution that lived life is always more complex than any explication of meaning can reveal, and that full or final descriptions are in fact unattainable.

To conclude this section it is necessary to make explicit the pre-understandings that I took into this study. At the outset I had assumed that:

a) Data analysis will reveal themes that are unique to a New Zealand community health nursing context.

b) There will be areas of similarity and difference in the findings between this research and Benner's research programme.

c) The participants may experience some discomfort or reticence in sharing narratives where they have made a difference to client outcome.

d) Narratives provide an opportunity for public health nurses to articulate aspects of expert practice that are often difficult to describe.

Research Method

The aim of this research is to describe and understand expert public health nursing practice within a New Zealand community health setting.

Participant selection

The participants for this study comprised a purposive sample of eight identified expert public health nurses currently working in a community health context. The criteria for identification of expert practitioners was based upon that used by Benner, Tanner and Chesla (1996), and included nurses who had five or more years experience and were considered 'superb' nurses. These broad criteria were used to reduce the possibility of biasing participant selection to reflect my personal image of an expert nurse. To avoid possible overtones of coercion, the potential participants were accessed from a community setting outside of the one in which I am currently employed.

Ethical approval was granted, and I obtained permission to conduct the research from the senior management team in the Crown Health Enterprise in which the study was to take place. Following a supportive response from the co-ordinators of the relevant nursing teams, I attended team meetings to discuss the proposed

research. I explained that participant selection would be based upon a process of peer recommendation, and asked each team member to submit to me a list of names of colleagues they considered to be expert public health nurses. The nurses decided to undertake this process at the time of the meeting. I clarified the point that, as I was seeking a sample of eight to ten, if I received up to 15 names, I would select the first ten names on the list, while if I received greater than 15 names, alternate names on the list would be selected. This meant that if a nurse was not approached to participate in the study, it did not indicate that she/he had not been identified as an expert practitioner. I believed it was important that this was made clear in order to sustain team relationships.

Following selection of ten from the list of identified expert public health nurses, I sent each potential participant the information sheet (see Appendix 1) and a covering letter that asked them to telephone the researcher if they wished to participate, or had any further questions. These strategies helped ensure anonymity of research participants because other team members did not know who had been approached, and who had consented to participate in the research. Eight nurses contacted the researcher, and the consent form (see Appendix 2) was signed at the first interview.

According to Morse (1991), when obtaining a purposive sample the researcher selects participants according to the needs of the study. This author notes that the method of sampling in qualitative research must be both appropriate and adequate. Appropriateness refers to the degree to which the choice of informants and method of selection fits the purpose of the study. As the aim of the present research was to describe and understand expert public health nursing practice, the sampling strategy seemed to be appropriate. It facilitated understanding of the phenomenon under consideration by focusing on the practice of those nurses identified as expert by their peers. Adequacy refers to the sufficiency and quality of the data obtained, and will be discussed in the section that addresses trustworthiness of the data. Morse acknowledges that a criticism of purposive sampling relates to bias, but makes the point that in this instance bias is used positively as a tool to facilitate the research. As my research had the aim of exploring a particular phenomenon, I sought a sample that had experience in the field of interest.

Description of participants and environment

The eight participants were female, their years of nursing experience ranged from

eight to twenty-seven years, while their years as a public health nurse ranged from two to eighteen years. One nurse had completed a Bachelor of Health Science degree, while three others had completed a post-registration diploma course. The focus of their role was health monitoring, maintenance and education for school children and their families. Specific aspects of their role included health promotion activities in schools and the community, co-ordinating health clinics, immunisation of children and case management.

The background information about the social and geographical environment in which the nurses worked is necessarily brief in order to ensure anonymity of the participants. I have endeavoured to provide sufficient detail to enable the reader to ascertain similarities between the working world of the nurses in this study, and that of public health nurses working in other settings. The geographical location comprised an urban/rural mix, with the former predominating, while the ethnic mix of the population comprised European, Maori and Pacific Island. It is an area that has a relatively young population, the population is growing rapidly, just over half the working age population is employed, and there is a substantial proportion of solo parent families.

Data collection

Data collection involved one or two narrative interviews with each of the research participants. Each interview was one and a half to two hours in duration, with the time and place being selected by the participant. The majority of the interviews were conducted at private, quiet locations within the participant's work place. Each interview was audio-taped and then transcribed verbatim by the researcher to provide the text for data analysis. Prior to coming to each interview, the participants were asked to reflect upon their recent practice, and to make brief notes about incident/s where they felt they made a difference, or which stood out in their mind for some other reason. This strategy helped to keep the interview focused, and it also assisted the participants to feel more comfortable with the process because specific instances of practice were more readily available for the telling.

During each interview care was taken to make the tone conversational and to convey an attitude of safety, trust and acceptance. Jasper (1994) noted that this helps ensure the experiences portrayed by participants are as complete as possible. I asked the participants to tell me narratives about their practice in which they felt

they made a difference or that were memorable for some other reason. The aim of each interview was to understand the narrative/s as these unfolded. A set of probes and questions for filling in aspects of the narrative (see Appendix 3) was used as a general guide and focusing device. These questions, which were broadly based on those developed by Benner, and used in the research conducted by Benner, Tanner, and Chesla (1996), helped achieve a balance between flexibility and consistency in data collection.

Taking care not to lead the participant's responses, I endeavoured to fill in as many details as possible about what happened, and what was important to the nurse in terms of her concerns, understandings and actions at each turn in the narrative. It was at times difficult to achieve the balance between not interrupting the flow and ensuring that sufficient detail was given for future interpretation. This was largely overcome by listening to the story with as little interruption as possible, and initiating clarifying questions only when the initial telling of the narrative was complete. At all times I was aware of Benner's statement that "the interviewer's goal is to empower the participant to tell the story in his or her own words" (Benner, 1994, p. 112).

Two interviews were conducted with the first four research participants. This allowed more than one narrative to be heard from each nurse, which in turn made possible a richer and fuller understanding of expert nursing practice. It also enabled both the researcher and participants to follow up on aspects that had emerged during the first interview. I was able to 'check out' tentative interpretive thoughts and, heeding Benner, Tanner, and Chesla's (1996) caution, I offered any initial interpretations in concrete terms that were linked to practice, rather than using more theoretical language. One narrative interview was conducted with the other four research participants. Due to an improved interview technique these interviews were more focused, which meant that more than one narrative was related during each interview. Both the researcher and participants believed these narratives were explored in sufficient depth during the interview.

As highlighted by Benner, Tanner, and Chesla (1996), using narrative interviews as the research method was congruent with the philosophical underpinnings of Heideggerian phenomenology for the following reasons:

* Narrative interviews captured the 'situatedness' of the nurses because they focused on their practice with particular clients in particular historical and social contexts. This contrasts with reflective accounts of practice in general.

* Full narratives about care of particular clients also gave access to the involved, engaged, practical activities of the nurses, as they encompassed the context, history, presentation, evolution of the situation, and the nurses' concerns and actions.

* Narratives allowed the temporal unfolding of events to be captured and interpreted.

* Through using a narrative structure, it was also possible to address the concerns that were orienting the nurse in the situation. This acknowledged the phenomenological premise that humans move and act within situations according to their concerns, or what matters to them.

Data analysis

It is important to acknowledge that interpretive dialogue began with the first interview, and that data collection, inquiry and analysis were closely interrelated processes. According to Benner, the aim of interpretive phenomenology is to "use indirect discourse to uncover naturally occurring concerns and meanings" (Benner, 1994, p. 112). She contrasts this with approaches that require theorizing, or examining a text according to pre-established lines of inquiry. Benner (1994) described three narrative strategies used in her research for entering practical worlds and understanding socially embedded knowledge. These formed the basis for interpretation in the present study and are summarised below.

Paradigm cases are strong instances of particular patterns of concerns, ways of being in the world, or ways of working out a practice, and are the most usual point of entering dialogue with the text. An open, descriptive approach to the initial identification of paradigm cases is important. This allows the researcher to understand the case in its own terms rather than attempting to identify in advance what the researcher is looking for. This can be considered a discovery process that allows skills of perception and understanding to guide selection of the paradigm case.

As described by Benner, Tanner, and Chesla (1996), and supported in the present study, early leaps in understanding often occurred when encountering a particularly vibrant example of practice, in other words, a paradigm case, that stood out from other examples. Part of the work of interpretation was puzzling through how and why this particular instance stood out. I initially read the complete interview text for a global understanding and then selected topics, issues, concerns, or events,

for a more detailed interpretation. A systematic moving from the parts back to the whole was crucial, the ultimate goal being to present multiple aspects of the text as fully as possible. The practical world of one paradigm case then created a basis for comparison of similarities and differences with other paradigm cases.

Paradigm cases were used as both a strategy of perceptual recognition and understanding, and as a presentation strategy. As occurred in Benner, Tanner, and Chesla's (1996) research, the paradigm cases in my study were of two types. The first included strong examples of clinical practice that stood out for the researcher as being new or puzzling, or as illustrating aspects of nursing that I recognised as important but largely unarticulated. The second form of paradigm case included stories about clinical practice that the nurses identified as important because they had changed or re-oriented the nurse's practice in some way. In studying a paradigmatic narrative, the aim was to understand the situation within the practical lived world of the participant.

A **thematic analysis** was undertaken to articulate broader understandings arising from the data and to clarify distinctions and similarities. This process involved a movement back and forth between portions of the text and portions of the analysis, within a cycle of understanding, interpretation, and critique. A key factor to consider was Benner's (1994) interpretive maxim that the other person's world is livable. Total rejection or excessive idealisation implies that the researcher has not yet grasped the lived world of the participant or situation. When presenting themes I was mindful of the importance of specifying the paradigmatic narratives that evidenced those themes, as well as the multiple exemplars that demonstrated variation within the themes.

Van Manen (1990) describes the concept of theme as giving control and order to our research and writing. He uses the term "mining meaning" (Van Manen, 1990, p. 86) to describe a process in which the researcher attempts to unearth something telling, meaningful, and thematic from the experiential accounts given. This author considers themes to be the threads around which the phenomenological description is facilitated. Van Manen makes an important distinction between incidental and essential themes and, in the process of apprehending essential themes I continually asked the question: Does the phenomenon of expert public health nursing practice lose its fundamental meaning without this theme?

The final analytic strategy was the use of **exemplars** that conveyed aspects of a paradigm case or a thematic analysis. This allowed demonstration of intents and

concerns within contexts that were often quite different. Each exemplar added nuances and qualitative distinctions. The use of a range of exemplars was described by Benner as allowing one to establish a "cultural field of relationships and distinctions" (Benner, 1994, p. 117). In developing the research report, the goal was to present a range of exemplars that allowed the reader to recognise the distinctions I was making. The collection and aggregation of exemplars was central to the interpretive task, and keeping track of exemplars selected as illustrative of a pattern allowed the researcher to follow a train of thought and to develop practical reasoning and understanding. It was also through the thoughtful taking up of example after example that understanding was deepened.

The concept of the **hermeneutic circle** was incorporated throughout the process of data analysis. Dreyfus (1991, cited in Walters, 1994) noted that when interpreting a text, one must move back and forth between an overall interpretation and an interpretation of significant parts. The aim of this strategy is to lead to a richer understanding of the text. Walters (1994) also described how Heidegger argued that all interpretation takes place against a background of previous understanding, and as our background understanding can never be made completely explicit, understanding is necessarily circular. Systematic analysis of the whole enabled new perspectives and understandings to occur, with this understanding then being used to examine parts of the whole, and the whole then being re-examined in light of insights gained from the parts. I followed this part-whole strategy until I felt satisfied with the depth of understanding achieved. Finally, as an interpretive researcher, I was cognisant of the importance of maintaining a stance of openness, allowing the participants' practical worlds and concerns to challenge my underlying assumptions. As described by Benner (1994), this critical reflective perspective created a true dialogue with the text.

Ethical considerations

A central concern throughout this study was to demonstrate respect for the practice of the research participants. The research proposal was approved by the Ethics Committee of the region, The Massey University Human Ethics Committee, and the Manager of the service in which the research was conducted.

The following strategies were used to ensure informed consent was obtained:

* The participants were accessed from a Crown Health Enterprise outside the

researcher's working area. This strategy helped reduce any possible overtones of coercion.

* Participant selection was through a process of peer recommendation that avoided possible compromise of the team co-ordinators. As the team co-ordinators had a role in performance management of the potential participants they could have been placed in a difficult situation if asked to recommend 'experts' in their teams.

* The information sheet (see Appendix 1) was sent to the selected potential participants, who then contacted the researcher if they wished to participate, or had additional questions. Once again, this strategy reduced possible overtones of coercion, and ensured potential participants were given sufficient time to read the information sheet and discuss their involvement with others if they wished.

The information sheet clearly described the following:
- nature and purpose of the research
- what would be asked of participants, including time commitments
- statements concerning anonymity and confidentiality
- their rights as participants in the research, including the right to decline to participate
- the identities of the researcher and her supervisor, and how to contact them.

* At the first meeting between researcher and participant, any further questions were answered and the consent form (see Appendix 2) signed. The consent form clearly stated that the participant has the right to withdraw from the study at any time, to decline to answer any questions, and to have the tape turned off at any time.

The following strategies were used to ensure privacy, anonymity and confidentiality of research participants:

* The sampling approach meant that other team members did not know who had been approached to participate in the study, and those who subsequently agreed to participate.
* The narrative interviews were transcribed by the researcher.
* Interviews were coded by number, not the participant's name.
* Transcribed texts and tapes were kept in a locked filing cabinet.
* Access to the tapes and transcriptions was restricted to the researcher and her supervisor.

* No copies were made of the tape recorded interviews.

* The participants had the choice of having the tapes returned to them, erased, or archived on completion of the study. All participants elected to have the tapes erased.

* Data gathered during the research has only been used for the purpose of the research, and any future use of the data will only relate to publications or presentations arising from the research.

* No identifying names of participants, colleagues, institutions, places, or clients have been used in the final report.

Credibility of findings

Benner (1994) noted that interpretive phenomenology must be auditable and plausible, that it must offer increased understanding, and must also articulate the practices, meanings, concerns, and practical knowledge of the world it interprets. The researcher must not read into the text what is not there. The reader plays an important role in critically reading the interpretive work, and in judging both the textual evidence presented and the interpretations made against the reader's own knowledge of the subject. Readers can therefore judge the "fidelity, clarity, insightfulness, and comprehensiveness of the interpretation of the text" (MacIntyre, 1993, cited in Benner, 1994, p.xvii). In the present research, comments from participants regarding tentative preliminary interpretations included "You've hit it right on the head", and "That's exactly what our practice is all about". These moments of acknowledgement occurred as I sought to clarify what the nurses' were meaning, and can be considered one measure of validity of the interpretations being made.

Benner (1994) noted that although the researcher sets up the inquiry with as much reflection and clarity as possible, the actual study is required to make visible and challenge aspects of the researcher's preunderstandings that are not noticed prior to engaging in dialogue with the text. For example, as this research progressed, I realised that I had expected a majority of the narratives to focus on cases that were easily recognisable as being complex, difficult, and emotionally wearying. The following chapters will demonstrate that although the complexity of expert public health nursing practice emerged, the narratives were often 'simple' tales, not the war stories I had anticipated. Challenging underlying assumptions in this manner relates to the concern raised by Benner, Tanner, and Chesla (1996) about entering the hermeneutic circle in the right way. This essentially means a way that is shaped

by one's early grasp of the phenomenon, but at the same time respects the possibilities of the phenomenon showing itself in new ways.

Concerns for rigour have also been addressed by providing a detailed discussion of the methods used in the present study. I acknowledge that there is no one, all inclusive description of expert public health nursing practice, and that there are multiple ways to understand and explain this phenomenon. Leonard (1994) notes that a tenet of interpretive research is that there can always be another interpretation of a phenomenon. Nevertheless, the account presented in this research is coherent, and systematically and rigourously worked out, reflecting a careful orientation of the researcher to the lived experience of the participants.

As described previously, considerable attention was paid to how the narrative accounts of nursing practice were elicited. From the first point of telephone contact with participants to the final interview, I communicated that I wanted them to focus on narratives from their practice rather than general comments. Multiple narratives were presented, this providing a mechanism for bias control through allowing patterns to emerge, and redundancy to occur. Care was taken in the interpretation of texts by completing multiple readings of each particular text and parts of each text. Presentation of interpretations was guided by a concern to articulate the clearest textual evidence available for the interpretations made, and the reader will find that paradigm cases and exemplars are used for this purpose.

Koch (1994) showed the way in which the decision trail of a qualitative research process can be maintained, arguing that the trustworthiness (rigour) of a study may be established if the reader is able to audit the events, influences and actions of the researcher. This author used the criteria of credibility, transferability and dependability as described by Guba and Lincoln (1989, cited in Koch, 1994), and I will conclude this section by discussing how the present research reflected these criteria.

Credibility refers to the presentation of faithful descriptions that are recognisable by readers confronted with the experience. In this research, maintaining the hermeneutic circle of interpretation was a key element in staying true to the original text, with presentation strategies focusing on providing multiple exemplars and paradigms to support interpretations made. Reflection and self-awareness enhance this process, and I kept a field journal throughout the research in which I recorded interactions, reactions, and thoughts. Tentative interpretations were also shared with, and supported by, the research participants during the interviews.

Transferability is used to refer to the 'fit' between a study's findings and contexts outside the study situation. In order to enhance this process, I have described the context of the present study in sufficient detail so that a judgment of transferability can be made by readers. Similarly, the method and study findings have been clearly described to enable another researcher to follow the decision trail, this satisfying the criteria of dependability. According to Guba and Lincoln, confirmability is established when credibility, transferability and dependability are achieved.

The research outcome

In the following four chapters the outcome of this research is presented under the following themes and sub-themes.

* Delving beneath the surface

    - Recognising that it is seldom simple
    - Seeing the full picture

* Watchful journeying

    - Forming relationships
    - Sustaining relationships over time
    - Closing with care

* Moving to the client's rhythm

    - Coaching in harmony
    - Focusing on the everyday
    - Valuing and supporting change

* Coping with the dark side

    - Keeping the child at the centre of the web
    - Maintaining personal safety
    - Walking along an ethical path

CHAPTER FOUR

Delving Beneath the Surface

I'm always sussing things out, looking, listening, feeling, asking what's going on here, my antennae are twitching in all directions. I look at interactions between people, nuances, how they talk about people who aren't there, what does the physical environment look like, are the kids hugged, that sort of thing. You need to really dig down under the surface layers looking for clues.

Implicit within this theme of delving beneath the surface is the notion of looking beyond the obvious and of being constantly alert. The dynamic nature of the finely tuned recognition and assessment skills that emerged in this study did not however involve an exaggerated response in which the worst is always expected, or the simple made more convoluted through over examination. The reality of the practice world for the nurses in this study is that much of it revolves around the complex, the greys, the blurred boundaries, and their assessment skills mirrored this complexity. Although a health issue is the usual point of entry into a situation, these nurses then spread their perceptual vision widely, with the depth and breadth of their assessment being shaped by their focus on well-being.

Seeing the full picture was fundamental to the assessment process and involved the nurses using all their senses, acknowledging where the client has come from, and the cultural, social and economic factors operating within the situation. It is also highly contextual, with each case being assessed on its own merits and within its own particular frame of reference. The nurses possessed extensive background nursing knowledge and skill. Although they acknowledged the relevance of previous experience with similar cases, they were careful to avoid a superficial assessment process that could lead to inappropriate interventions.

The assessment process emerged as one requiring a high level of sensitivity because the public health nurses are often dealing with vulnerable people at vulnerable times in their lives. They must tread cautiously and read cues accurately if future relationships are not to be placed in jeopardy. One participant described this ability to judge how far to go as a process of recognising and not breaking through those metaphorical "glass walls". Although a wide net is cast during the assessment process, when barriers emerged these nurses entered a circle of reflection during

which questions were asked about whose needs would be served if the issue was explored further. Assessment is conceptualised as an ongoing process rather than a task to be ticked off when completed, and often, assessment and action occur simultaneously. This reflects the nurses' ability to hone in on the central issue and take immediate action if required. The nurse knows what to do, and has the ability to do it. However, it is important to note that assessment is also about not always getting it right. These nurses were not infallible, but the reflection and questioning that was so much a part of their practice ensured that prompt recognition, review and refocusing did occur.

The body of this chapter will elaborate upon and support these introductory comments with the theme being addressed under two sub-themes:

* Recognising that it is seldom simple

* Seeing the full picture

The paradigm case for this overall theme stood out for the nurse involved as an experience in which her assessment skills made a real difference to the young school boy who was the focus of her narrative. John had been referred to the nurse by his teacher who was very concerned about his nervousness and tearfulness in class, she was concerned this ten year old may be depressed, and didn't quite know what to do about him. Excerpts from this paradigm will be interspersed throughout the chapter, with a selection of other exemplars used to highlight and further support particular aspects.

Recognising that it is seldom simple

A key feature of this sub-theme was the way in which the nurses would listen with all their senses whenever they entered a situation, whether within a school environment or family home, within a beginning or long standing relationship. They maintained a watchful vigilance; constantly checked things out prior to, during and following interactions; listened to what was not being said; noticed body language, how people interacted and what the living conditions might indicate. This constant state of alertness enabled the nurses to filter information in terms of what was central and what was peripheral, to read situations accurately and respond appropriately, and to recognise the complexities of a case.

Paradigm: Before I even saw John I was thinking about what his teacher had told me, about his panic in class, and I had spoken to his Mum who was really worried about how unhappy he seemed. So I was starting to build up a picture of what might be happening here. When I first met John I told him that we were all worried about him and then it was a matter of letting him talk about what was happening for him. And while he was talking I was looking at his body language, the way he was talking, his tone of voice, and his general affect. And because I knew a lot of kids who are really depressed will often self mutilate, I was looking at his body for any physical signs of that. While he was talking he started to take these little gaspy breaths. Then he said his fingers were starting to get all tingly, that this was what happened all the time and he would get even more panicky. I could see he was hyperventilating and so we tried some deep breathing there and then and it worked remarkably well.

The nurse had started to build up a picture in her mind before meeting this young pupil. She had checked that counselling was readily available if this had been necessary, and during this initial meeting her radar appeared to be constantly moving – looking, listening and contextualising the information gathered. Although the nurse acknowledged the teacher's perception of the situation and was aware of some upheaval in his home life, she was careful not to take this information at face value and 'label' John depressed. One nurse described a process of gathering data from diverse sources, placing this into its own space, and then constantly comparing and contrasting the information received without focusing on one dominant or preconceived view.

The nurse in the paradigm case used many sources and senses in a conscious endeavour to ascertain the full story, to discover not only the what but the why of the panic displayed by John. She worked through a process of connecting up patterns that assisted her to fit the pieces of the jig-saw together into a coherent whole. Integral to this process of connecting up patterns was using past experience as a frame of reference, evidenced as she looked for signs of self mutilation and recognised hyperventilation. Through connecting up patterns the nurse was able to hone in on the problem and ascertain the missing link that had not been seen by others, namely what the physical signs meant within this context. The assessment process continued as the nurse delved beneath the physical manifestations to discover the underlying factors that she knew must not be ignored if her clinical judgment was to be reasoned and sound.

Paradigm: This total panic he displayed was a problem that had actually been going on for over a year and was getting worse and worse, to the point where there would be weeks where John was unable to cope with his school work. What came out in our talking was that he was a real perfectionist and any little bit of pressure would put him into that cycle of hyperventilation. The end result was this total panic, to the point where he had lost a lot of friends and wasn't functioning well at school, despite being a very bright boy. And the school had tried all these different things, but hadn't picked up on the link between the incredibly high personal standards he set for himself and what they were seeing physically. So it was quite magical really, the difference that knowing what was happening, why it was happening, and then being able to work together to do something about it, actually made to John.

The ability to connect up patterns skilfully, accurately and quickly when required was particularly essential when dealing with those situations when assessment and action must occur simultaneously. Diverse examples from the narratives included the prompt recognition of a worsening asthmatic episode, with the nurse transporting mother and child to the local medical centre, and the early morning call to one nurse by neighbours of a family with whom she had an ongoing relationship. One of the children was in the midst of a very vocal tantrum due to a lack of willingness to go to school, while her mother cried in despair on the couch.

Exemplar: Knowing this family as I did, when I walked in and saw the mother sitting there, with this child screaming her head off, I knew the priority was to get Mum back onto an even keel again. So I packed the child off to school with her two older sisters. I told them that I needed her out of the house so I could help their Mum get back on deck, and then I followed up the child's behaviour later that morning.

Through connecting up what she was seeing and hearing with her previous knowledge and interactions with this family, as well as prior experiences with stressed families, the nurse's assessment and action became almost inseparable. There are occasions however when this fluidity, this meshing of assessment and action, places the nurse in an unenviable situation, when relationships developed over time may be destroyed, or personal safety compromised. This is highlighted in the following exemplar where the nurse describes a child protection case involving a young child who had a broken arm following a bad hiding from the father.

Exemplar: This little child was at school in a really dejected manner, and I will never forget her face, she just had nothing in her eyes, they were dead. We couldn't get hold of anyone from the family, and I got the school's permission to take her up to the medical centre while they continued trying to contact her family. Well we got to the centre and the father arrived, he just sort of loomed up in front of us, and this little girl slunk back against me, and very quickly I thought this is going to deteriorate into a really serious situation. And in the meantime the mother arrived and was saying to the child, tell them it was an accident, tell them you fell in the playground, don't say he hit you, don't say that. And that would have been an easy option, to fudge it, to defuse the situation. So I moved the child to safety, muttered to the receptionist to get security there fast, and turned to the mother and said very quietly that things had gone too far, that we couldn't cover this up. And the upshot of it all was that security came and put Dad in a safe room, and he was actually arrested from the medical centre, and it was terrible, quite ghastly, but it had to happen that way.

The nurse in this fraught situation demonstrated a sense of professional responsibility and a moral courage that served to underpin the assessment and action undertaken. The ability to cope with integrity and expertise when facing what can be termed the dark side of life will be addressed in Chapter Seven, but it is important to acknowledge here that assessment and action continue despite extreme circumstances at times.

One further skill that emerged within this realm of recognising that it is seldom simple was the creative use of reflection. This can be symbolised by circles and spirals, and captured within words such as circularity, constant questioning, searching, and checking things out. Reflection is a moving, dynamic process, not a static element that can be captured within a point in time, or by some objective measurement. It is a process of revisiting what has gone before in the context of where the situation is now and what the future might be. It involves an awareness by the nurse of the need to constantly ask questions such as: What is happening here? What does this mean? Is this working? What should I do? Is something missing? The nurse trusts her clinical judgment, but she balances this with an awareness that, as with life in general, there are always more questions than there are answers. Through reflection the need for action or an additional level of watchfulness may become apparent, or perplexing aspects of a situation may become clearer. One nurse described this process as "the fog finally lifting".

Paradigm: So I taught him the deep breathing, and even though it sounds really strange for a ten year old, he was able to get more in touch with his body because of that. We had some good talks about setting realistic goals, planning for changes, that kind of thing. So we were coming at the problem from all angles really, including how to prevent the attacks and how to get on top of them as quickly as possible. And whenever we met he would feed back to me how things were working out, and I was able to keep an eye on the situation to ensure my initial assessment was on track, that he didn't need additional counselling, that he was safe and coping. I was sussing it out all the time. And he would give me the thumbs up or down when I saw him in class to let me know how he was feeling.

Exemplar: Earlier this year I went to do a home visit that was a simple referral for scabies in a new entrant. I walked into the house and the mother called out to me. She was lying in bed and there was this young baby in the next room screaming its head off, and the mother was saying to me, get rid of it, get rid of it, and she was talking about the baby. So I quietened the baby down and sat down and talked to her, and there were lots of things going on for her. Her partner had walked out on her, she was totally isolated in the community, and she hadn't told anyone what was going on. And your first reaction could be, get her to mental health, get the experts in, but I actually asked her who she wanted, and she said her mother ... Her mother was in (city) and as soon as I phoned her she was on her way. And that's all it took really, she didn't need anyone else.

In both the above situations the nurses demonstrated a process of reflection and action occurring together, with a constant silent dialogue taking place between the nurse and the situation. They were mindful of the need to question what was happening in the particular context, what was needed, was the situation safe, what approach would work. In the exemplar the nurse looked beyond the initial simple scabies referral to focus on the central issue as it presented itself upon her opening the door. She used all her senses to hear what the mother was saying, to see the state the mother was in, and placed this within an understanding of the isolation this woman was experiencing within the community. Her background experience assisted her to ask the right questions and prevented her from judging the situation at face value. She walked a fine line between making a situation more complex than it was and ensuring appropriate action did in fact occur. Finely tuned recognition and assessment skills indeed!

This creative reflection assisted the nurses to recognise what one participant described as "glass walls", and not to go breaking through these unless it was unavoidable. The nurse elaborated upon this term as referring to those invisible barriers that provide a metaphorical line over which the nurse must not walk. It conveys a sense of maintaining boundaries between the world of the nurse and that of the client, be this in the physical, social, cultural or emotional sense. A fine judgment call based upon sensitivity, identifying cues, and feeling comfortable in making the decision not to pursue particular lines of enquiry, emerged as a specific skill within the repertoire of these nurses. One nurse, in describing her relationship with a family consisting of a solo father caring for his children, talked about this aspect of her work in the following manner.

> *Exemplar: The children's mother didn't seem to feature in their lives very much at all. I actually suspected she might be in prison or mentally unwell, or something like that, but I didn't need to know, because it didn't seem to be impacting on the children at this particular time. And I had the feeling from the children that their mother hadn't been a part of their lives for a long time, and you get these barriers, things that aren't talked about, and you let that lead you. You have to ask yourself why you would stir up things you don't need to, and I'm very careful not to set families on a path that they haven't chosen, or that's not sustainable for them.*

It must be acknowledged that the focus in this study on expert public health nursing practice does not imply an omnipotence on the part of these practitioners. Reflection and the ability to connect up patterns facilitated early identification of situations that are not progressing as expected. In these instances, the nurses entered a more intense reflective phase in a concerted effort to solve the puzzle, or come up with a better answer. In the final exemplar for this section the nurse is talking about a relationship with a solo mother and her three children that had been sustained over a year. It had been initiated by concerns the school had regarding the social skills, general hygiene and behaviour of the children.

> *Exemplar: I realised early in the relationship that the mother was fairly unmotivated in terms of taking some control and responsibility for her children's behaviour. I felt there was something I was missing, but I couldn't quite put my finger on it. And my hands were tied to a large extent because for a long time she absolutely refused to allow me to make contact with her extended family. I persisted in asking about this because of the uneasiness I was feeling, and when she eventually said okay, and I made contact with her*

parents, I finally felt like I was getting somewhere. It turned out she actually had some medical problems and so a lot of the interventions I had tried had been doomed from the start ... If I had had the information during the first few months that I acquired during that second year, I would certainly have handled things differently, but at the time I could only work with what I had, and keep on digging.

Although her assessment had been limited by factors beyond her control, the nurse recognised that she was only touching the surface and she persisted in her attempts to uncover information she knew was important but was unable to clearly articulate. When the breakthrough came, she felt as if she was now in a position to make some real progress. Her persistent cycle of reflection finally enabled her to connect up the patterns and make a difference.

Seeing the full picture

Although the public health nurses in this study usually entered a situation on the basis of a health issue, they did not limit their assessment to the physical alone. An awareness of the importance of being able to see the full picture meant that the wider concept of well-being was integral to the assessment process. There was an understanding that health encompasses not only the physical, but also behavioural and psychological factors, and that social, economic and environmental elements must be taken into consideration. A focus on well-being provided an overall framework for the assessment undertaken by these nurses, and the subsequent connecting up of patterns. This in turn facilitated their ability to prioritise and intervene appropriately. However, these nurses were acutely aware of the limitations of their practice, and recognised that it was impossible to solve all the complex issues that impact upon the lives of families. In order for the nurse to centre on well-being, a broad knowledge and experiential base is essential. One nurse related a discussion she had with a young girl who had been sexually molested, this conversation taking place in a cafe following a doctor's visit.

Exemplar: We sat down and were drinking our milkshakes, there was no-one else around, and I thought she might not have understood everything that had been happening, and so I asked if there were things she wanted to know and that opened the flood gates. She started asking all these questions about her body, like what discharge meant, how you got pregnant, and we had a really good talk about all those things. And then we talked about the counselling

that had been mentioned by the doctor, because I had seen she was a bit taken aback by this suggestion, and she said she was worried that other people would know what had happened to her. So I was able to reassure her about the whole confidentiality bit, and how it often helps to have someone to talk through these things with. And she thought that would be okay, and then she muttered in an embarrassed kind of way, what she would do if it happened again. So I was also able to say to her, look, what are some strategies we can plan together to make sure this doesn't happen again, given the fact Mum does have parties and a lot of different men are coming to the house. And she was really relieved I think that I had put it in that way, as she does love her Mum, so we talked about some possible strategies and she knows I'm here as well.

This exemplar highlights how focusing on the full picture means that physical, psychological and social elements are addressed together and that a broad knowledge and skill base is needed to assess these appropriately. In this situation the latter included knowledge of adolescent and sexual health, family therapy, anatomy and physiology as well as previous experience. An understanding that the wider environment in which this young girl played out her life was also a contributing factor to take into account, was an important part of the assessment process. One nurse described this perspective as "looking to the heart and soul of the client", a phrase that in many ways captures the depth and breadth of the assessment that is undertaken.

Although the narratives recounted by the nurses in this research study covered a diverse range of scenarios, I could not find an instance when the importance of being able to see the full picture did not come to the foreground. A significant dimension of this concept was that it was not frozen in the here and now, but incorporated an understanding of where the client had come from, where they were now, and future possibilities. In the paradigm case that we have been following, it is apparent that the nurse did not address the hyperventilation in isolation, but assessed and worked with John as he came to understand himself more, and learned to cope with his life.

Paradigm: He talked a lot about how he always felt the need to be perfect, how he hated to hand in work that wasn't perfect, and we did talk about how everyone is human, and bring it down to, hey, how do you think other people would get on if they had such tough rules for themselves. So through our talking, and his receptiveness to new ideas, and ability to take things on

board, he actually came to understand himself a lot better. At our last session before school broke up he told me he wanted to be a scientist, and he hadn't even been able to think about the future when I first met him, he was so bound up in what a failure he felt. So it was rather neat that his thinking had come so far.

Understanding and incorporating a cultural dimension into their clinical practice emerged strongly within many of the narratives the nurses told. Although this aspect was visible throughout the themes, it was pivotal to the assessment process. It included being open and receptive to the cultural world of another and intruding with care and sensitivity. These nurses demonstrated an ability to receive cultural messages and to integrate these into their practice, while at the same time being aware that it is not possible to 'be' that cultural other. It was also a process of continual learning. One nurse spoke of the privilege she experienced in working with diverse cultural groups, while others described how exposure to the spiritual dimension of health had impacted upon their personal and professional growth. This cultural lens seemed to be so much a part of the world of these nurses that it did not appear as a separate entity. It was not the central focus, nor was it peripheral, but rather an integral and integrated part of the whole.

Exemplar: There was this little (cultural group) girl who had quite a rare medical condition. On this particular occasion, she hadn't been at school for a few days and so I did a home visit to see what was going on. When I arrived I found this little girl lying on the lounge floor, and she was so swollen with fluid that she couldn't even stand up or walk. So I sat down with the family and it turned out they were treating her with their traditional healer. They had been to their local doctor and the hospital but she hadn't been cured, so they had gone to their healer who refused to treat her if they were using any Western medicine. So the family were put in a real dilemma. I remember sitting cross legged on the floor with them for over two hours, talking to them about how sick their daughter had become, that she could maybe die if we didn't act straight away. They were worried the healer wouldn't work with them again and I was able to tell them that there are healers around who will work with Western medicine. And eventually they agreed with me and we got her into hospital, but it was touch and go there for a while.

The nurse demonstrated an attitude of respect and understanding, and within this she was able to offer alternatives to the family that were acceptable within their cultural realm. She was quietly assertive without being demeaning, pushing at the

boundaries for the safety of the child, but intruding with care and sensitivity. The cultural dimension emerged as a 'natural' part of the assessment, shown both in her ability to understand the perspective of the family, and in her approach of sitting and talking with the family as they worked through the issues together.

It was also acknowledged by these nurses that working within this cultural frame of reference had its challenges. They often found themselves on a steep cultural learning curve that required an openness, a valuing and respect of diversity, and a genuine desire to work in harmony with their clients. The final exemplar captures some of the potential dilemmas faced by nurses within this realm, and how one nurse was able to work through these.

Exemplar: I had a little boy who was molested. His young Mum was someone I had worked with quite a bit and got to know fairly well. Anyhow, he was molested and she was absolutely shattered, but she wouldn't allow any counselling for him. She let a doctor examine him, but the child has never had counselling because the (cultural group) won't allow it, it's not something they do. And I found that really hard, but I had to agree. And I still see him at school for general health checks and I keep an eye on his mood and behaviour, but its an unaddressed issue for him that he often brings up in the clinic. So that has been hard. But I did achieve a lot with the school by running an extra safety programme, and I worked with the council and the police to get the area looked at. And that's all you can do sometimes. I had come up against a cultural block and I had to work around that and do something else.

Being open to cultural indicators and working within these does require diplomacy and sensitivity. As evidenced above, a form of lateral thinking is often required to ensure the best possible outcome is reached within particular circumstances. Although she found it difficult, the nurse took on board the cultural reality as it presented itself and she worked within this re-framed situation with skill. Given the circumstances, she accepted that this was the best that could be achieved.

Discussion

This section will discuss the findings that have emerged within the theme of 'delving beneath the surface' as they relate to some of the findings from Benner's research programme. In her original research Benner (1984) identified seven

domains of nursing practice that were derived inductively from 31 competencies. In relation to the theme of this chapter Benner's diagnostic and monitoring function, and the effective management of rapidly changing situations, are relevant domains.

The ability of the participating public health nurses to listen with all their senses and to connect up patterns, together with their creative reflection, can be compared with Benner's concepts of detecting changes, anticipating breakdown, and thinking about the future course for the patient. In the paradigm case for example, one sign of improvement with John was the change in his handwriting. The nurse used this as one gauge of his progress, and during her regular meetings with John she was constantly alert for signs that might indicate the need for more in-depth counselling to occur. She also had one eye to the future, anticipating that John may find it difficult to cope when he started at a new school, and working with him to develop strategies to deal with this.

While Benner's domain of effective management of rapidly changing situations included the management of life-threatening crises, one nurse in my study did remark that many of her clients experienced "social arrest". The nurse used this term to refer to clients who seem to have come to a standstill in relation to being able to cope with their lives. When situations seem utterly overwhelming for clients they require skilled assessment and appropriate interventions that will assist them to return to a state of balance. The simultaneous assessment and action that was described in many of the exemplars highlighted the nurses' ability to grasp complex problems quickly, to intervene appropriately, and to assess and mobilise the help that is available. The nurse confronted by the father in the medical centre for example, demonstrated considerable knowledge and skill in handling this situation, acting and using resources appropriately until further assistance was available.

Although similarities are apparent between these domains as described by Benner and the findings from the present research, differences are also evident. These seem to primarily reflect differences between practising in a community environment and in an acute nursing context. For example, the monitoring of physiological parameters and interpretation of diagnostic tests were important components of nursing practice in Benner's work, but these were not a central feature of the assessments undertaken by the public health nurses in my study. It was also noticeable that the cultural dimension was absent from Benner's work, and yet in the present research it was an integral component of expert public health nursing practice.

In examining the concept of intuition Benner and Tanner (1987) defined this term as understanding without rationale. They related the examples of nurses' intuitive judgment to Dreyfus's six key aspects of intuitive judgment which include: pattern recognition, similarity recognition, commonsense understanding, skilled know-how, a sense of salience, and deliberative rationality. If this description of intuitive judgment is recognised as one possible interpretation, some resonance can be found in the present research within this theme of 'delving beneath the surface'.

Pattern recognition is a perceptual ability to recognise relationships without pre-specifying the components of the situation and was conveyed in my study in the nurses' ability to connect up patterns. In the paradigm case for example, the nurse did not have a label ready to pin onto John, but rather demonstrated an ability to bring some coherence to the multiple cues received. This also related to the capacity to recognise similarities with past experiences. The nurse's previous experience with hyperventilation and depressed children helped make problem identification possible in circumstances that were somewhat ambiguous. She then worked to identify factors contributing to the hyperventilation. Commonsense understanding refers to a grasp of the culture and language so that flexible understanding in diverse situations is possible. The ability to listen with all their senses, the cultural dimension of their practice and the art of reflection assisted the public health nurses to understand situational meaning from the client's perspective. Nowhere was this more poignantly highlighted than with the nurse who continued working within and around the situation where counselling was deemed culturally inappropriate following the molestation of the young boy.

The concept of skilled know-how was captured in the skilful, fluid actions of the nurse in the medical centre who was faced with the angry father, the frightened child, and the mother who wanted to gloss over what had occurred. In the midst of a highly charged situation this nurse's actions were at the same time unthinking, yet well thought out, simple and yet highly complex. A sense of salience emerged in many of the exemplars, such as the nurse following up the 'simple' scabies referral who quickly ascertained the importance of addressing the apparently depressed mother. Although this may border on the obvious, the nurse was able to shift her priorities with seeming ease, and further demonstrated salience by ascertaining what *this* woman in *this* situation actually required. Although these public health nurses assessed each situation within its own particular frame of reference, the concept of deliberative rationality also emerged. They used their wealth of knowledge from past experience and knowing a particular client over time, as a way of clarifying their current perspective.

As shown above, the findings from my research support the concept of intuition as described by Benner and Tanner (1987). In their most recent work, Benner, Tanner and Chesla (1996) also address the concept of intuition but they place this within a broader description of expert clinical judgment. This encompasses the role of the situation, the use of emotion, intuition, and the importance of knowing the patient. These aspects also emerged in the present study as the public health nurses assessed their clients with skilful expertise.

The highly contextual nature of the assessment process was a recurring theme, with the ability to focus on well-being and to listen with all their senses being important as these nurses asked for, and acknowledged, the clients' stories. As shown in the paradigm case, sitting and listening to the young pupil's story was crucial to the ongoing assessment undertaken by the nurse. 'Knowing the patient' is a concept that will be further explored in Chapter Five, but this "pervasive, yet virtually invisible aspect of nursing practice" (Tanner, 1993, p. 28) was relevant to the assessment process. For example, the nurse dealing with the child tantrum and the despairing mother assessed and acted to a large extent on the basis of knowing the family, while the nurse in the paradigm case was able to work with John through knowing what he had achieved and what, therefore, were realistic future options. This theme of 'delving beneath the surface' also captured the importance of emotion, evidenced with the nurse who felt uneasy that her assessment was missing some vital clue, and who persisted until the "fog finally lifted".

According to Benner, Tanner and Chesla (1996) the term clinical judgment includes deliberate conscious decision making and holistic intuitive responses, both aspects emerging as part of the expert practice of the nurses in my study. Assessment was a conscious process that was skilful and fluid, reasoned and careful. It also included an intuitive response that was particularly noticeable in those instances when assessment and action occurred simultaneously. In these situations the public health nurses were able to link seeing the salient issues in a situation and responding to them. "Getting a good clinical grasp, the skill of seeing" (Benner, Tanner and Chesla, 1996, p.5) could almost be an alternative title for the theme described in this chapter, and captures the central role of assessment within the realm of expert nursing practice.

Other aspects that emerged in my study were also described in the work of Benner, Tanner and Chesla. For example, taking past, present and future into consideration in order to gain a clinical grasp of the situation was imperative as the public health nurses 'delved beneath the surface' in order to see the full picture.

Benner, Tanner and Chesla's description of the big picture includes not only a strong sense of future possibilities for the patient and family, but also an expanded peripheral vision of what is happening in the unit. The centering on well-being that has been described in this chapter portrayed a broader perspective that included the cultural, social and economic factors that are closely interrelated when the focus is on the full picture. It was only in *The Primacy of Caring* that Benner and Wrubel (1989) used the term well-being, noting that a phenomenological definition of health must be based upon an integrated view of mind/body/spirit. These authors describe well-being as contextual and relational, and as reflecting the lived experience of health. This definition certainly melds with the concept of well-being that has been identified and described in my study.

Summary

As was highlighted in the exemplars and paradigm case for this theme, 'delving beneath the surface' required finely tuned recognition and assessment skills. Beginning from a premise that it is seldom simple meant that the public health nurses in this study were constantly alert, moving onto the next layer of assessment as more information and clues are revealed. In the paradigm case for example, the nurse gathered background knowledge, gave meaning to the physical manifestations, searched for contributing factors and continued to assess and act throughout the relationship. As they delved deeply, seeing the full picture ensured the assessment was also broadly based. The findings supported many of the concepts that have been described in Benner's research programme, but the cultural dimension that was an integral component of the practice of the nurses in my study, was absent.

CHAPTER FIVE

Watchful Journeying

It is such a different world out here, you can't put people in boxes and expect them to behave as you think they should ... you're the guest on their turf and that puts a really unique perspective on the journey you take together. And it's hard to explain that to people who don't have a community focus.

This theme describes a process of nurse and client, be that an individual, family, or school, journeying together, walking alongside each other on a part of that complex road that is life. The narratives of the public health nurses highlighted that this was very much about working within and as a part of social settings. The forming of relationships takes time, and includes the nurse accepting the role of an invited guest within a given situation. The development of trust emerged as a key issue and it was often necessary for the nurse to place her personal value system 'on hold' to a certain extent. An attitude of respect was essential as boundaries are constantly negotiated, one nurse describing this process as "getting into another's space for a period of time", with engagement being followed by a weaning away, a rather unique process of moving in and out of clients' lives.

Public health nurses often deal with the social intimacies of life, and in so doing, they form special and privileged relationships with clients. This is simultaneously both a challenge and a positive experience. The sensitivity displayed by the public health nurses in this study was a strength rather than a burden, and demonstrated an ability to remain objective yet involved, moved yet practical, vision seeking yet reality based. The narratives revealed a forging of relationships that were not always positive and rewarding, but neither did they focus exclusively on despair and heartache. These nurses deal with humanity as it presents itself in all its colourful hues and, while demonstrating a certain willingness to enter into other people's painful areas, they did not allow themselves to become submerged, and therefore potentially less effective. The situation specific nature of the nurse/client relationship was apparent, and the nurses acknowledged that relationships with clients reach different levels of intimacy.

The public health nurses displayed an extensive and diverse range of strategies when dealing with clients, knowing not only what to do, but when and how to do it. In many of the narratives the nurses articulated the importance of being aware

that their actions may lead to both visible and less visible consequences. They also displayed a moral courage when relationships painstakingly built over time are of necessity undermined through actions taken by the nurse. The skill required when making decisions regarding when, how, or even if, to close a case also emerged. The word 'acceptance' is pervasive within the theme of 'watchful journeying' - the public health nurse must be accepted into homes, schools and the community at large, they must demonstrate an acceptance and ability to work within diverse situations, and they must accept that often, outcomes are not ideal.

Following the same format of the previous chapter, the body of this chapter will elaborate upon and support these introductory comments, the theme being addressed under the following sub-themes:

* Forming relationships

* Sustaining relationships over time

* Closing with care

The paradigm case for this theme stood out for both the nurse and researcher as a situation in which a relationship was formed and sustained in the context of a complex social situation, with the nurse performing a fine juggling act as she both supported and encouraged the mother along a path to enhanced self-esteem. In this narrative, we have an immigrant family consisting of a number of children, a father who is frequently absent from the home because of work, and a mother who is not coping well with life or caring for her children. Excerpts from this paradigm will be interspersed throughout the chapter, with a selection of other exemplars used to highlight and support particular aspects.

Forming relationships

An integral part of forming relationships with clients is the finely tuned assessment undertaken by the nurse. As the nurse assesses and interacts, the beginning threads of the relationship are woven. A key element referred to by many participants in this study was the notion of being a guest, a visitor on the client's territory, the words 'by invitation only' conveying an acknowledgment that it is the host (the client) who welcomes, sets the scene, and directs events. This does not however imply a passivity on the part of the public health nurse who often

becomes an invited guest through persistence, through chipping slowly away at barriers, and sometimes using what one nurse described as "the back door approach" to enter a situation. This was highlighted by the nurse who described building a relationship with a school that developed from a point of resistance to her role, to where she was a welcomed and important part of the life of the school. This took two long, frustrating years to achieve.

Exemplar: I started off in this school by seeing the principal to talk about my role, that I was very interested in being involved in any health education, that I was happy to accept referrals from the children themselves and their teachers, and so forth. And at the end of a fairly short interview he said well thanks very much, but I can handle anything that happens in my school, and that with any health related issues he would get the family to see their local doctor. So months passed and I visited the school religiously each week, no referrals of course, but I made sure I visited at morning tea time so I could get to know and become known by, the teachers. And over time, the teachers started to ask my opinion on a variety of matters, but they didn't make formal referrals because the principal had said they must all go through him.

Although the nurse is present she has not been invited into the school, and she is careful not to intrude where she hasn't been asked, acknowledging that she must take one step at a time if there is to be any worthwhile future relationship with the school. The power rests with the client, and the public health nurse must be able to accept and work within this reality. One participant commented that without the symbolic power of a nurse's uniform you are essentially a stranger who must prove your worth, and that you must never assume you are welcomed, or even needed, in a situation. To return to the nurse in the exemplar, she slowly builds a rapport with the teachers in the school and becomes involved in various education programmes over the next two years, all the while being largely ignored by the principal. The story is taken up at the beginning of the third year.

Exemplar: I started off the year going to see the principal as I had done the previous two years, and I talked about some of the activities I had been involved in, and his response just blew me away really. This time he actually asked me what involvement I would like to have in the school, he offered to arrange times for the teaching sessions and such like. And the outcome is that now I'm timetabled into the school's programme, I have a self-referral clinic, and I have the teachers and principal referring children to me. So after living

and breathing that school for two years and seeming to get nowhere, now it's
absolutely wonderful, we work together really well.
(Interviewer: So what made things change?)
My perseverance was a big factor I think. To be honest, in that second year I
felt very tempted to say to hell with it, but I knew there was so much I could
offer the school and the community if I was given the chance, so my patience,
tenacity, and the success of the education programmes paid off eventually.
And principals often need time to suss you out, to trust you, and you have to
go along with that. Essentially, I didn't have a right to be there and if you're
not user friendly, you just won't get invited in, and then your hands are well
and truly tied.

The concept of being invited in provides a unique starting point for building
relationships that has a clear focus on the client. It also extends out into the wider
community, nurses describing the community grapevine that spreads the word
about whether their public health nurse is "kosher", whether she can be trusted,
and is both accessible and acceptable. The nurse in the exemplar commented that
finally being invited into the school had a ripple effect within the community,
easing her acceptance into other schools, and impacting not only on the nurse and
the schools, but on future families that have not as yet entered the picture. It must
be acknowledged however that there are instances when the legislative requirement
will always take precedence. This is particularly relevant with child protection
issues where the nurse must follow clearly defined protocols.

As the nurse is invited into a situation, so she begins the delicate process of
negotiating boundaries, recognising family norms and domains and taking care not
to cross the line between what is acceptable and what is not. This was seen as
particularly important during the forming stage in the relationship when much good
will and the anticipated walking alongside, can be irrevocably threatened. In order
to successfully negotiate what one nurse described as a "social minefield", the
public health nurse must possess a superb sense of timing, knowing when to move
in and take over, and when care, circumspection, and the 'softly, softly' approach
is more appropriate. She is constantly negotiating boundaries surrounding both her
role and the relationship that is acceptable within a situation.

Exemplar: There's a family I'm just starting to get involved with, a solo Mum
with a five year old who has just started school, and an infant who is nearly
two. The school aged boy has some developmental delay and he has poor
social skills. And when I visited the mother it became quite apparent that she

had real difficulties in her relationship with that little boy, and she was finding it increasingly difficult to manage his behaviour. And in contrast, the younger child was there, and she just can't get enough of him, she cuddles him, touches him all the time, says what a lovely kid he is, how wonderful he is, while with the other child it's all totally negative. So it's a really concerning situation and she was asking for help. She said, look, I can't handle him anymore, I want to do something, what can we do? And she cried several times. And I turned it around at one point and said, so is your relationship with your son an issue that you want to try and address, and she said yes. But as soon as I started to talk about some possible strategies, her body language turned right off, she started fussing with the baby, avoided eye contact. So on the one hand she was saying please help, and on the other saying I don't really want to get into this. So I didn't go along that track any more at that meeting. I felt she had started to trust me, she opened up a lot, and I'll need to build on that.

The nurse had been invited into the situation, and was now working through those boundary issues with care and sensitivity, being cognisant that guests can be asked to leave. She recognised that the time was not right to push at the existing boundaries surrounding the mother's relationship with her son, and that the development of trust was essential if the emotional walls were to be broached at some stage. The nurse in this narrative conveyed an attitude of honesty and an ability to understand another person's world. One nurse asserted that "clients can see right through you if you're not sincere and genuine, and they're quick to judge and slow to forgive a lot of the time". Trust is not the nurse's automatic right. Her way of interacting with the client sends messages that can make or break a relationship before the nurse even has the opportunity to negotiate those boundaries.

Paradigm: With this woman, we've done a lot of good things working together, but the building up of that trust was crucial and certainly took time and commitment. She was a bit frightened of people finding out about her past history with the courts, but she volunteered that information quite early on, saying she felt safe with me because I seemed to accept things and not go blaming people. You do hear some real tales out here, and you have to learn to go in neutral so to speak. You accept what you hear but that doesn't mean you agree with it all of course. But she needed me to know and to understand. In the beginning stages of our relationship in particular, when I would go around to do a home visit, I'd often just help her hang out the

washing, and she would talk about how she was managing with the kids, and what was getting her down. And I still do that. Building up trust over time was absolutely essential before we could start to work on things together.

As with any guest, expectations vary depending on the circumstances. When the public health nurse has been invited in, boundaries must be constantly negotiated. This requires flexibility, skill, knowledge, and an ability to read the signs and go with the flow to a large extent.

Sustaining relationships over time

Although some of the work of the public health nurses in this study involved short-term interventions such as immunisations, or specific treatment regimes, a significant proportion involved working with families over extended periods of time. Within this context, sustaining relationships takes on subtle meaning and complexity. A key strategy that emerged in many of the narratives was the process of moving in and out in clients' lives. This included a coming together followed by a moving apart, and was described by the participants as a process of working with families to get them back on track, and then stepping aside, of nudging families in the right direction and then watching them develop. A sense of partnership with families was evident and was based on a belief that family roles must not be taken over by the nurse. These nurses acknowledged that families have been solving their problems long before the nurse arrived on the scene, and they will continue to do so long after she has gone. However, the public health nurse perceives herself as bringing a specific expertise that complements and enhances the resources available within the client's present circumstances.

Moving out does not necessarily involve a complete severing of all ties and links with a family, but it does convey a lessening in the relationship, a breathing space. It is a dynamic and fluid relationship. A skilled sense of timing underpins this process, and is based upon the nurse's contextual understanding that is specific to time, place and client. This moving in and out occurred both during periods of relative stability, when the nurse might have a monitoring role, and during times of crisis. One nurse observed that some families almost lived in a crisis mode, and in these situations the nurse would move in, work with the family, and then move out, watching and waiting, ready to move back in when required to do so. Although this could be seen to border on a 'laissez-faire' approach, there was an awareness that, in the end, the client leads the care, and that small steps forward

are at least steps in the right direction. This ability to move in and out with seeming ease was an important factor as the nurse in the paradigm case sustained a relationship over a lengthy period, the following excerpt highlighting her skilled judgment in managing this process.

Paradigm: This has been an ongoing relationship, but that is not to say that we function at the same level of intensity all the time. That would be no good for anybody. What happens now is that I see her on a semi-regular basis, just to see how she's coping, and for her to know that I'm still there for her when needed. That trust has built up now and it's something you don't want to let go of easily, because it's so fundamental to working with families who don't give their trust lightly. And then I'll get more involved when needed. Not long ago for example, her eldest son who had been living away from home suddenly returned, and that really rocked the family boat for a while. The mum felt guilty he had been sent away in the first place, the other siblings suddenly had their established structure disrupted, and the young boy took out his fears and frustrations on everyone. So I had quite a bit of input there, working with the school, setting contracts at home and school with him, and being there for Mum to bounce ideas off. And then things settled down and I moved away a bit, because she was coping well, but right now she's finding it hard to set limits for all the kids so I'll work with her again.

Moving in and out was a central factor as the public health nurses worked to balance their sense of involvement with clients over time. These nurses were consciously aware of that fine line that exists between what can be termed over and under involvement. They could not maintain a distant, objective stance, neither could they become submerged in the chaos and despair experienced by some of their clients. Their narratives suggested a world-view that saw client and nurse walking together, sharing the highs and the lows without the nurse feeling total responsibility for the outcome. This included the view that, while clients have the right to choose and lead the care, the nurse has an attendant responsibility to share ownership for the outcomes associated with health care and status.

One strategy used by the public health nurses to balance this involvement included the use of a negotiating and contracting process to set boundaries and to clarify roles and responsibilities. This was also important in terms of balancing workload demands. The reality of the working world of these nurses was that, physically and emotionally, they cannot be all things to all people. This sense of involvement was

captured in some of the language used by the nurses, with terms such as enabling, supporting and guiding being used frequently. They were clear that, in most instances, the client chooses the direction and the destination, with the nurse providing compass readings that may or may not be followed. The nurses also demonstrated an awareness of the possible consequences of the journey they were undertaking with clients and the ethical stance of not fostering a dependence that is ultimately non-sustainable was a recurring theme. In the following exemplar the nurse is talking about a family with whom multiple agencies have had a great deal of involvement. The solo mother is experiencing problems bringing up her children, and the nurse has been involved in many and varied crises with the family.

Exemplar: Although it certainly hasn't been the easiest of situations to work within, we have made some really significant progress along the way, like getting the little boy grommets and encouraging more self care in the mother. And this wasn't only physically, but has also included things like getting her to the stage where she can now do her own shopping and make appointments. And this is in a context when she really suffocated me at times, ringing me for all kinds of trivia and not taking responsibility for herself or her children. And I had to work hard to be both there and not there. Often, the best way to handle the situation was to watch from a distance, as once you showed any open interest or sign of becoming involved, whoff, you'd be swept up again. So I would monitor the situation through the school, and social welfare and I liaised closely as well. So basically, I work with her through the low points and then I have to step aside, or its disastrous for everyone.

The nurse provided a safety net for the family and fostered a degree of independence in a woman who relied heavily on outside support. At the same time she performed a delicate balancing act in order to achieve what she considered to be an appropriate level of involvement. This exemplar also demonstrates that the ever changing, living and dynamic process labelled involvement is not always easy to achieve. On occasions, the nurse must accept that the level of involvement reached with clients is less than ideal, that relationships can be fraught with difficulties and frustrations, and that links formed are often fragile and tenuous.

Exemplar: There's one woman with whom I've had quite a bit to do, and yet I don't really think I've formed any rapport with her really. She's a very aggressive lady in her manner, and her way of dealing with things is to get hot on certain issues and really go for it verbally. Like her youngest child has

got chronic glue ear, and last week she decided she wanted grommets now, so I sat and talked about the pros and cons, and then it was, oh let's forget it, I've had enough, that's it. And she's always like that, blows hot and cold. And I do what I can in terms of giving her options, and then I leave it up to her basically. It's not ideal, but she calls the shots, and I do what I can within the particular situation.

An important skill, and one that was necessary to sustain relationships over time, was the situational judgment demonstrated by these nurses who had developed an ability to know not only what to do, but when and how to do it. They possessed an extensive and diverse range of strategies that had been built up over time, this being variously described as "a carpet bag of tricks", and "storehouse of ammunition". This requires a breadth of knowledge and an experiential base that enables the nurse to consider alternatives and to reflect upon past successful strategies used in similar situations. At the same time she maintains a clear focus on this particular client within this particular context. The knowing what to do, or the planning phase, involved a skilled assessment and a process of prioritising, remaining focused on the central issue, and maintaining flexibility.

The nurses described familiarity with clients over time as a key element in deciding what approach to take. This encompassed an awareness of the past as it relates to the present, and extends out into the future. They were constantly alert to deal with the unexpected and accepted that challenge and change are part of the world they shared with their clients. There was an acknowledgement that the journey is often more indirect than straightforward, and that nurses must be flexible and adaptable if they are to respond to changing scenarios and needs.

Exemplar: There was a little girl that I dealt with over quite a long period, and it was a very complex situation involving previous abuse. There were some signs that this might be an issue again, but it was very difficult to prove really, so I had a strong monitoring function. And sometimes I'd do a home visit, and the mother would be very aggressive, and I couldn't get past the door, while on other occasions she would be really welcoming, extremely open and friendly. So you couldn't pre-plan in that situation, but I knew that, and could therefore cope with whatever confronted me when the door opened, and work out my strategies as I went along. But in saying that, I also knew her, and what wouldn't work ... I remember one visit with the medical officer when she refused to let us in the house, and rather than come down the heavy, I actually stood on the doorstep in the rain for about half an hour,

talking to her and convincing her that we weren't there to judge anyone, we were concerned about the child, and she did let us in eventually. I knew the strong arm approach would have got her back up and she'd have told us to get lost basically.

This was a difficult situation for the nurse to anticipate in a logical fashion, as there was very little logic to the reception awaiting her each visit. Knowing the client and the circumstances however, enabled her to work with integrity and courage within the intricacies of the situation. This exemplar also highlights the nurse's ability to think through strategies as the situation is being experienced, and to work subtly when this approach seems appropriate.

Throughout the narratives, a focus on practical interventions emerged, the nurses being wary of adding unnecessary complexity to a situation. They identified the importance of using the repertoire of strategies they possessed in order to deal most effectively with what confronts them on a daily basis. Although the strategies may appear simple on the surface, the work of sustaining relationships over time requires the nurse to be both focused, while also thinking beyond the narrow confines of a presenting problem to be solved. The nurse in the paradigm case for example, in addition to working with the mother to develop parenting skills, ensured practical measures for child safety were undertaken, and acknowledged the mother's strengths and her right to choose between options. She provided a monitoring and supportive role, constantly negotiated the level of input required and used the negotiating/contracting process when this was deemed beneficial. The consequences of nursing interventions that occur over a period of time were revealed in the gradual development of self esteem within the mother. This had potential to impact on many aspects of her life.

Paradigm: I guess you would say this mother's hanging in there, she comes and goes. There are times when she'll get quite depressed with all these children, no money and so on, and then she'll be okay for a while. And she has built herself up really well in so many ways, like she keeps the house spotless, she has decided she can do that, and we've worked on developing some parenting skills around discipline and setting boundaries for the kids. And I've also helped her approach the landlord to get the place fenced to make it safer for the children. She didn't know she had the right to make those kind of requests. And she's gradually building up a belief in herself, and has more confidence in approaching people. So it's often the little things we do, but they add up over time. And I'm always trying different things with

her. For example, we talked about child care options, just to give her a break, and she actually went and had a look at a few places, but she decided they were her children and she could manage, so that's fine, it is her choice. I think one important part of our role is to present options because there is a lot out there if you know where to look and how to access it.

Sometimes however, the public health nurses must acknowledge that their extensive input merely serves to maintain the status quo, that some situations will never change greatly, and that their role is to work to prevent the spiral downwards. Their attitude was both one of acceptance and one of optimism, with one nurse noting that although you may not make a noticeable difference in the here and now the effects may become visible further down the track. The nurse in the following exemplar paints a picture of a situation that is bordering on the disastrous, and demonstrates how a skilled public health nurse can work within the chaos to achieve the best possible outcomes in this context.

Exemplar: There's one family I deal with, and the situation is quite overwhelming really. Both parents are unemployed, there are five young children, three dogs and their litters, two cats and their litters, and there's all this coming and going all the time, and life is a bit out of control. And the children's basic needs are just being met. They're often unclean, they're often hungry, and health problems are never followed up on. Mum only just manages, but she's a very cheerful kind of soul, laughs in the face of all the chaos, but basically wants to plod on and deal with things as they come up. She just doesn't have the energy or desire to make any longer term goals. So I have to accept that that's how they choose to live, and I get involved as things crop up. Like the food issue seems to be emerging at the moment. The school is worried the children aren't being fed properly, so I'll go and do some work with her around food planning and get some food vouchers, so it's surface stuff, but at least it stops things getting any worse.

As has been demonstrated in the paradigm case and exemplars, the communication skills of the nurses in this study were an important component in maintaining relationships with clients over time. Public health nurses must communicate with a wide range of health and non-health professionals, as well as a diverse client group, and they must tailor their approach to suit diverse needs and situations. These nurses demonstrated the art of communication which is constantly played out against the background of life as it is being lived.

Exemplar: A colleague and I did a home visit not so long ago because there was a little girl at school who just didn't want to go home because her Mum had got really stuck into her. We did this visit, and the Mum just went crazy, calling the kid all kinds of names, screaming and yelling at us for coming and interfering, that she had all these kids, and had just arrived in the area. And we just managed to sit there, and it took an hour to calm her right, right down so we could have some sort of conversation. And when we finally left, things were on an evenish keel again. And the next day she rang and acknowledged that yes she had been tough on the kid, and she would be appreciative of any pamphlets we had about parenting. So that was quite amazing in view of the reception we had received.

(Interviewer: So how did you defuse that anger?)

We just said how we knew it must be hard for her, and were silent as she raved on about the neighbourhood, the kids, her lack of money, and she broke down and had a good cry while we were there. But when she started in on us having no right to be there, I very firmly said that we did in fact have to follow up on situations like this, that our role was to find out what was going on at home. And in the end, it was about bringing those feelings she had out into the open, and pointing her in another direction.

It is impossible to capture all the shades and nuances that make up this art of communication within one exemplar, but this excerpt does uncover elements that were repeated in many of the narratives. The ability to defuse anger through listening skills, being calm and assertive, clarifying what the mother was feeling, and re-framing the situation to enable the mother to view events from a different perspective, were some of the skills displayed. These nurses provided a safe environment for the mother to reveal her feelings, and probed with caution. Their approach was successful as evidenced by the situation gradually settling down, and the mother's response the following day. Similarly, in the paradigm case, the nurse displayed empathic listening, conveyed ground rules for child safety in a clear yet sensitive manner, and provided non-verbal support through sharing simple household tasks. An ability to listen carefully was evident throughout the narratives.

The cultural dimension of care was also pervasive throughout this theme of 'watchful journeying'. As articulated in the previous chapter, this cultural aspect was embedded in the practice of the public health nurses and did not therefore emerge as a separate entity to be viewed in isolation. On a practical level, interpreters and allied workers from the client's cultural background were brought

into a situation when the family felt the time was right, and nurses used their extensive community links to increase their cultural understanding. At no time did the public health nurses presume that they could fully understand the cultural world of another, but their genuine acceptance and flexibility were intrinsic to their expert nursing practice. This is highlighted in the following exemplar.

Exemplar: There's a family I've been working with lately, a solo Dad who hasn't been coping very well with his three kids, but his mother, a wonderful (cultural group) lady was knocking him into shape about being a father and had gone through the house like a tornado. And I was having input into dealing with the kids' ear problems, setting up appointments, following them up at school, things like that. And the nanny and I worked together a lot, we had some great talks at the kitchen table over a cup of tea ... Sometimes I knew I had probably used the last tea bag in the house, but I couldn't say anything because it was part of that engagement and she would have been so very offended if I had broken that ritual. ... Anyhow, I was at the school one day and the father was there and he saw me and yelled at the top of his voice, see that bitch over there, and I thought, oh no, what's coming, and he said, she's the tops, she's sorted me and the kids out a treat. And that really made me think, you know, here was me, a middle aged pakeha woman moving in their world to some extent, and having some effect, or at least that's the way he saw it.

A final strategy within this sub-theme was the ability of the public health nurses to spread the net widely, this referring to the wealth of knowledge they possessed regarding community resources. They not only knew what was available, but they also had an awareness of how the various services were organised. This enabled the nurses to clarify expectations for clients, this being a key factor in ensuring that choices made by clients were based upon as much understanding as possible. The nurses worked closely with school communities, social agencies, extended families and voluntary groups, often providing a liaison or brokering role between the client and these other services. In the paradigm case for example, the nurse was able to present options for support to the mother who was then able to make an informed choice. The importance of families choosing who they wish to become involved in their personal lives was stressed by many of the nurses. One described herself as a "community encyclopaedia ... you have a lot of the information, and the reader decides what, if anything, is of value, or has relevance to their world".

Closing with care

Closing cases requires careful judgment as the public health nurses balance present and future client needs, and recognise that the often tenuous and precarious links formed with clients should not be severed without careful consideration. An ethical and practical stance seemed to underpin this perspective. The nurse in the paradigm case for example, having gradually worked with the mother as she built self-confidence, continued in a supportive role as this woman dealt with her past, coped with the present, and started to build a future. By not severing ties completely, the public health nurse is also able to move back into a situation more easily because a certain level of trust and acceptance has already been established.

> *Paradigm: One time when I did a home visit, she seemed really down. She was so tired, and was saying how the kids were having to sort themselves out in the morning because she was still asleep, and how bad she felt about that. And because I knew she didn't feel happy with child care, we had explored those options before, I talked about the possibility of health camp. And the up-shot was that two of the kids went off to camp for a couple of weeks, relatives took two, and she was just left with two at home, and the difference that made was amazing. The kids had a great time, and she was able to recharge her batteries and get herself going again. Because we already had those links and shared history, it was easier for her to open up, and for me to present an acceptable option, not perfect, but acceptable, workable, and worthwhile.*

The nurse in the paradigm case acknowledged that, at times, the nursing aspect of her role became a little blurred, but the mother had decided she wanted the public health nurse to be her main support person, and it bordered on the unethical not to respect her choice. Far from the desire to hold onto cases, the public health nurses demonstrated understanding and sensitivity as they worked through the delicate process of ascertaining how far the door could, or indeed should, be closed. Each case is assessed within its own particular frame of reference, and although closure is straightforward in some instances, there are also times when the actions of the public health nurse may close the door prematurely on a case. This knowledge did not however prevent the nurses from making decisions they perceive to be morally correct. In the previous chapter, one of the exemplars described an instance when the nurse, faced with an angry father and protecting a physically abused child, initiated the arrest of the father from the medical centre, despite the mother's pleas to the contrary.

Exemplar: It was a really ghastly situation, and while we were at the centre the mother was crying and saying how no-one was ever there when she needed them to be. She was devastated by the whole thing, terrified of the father, and not knowing what to think of me really. On the one hand she was relieved, but on the other, she was so much the abused woman that she had to go and visit him in jail that night. Anyway, they had a family group conference, and the mother rang and said to me on the phone, don't you want us, have you dropped us you bitch, that was the way she talked. And I said that it was up to her who went to family conferences, that we don't just turn up uninvited. And what had happened was that other people had decided I shouldn't be there, but here was this woman saying you're the only one who has ever helped me and I want you there for me. So it was amazing that after all that had happened, the relationship I had with her was sustained.

Although the nurse realised the possible consequences of her actions in terms of the potential negative impact on the relationship that had been formed over time with this mother and her children, she knew what needed to be done and did it. As she stated, it was indeed amazing that the mother chose to keep the door open. This illustrates the impact that public health nurses can have on the lives of their clients. Another example of this was the paradigm case from the previous chapter where the nurse worked with the young school boy. In this instance, her care was based upon the premise that he needed to own the changes as coming from himself, and she consciously gradually withdrew her input over a period of months. This was a negotiated process of closing with care, and although the goal was clear, she was prepared for, and worked within, the inevitable set-backs that occurred. The nurse mentioned her enjoyment in working with this pupil and how easy it would have been to continue the relationship, but she realised this would not have been in his long-term interests. Once again, the notion of what is acceptable emerged as central to the public health nurses work of closing cases with care.

Discussion

Following the same format as the previous chapter, this section will discuss the findings described within this theme of 'watchful journeying' in relation to some of the findings from Benner's research. In *From Novice to Expert* Benner (1984) described nurses as establishing a context of attentiveness. This idea conveys much of the essence of the theme described in this chapter. The nurses in the present study were extraordinarily attentive to their clients changing needs. They

demonstrated a finely balanced sense of involvement, and moved in and out of clients lives skilfully and appropriately. Benner also introduced the concept of practical holism in which the situation and the relationship determine what is possible and holistic. The nurse in the exemplar who was monitoring the possible child abuse situation demonstrated the ability to quickly and accurately assess the meaning of the reception that awaited her as the door opened. Her expert decision making was based upon practical holism because her assessment of the situation structured her response in a way that could only be very loosely pre-planned.

There were some similarities in the findings discussed in this chapter and the competencies that Benner (1984) described within the helping role domain. These included aspects such as the establishment of a healing relationship; the concept of presencing, or being with a patient; maximising the patient's participation and control; and providing support to families. For example, the paradigm case for this chapter gave evidence of a healing relationship established between the nurse and the client. The nurse mobilised hope in the mother who came to appreciate that she was not alone, and to realise that she was capable of having more control over aspects of her life. The nurse's networking skills gave the mother information and confidence to reach out for additional assistance if she chose to do so. Through skilled communication the nurse assisted the mother to deal with her past, and to build a present that could indeed take her into the future with greater understanding and self respect.

Benner's description of the importance of being with a client, or presencing, was demonstrated by the nurse in the paradigm case who conveyed non-verbal support and understanding as she and the mother shared the simple task of hanging out the washing. The nurse had the confidence to see the value of her presence which conveyed an invitation to the mother to share concerns if she felt the need to. The strategy of moving in and out, whereby the out was not absolute but often involved watching from a distance, meant that 'doing for' was certainly not the central focus of the nurse/client relationship. Maximising the client's participation and control within the situation also emerged strongly within my study. This was the starting point for the forming and sustaining of relationships over time. The public health nurses waited to be invited in, constantly negotiated boundaries, and used strategies such as negotiating/contracting to elicit the client's involvement and control. Validating and building on the abilities and strengths within the mother was another way in which the nurse in the paradigm case worked to gradually develop a greater sense of client control. As this nurse noted, for many of their clients, the public health nurse is often one of the few who can really see beyond

the chaos, the poverty, and the despair. This understanding was important as these nurses attempted to maximise client control over their current life situation.

The practice of the public health nurses in this study had a predominant family orientation, the nurses rarely focusing on an individual in isolation from the broader social environment. Their narratives provided many example of how the nurses considered the family as client, monitoring, supporting and involving the family unit as appropriate. For example, the nurse in the exemplar who was dealing with the complex scenario of suspected child abuse monitored the total picture, not parts or individuals in isolation from each other. Her expert situational judgment that focused on the child, the family and the environment was essential in maintaining a safe situation.

Although similarities were apparent in the findings presented in this chapter and Benner's (1984) original research, the context specific nature of expert nursing practice infers that differences will also be apparent. Some of these differences were revealed in the language used in the narratives of the public health nurses. For example, the word 'helping' was noticeably absent from the narratives in my study, being replaced with words such as walking beside, working with and following the client's lead. These terms seem to convey the nature of nurse/client relationships that are formed in a community setting where client participation and involvement is paramount. Similarly, for the public health nurses, a healing relationship was often more attuned to social and emotional well-being rather than the physical. Within the helping role, Benner also described the frequent use of touch, as nurses reached out to patients and provided comfort, but this emerged only occasionally in the narratives shared within my research. One could tentatively hypothesise that cultural norms, social rules, and a relationship led primarily by the client, are perhaps some of the factors involved here. As the nurses journeyed with their clients however, they could be described as 'touching' their lives in multiple, although less visible ways.

Benner and Wrubel's (1989) work can be used as one framework to describe expert caring. These authors described eliciting and understanding the client's story as essential to expert practice and this was supported in the present research. Understanding was crucial as the public health nurses endeavoured to accept and work within the world of another. To illustrate this point, the nurses confronted with the angry mother whose daughter was afraid to go home, conveyed their understanding of her situation both verbally and non-verbally. They were careful not to condone the mother's behaviour, but their approach had therapeutic

intention as they calmed an emotional situation to the stage where the mother felt less isolated, and could work through the issues. Their understanding conveyed a caring stance and was central to their skilled situational judgment.

Benner and Wrubel discuss the role of concern as a way of being involved in one's world. The ability of the public health nurses in my study to understand the concerns of their clients was a key factor as they built and sustained nurse/client relationships that were based upon trust. A concern for the client's situation impacted upon decisions made around closing cases with care, balancing the nurse's sense of involvement, and working to maintain even tenuous links in situations where it was difficult to visualise a positive outcome. Benner and Wrubel also elaborate that because nurses themselves have concerns, different patients and aspects of their situation have salience for the nurse. The public health nurse who described the lengthy process of building a relationship with a school community was motivated by a concern for the life and future of the people in this school. Her perseverance was motivated by an underlying concern which attuned her to what was needed in the situation.

Tanner, Benner, Chesla and Gordon (1993) presented analyses related to the meaning of knowing the patient that emerged as a recurring theme in their study of the development of expertise in critical care nursing. These authors described two broad categories of knowing the patient, in-depth knowledge of the patient's patterns and knowing the patient as a person. In their work, the former had a predominant physical and physiological orientation, but when this is expanded to include cultural, social and emotional aspects, resonance can be found with my research. For example, the nurse in the paradigm case was able to recognise when the mother was feeling less able to cope, one example being the emerging pattern of the mother staying in bed rather than organising her children for the day. The nurse used this understanding to move back into the situation with additional resources.

Knowing the client as a person also emerged as the public health nurses built relationships over time, all the while balancing their sense of involvement, negotiating boundaries, and judging with skill when to move in and when to move away. The narratives in my study support Tanner et al's (1993) assertion that knowing the client is central to skilled judgment. Knowing the client was specific to time, place and context, and provided the basis for "particularising care" (Tanner et al, 1993, p. 278). In other words, the nurses knew what to do and how to do it within a particular situation. A related skill was the ability to distinguish changes in

behaviour and circumstances by comparing the current picture with previous experiences with a particular client. In the paradigm case for example, certain aspects within each encounter stood out as salient, whether it was how the mother was coping with her children, family dynamics, or strategies to ensure child safety. Knowing the mother and her circumstances facilitated accurate assessment and appropriate intervention. When expressions used by this nurse such as "she seemed really down", or "she was coping very well with things" are viewed from a perspective of being involved and knowing the client, they indicate an understanding that is central to clinical judgment.

In elaborating upon the practice of the expert in their latest work, Benner, Tanner and Chesla (1996) note that it requires remaining open and attuned to the situation and the demonstration of fluid, almost seamless performance. The public health nurses in my study were open to challenge and change, and had a rich repertoire of strategies that they used in a variety of contexts, their responses being shaped by a careful understanding of the situation. Benner et al describe how nurses at the expert level of practice have an increased facility and comfort in their level of emotional involvement with clients. This emerged within my study in the overt acknowledgement and acceptance that the level or type of relationship formed with clients will vary, and that there is no set formula for success. The nurses were aware of possible consequences that can occur when one becomes involved at times of extreme vulnerability for clients, and they articulated a moral responsibility not to foster dependency. The narratives of the public health nurses lend credence to Benner et al's assertion that there is no context free, 'right' level of involvement.

A final aspect to address is the notion of embodied know-how which was described by Benner, Tanner and Chesla (1996) primarily in terms of the fluid and skilled performance of technical tasks. This concept has relevance to my study in relation to the assessment and action that often occurred simultaneously in the practice of the public health nurses. The well-honed skills required to judge the situation and the appropriate response often included the art of communication, where knowing what to say and how to say it was absolutely paramount. In the paradigm case for example, the nurse's way of 'being' with the mother was based upon an understanding of what was required in this particular time and place, and this was mirrored in the subsequent interactions. Skilled performance is not only about technical competence, the findings from my study extending the concept of embodied know-how to encompass and value less obvious but equally important strands of expert performance.

Summary

'Watchful journeying' has emerged as a complex process that involved the public health nurses in building and sustaining relationships with clients over time and closing cases with care. The nurses could be considered close travelling companions as they shared one part of life's often uncertain journey with their clients. In the paradigm case, the quality of the relationship formed between the nurse and client was based upon trust, acceptance, boundary setting, skilled clinical judgment and utilisation of a broad range of interventional strategies. Integral to the practice of these nurses was an understanding that each person is linked both with others and with the environment in which their lives are played out. As in the previous chapter, many of the key concepts articulated in Benner's research were supported in the findings described in this theme of 'watchful journeying'. Differences were context bound, my study reflecting both a community nursing perspective and a specific cultural dimension. As the essence of this phenomenon of expert public health nursing practice begins to emerge, it is important to acknowledge that, in the practice world of these nurses, the diverse elements cannot be viewed in isolation, but form a highly complex and integrated whole.

CHAPTER SIX

Moving to the client's rhythm

I used to think I could solve everything, that I could just walk in on people's lives, fix the problem and move on. Over the years my world view has changed so much ... You have to go with the flow, work with people, and realise that your way is not always the best way.

This theme of moving to the client's rhythm encompassed the skilful coaching that was an integral part of expert public health nursing practice. Coaching involves having knowledge to share and the skill required to share this in a way that can be understood by clients and integrated into the very fabric of their lives. The word coach implies a working with people, being on the sideline encouraging and supporting, but not playing the game, recognising that ultimately it is the players (clients) who make the changes. The aim is not to move in and take over a situation, but rather to move to the client's rhythm and support family roles as those with the power to make the changes learn the skills or develop the will to do so. There is an acknowledgement that clients lead the process, but this does not imply a passivity on the part of the public health nurse, rather a unique ability to simultaneously lead, follow and be side by side.

Although the coaching role does not have a clearly defined beginning and end that can be documented on a lesson plan and evaluated, it is not some amorphous entity. Rather, it was embedded within the expert practice of these nurses. Coaching was significant and recognisable within the relationship where it had a definite purpose, whether that was to share knowledge, to develop life skills, or to assist clients in their problem solving abilities. At all times the nurse sought to be responsive to the demands of the situation and to acknowledge that changes, if they do occur, are not always easy to maintain. A feature of this theme was the apparent ease with which the nurses applied their nursing knowledge base, striving to share information in a way that did not demean the other or dilute the essence of what they were conveying. This ability is based upon understanding the circumstances of clients' lives, a fine sense of timing, and an acceptance that their role is often facilitative in nature.

In the previous chapter, knowing clients over time was important in sustaining relationships, and within this theme the notion of being there for clients supported

and encouraged change. As will be highlighted, a coach takes on many roles depending on the circumstances, with skill and experience guiding decisions about the most appropriate approach for a particular situation. This coaching role was oriented towards the future with the nurses seeking to open doors on what life could be, and then working with clients as they decided when, how, or even if they wanted to move in that direction. It also involved the nurses being genuinely open to learning from their clients. The notion of learning from clients recognises the shared mutual expertise present within a relationship. The formal health promotion undertaken by these public health nurses is also addressed because this was rarely an isolated event but rather an impetus for ongoing coaching.

Following the same format of the previous chapters, the body of this chapter will elaborate and support these introductory comments, the theme being addressed under the following sub-themes:

* Coaching in harmony

* Focusing on the everyday

* Valuing and supporting change

The paradigm case for this theme changed the way one nurse viewed the coaching aspect of her role. It crystallised for her the difference that expert coaching can make to the present and future life of a family. The family at the centre of this narrative comprises four children and their parents, with the nurse making an initial home visit to discuss the children's chronic ear problems. At this time it became apparent that the family was facing many issues and although the parents were eager to find some solutions, they lacked the resources to know where to start. Excerpts from the paradigm will be integrated throughout the chapter, with other exemplars used to reinforce particular aspects.

Coaching in harmony

The public health nurses in this study recognised that a large part of their work was to support and strengthen family roles, not to take over and do for. This emerged strongly within the coaching theme. The underlying premises were acceptance of the values of an individual, family, school or community, and acknowledgement of differences without judging one perspective as superior to

another. This world–view provided a distinctive framework for the coaching undertaken. There was valuing of client choice and ownership and a focus on needs as perceived by the client. These public health nurses were aware that they must tread with caution, and that coaching should suggest, not direct, if changes in life patterns are to be initiated and maintained.

Exemplar: I have a family I'm working with at the moment who have a number of issues going on, and one of them is that the children have got nits. When I talked to Mum about this I didn't go in saying, this is the problem and you have to use this shampoo, and do this, this and this. You have to tread with caution and put things in such a way so that it's a suggestion and not an order. So I said that I knew of a very good shampoo that might be of benefit and I actually had some bottles of it if she chose to use it. This family is pretty hard up and it's difficult to find an extra few dollars for special shampoo. So she took the shampoo and it's up to her if they use it or not. And I also talked about treating everyone, washing the towels and bed linen, that kind of thing, but I can't make that happen. What I can do is gently follow up on things like how she's found using the shampoo, whether its worked, and continue discussing general hygiene.

The nurse in this exemplar did not presume the mother would accept the suggestions made. She was careful to speak in terms that were clear and understandable to the client, to set realistic and workable goals, and to be available to the mother for ongoing coaching. Health education in its broadest sense was a part of many of the conversations that the public health nurses engaged in with their clients, and the focus on well–being was evident. To illustrate this perspective, the nurse in the above exemplar used appropriate moments during interactions with the mother to discuss general family hygiene, diet, and environmental cleanliness. As one of the participants noted, " you have to strike while the iron is hot and the client is in a receptive frame of mind because you never know when a similar moment will come again".

There is a definite skill involved in being able to support family roles. This is highlighted in the following exemplar where the nurse is describing a telephone conversation with a woman she has known for a number of years.

Exemplar: The ten year old in this family was onto her sixth streptococcal (strep) throat infection and I wanted to talk to May about what we should be doing, but she works such long hours that it was really difficult to find a

time. So I gave her my home phone number and she called me latish one night and we ended up talking for over an hour. And it was great, a very quiet, peaceful time. And we came up with this really good plan for following up the rest of the family for strep infections ... She asked some very perceptive questions about the strep bug and I was able to talk about what happens if it doesn't get treated, and she connected that up with other family members who had had heart problems, and that got us on to other parts of the body. And by the time we had finished we had covered sores, nits, diet, hygiene, safety, the works. So although the initial aim was fairly simple, because she was interested and ready to hear, we ended up doing this huge ring around the family and about a lot of issues. And it was all led by her.

The nurse tailored her approach to the situation, allowing herself to be led by the needs of the mother, and possessing a broad knowledge base that ensured she was able to provide accurate information on a wide range of issues. Her flexible approach assisted this nurse to take full advantage of the coaching opportunity as it presented itself. This is differentiated from, but closely allied to, the relationship building skills described in the previous chapter, coaching having a more clearly defined purpose. This nurse spoke of the great hope she felt for this family and her admiration for a mother who worked long hours and experienced hardship, but who still found the energy to come on board with health issues when the time was right for her. This attitude of respect and understanding was evident in many of the narratives as the nurses supported, encouraged and in some instances expanded, family roles.

It is not always possible for public health nurses to pre-plan their coaching. It was therefore essential that they possessed knowledge, a positive attitude and flexibility to adjust work-load according to the needs of the situation, if they were to coach successfully in harmony with their clients. The public health nurses in this study recognised that clients must be ready to move forward before they can in fact move forward, a fine judgment call being required to ascertain readiness to learn. Capturing the moment is central to supporting family roles as it facilitates a moving forward together towards goals identified by the client. There was an overt acknowledgement that working with clients in a meaningful way means the focus must be on what is viewed as important by the client, the nurse then adapting her coaching to take into account where the client is at.

Paradigm: What really struck me while I was talking to the parents was that I had come upon them at a time when they were seeking answers and solutions,

but they didn't know where to start or what to do. And the feeling started when they said they were glad I had come to talk about the kids' ears because no-one had ever explained things to them before, which may or may not have been true, but that was their perception. ... And as the conversation proceeded, it became apparent they were just on the verge of understanding that there were things they could do for themselves and of realising that the situation they were in wasn't very good.

Although in this situation the desire to move forward was quite overt, during the telling of this narrative the nurse remarked that she was aware of the future possibilities for this family if she was prepared to take advantage of the situation. This reflected a dual responsibility in the coaching process, where clients might identify perceived needs and the nurse then works with the client to address these needs. The nurse in the paradigm case realised that changes would not occur overnight, and she used a contracting process to make sure that issues were addressed in a systematic manner, that goals were clear, and that roles and responsibilities were well defined. Contracting with clients was used by many of the public health nurses as a mechanism for prioritising need and ensuring that coaching strategies were based upon what was possible, manageable and acceptable to the client. It was also a way to identify and validate the strengths within a family and of giving a message that the nurse and client work together, rather than the nurse giving instructions or telling the client what must happen.

Paradigm: After the first session about the ears we sat down together and they listed all the issues they thought they should attend to, and for them it was predominantly the physical things, the ears, the skin problems, the head lice that they couldn't seem to get on top of, and they also identified nutrition as a big deal. And then I helped them sort out a priority list and we worked together by breaking each problem into smaller parts. For example, with the skin problems I talked about reasons that these occur, bringing hygiene and diet into that, and they were able to work out what to do. So often, once you give the information in a way they can understand, families can then do something to help themselves, and that's what happened here essentially.

The nurse in this situation followed the client's lead, and she was cognisant of the wider picture, realising how small steps could have future impact on this family in terms of their ability to self care, to cope, to problem solve, and to take responsibility for where they were heading. In supporting family roles she moved along the path selected by the parents and built on previous success as more

potentially difficult issues were addressed over time. For example, she noted that discussions around problem solving strategies occurred further into the relationship when trust had been developed, and when visible differences were achieved with physical issues such as the skin problems. Many of the nurses in this study supported this approach, describing how the strategy of dealing with the simple issues first lays a solid foundation for future coaching around more complex aspects. This was also related to an understanding that the nurse's perception of a priority issue will not always coincide with the client's, and she must accept this.

When asked how they dealt with situations where the client's priority may be vastly different from their own, a common response from the public health nurses was that this seldom emerged as an issue. Once the choice was made, that was the reality with which the nurses then worked. This perspective encompassed a view that the nurse's role is to facilitate not control, to coach not lecture, and to work with not impose. One nurse described a situation where she needed to work with a mother to develop strategies around dealing with her son's chronic ear problems. However, the mother's priority was that her child had no shoes for winter and the nurse needed to address that first, recognising that coaching needs an environment of openness and honesty that is difficult to achieve if goals are not shared.

The coaching undertaken by the public health nurses should not be interpreted as a passive role. As was highlighted in the previous chapter, the skills demonstrated by these nurses as they built relationships and developed a climate of trust and acceptance with clients, means that they can often initiate coaching based upon their assessment of the situation. However, the underlying assumption of the need for client involvement in the process remains constant. In these instances the nurses conveyed a message that although they recognised and accepted the client's right to think in a certain way, they knew a way that was perhaps better and safer, and that they would like to share this with their client. Specific approaches used by these nurses included remaining focused on the issue at hand, involving other family members when necessary, using appropriate language, and presenting information in small segments to prevent information overload. In the following exemplar the nurse assesses a need for coaching, but she is careful to tailor her approach to support the mother's role rather than taking a stance which blames or accentuates deficits.

Exemplar: The mother in this family is very loving and caring, but she really has no idea about what children at various ages are capable of. For example, she expected the four year old to be able to keep the other children off the

road while they were all playing outside. So she was aware of road safety and loved her children, but her expectations were quite unrealistic. So I've been talking to her about how children think and behave at various stages and ages. And we've just been doing that in small chunks when I do a home visit. And she's really starting to connect up her mothering with what children can in fact take on board and she asks lots of questions, she's quite interested in it all now. So sharing that information has been very positive for the whole family. I was very aware however of not demeaning her abilities but of finding ways to build on them together.

Coaching in harmony was also revealed in the more formal planned health promotion undertaken by these nurses. Many of the participants described how they were often able to draw on the knowledge used in planned education sessions during incidental exchanges with their clients. A variety of teaching skills were revealed in the narratives, including the facilitation of debating forums, role playing, using age and culturally appropriate teaching aides, involving peers, and practical experiences, to name a few.

Exemplar: I had a really magical experience the other day when I was doing a pre-puberty talk in a bi-cultural school. The teacher and the kids had decided they wanted me to do the talk, and what we set up was that I spoke in English, and Dee sat with me, and every so often she would say something quietly to the girls in (language) and it was just amazing how it all fitted together. I came away feeling that it was a real privilege, and it was. You can't work out here without having an understanding of cultural issues and that has really changed me in a spiritual kind of way that is as wide as wide. ... And the great thing was that afterwards one of the mother's phoned to thank me for giving the talk as it had helped her get started on the subject, and one of the girls wrote me a note saying IT had happened and it was all okay.

The nurse worked within the presenting circumstances with seeming ease. She was flexible and willing to learn from the experience, evidenced in her openness to use what was for her, a new teaching approach.

As the public health nurses coached in harmony and supported family roles, they demonstrated an ability to assist clients to re-frame situations, or to view situations from an alternative perspective. Situations can often seem overwhelming when one is intimately involved and it can be difficult to ascertain needs from a

position of distress. At such times the coaching role includes supporting the person to attain a position which gives them choices.

Exemplar: There's a little chap I dealt with last year who's got true Attention Deficit Disorder, he's on the go mentally all the time, you know, go, go, go, his brain just fires off, he can't stop to focus and he doesn't get on well with his peers. ... The school asked me to have a chat one day because he had turned up at school really subdued, quite out of character, and the up-shot was that there were problems at home between his father and step-mother. I did a home visit and spoke to the step-mother (Mary) and basically she was at the end of her tether. She was the main care-giver for the young boy and knew there were problems but the father wouldn't admit there was anything wrong at all. So firstly I was able to validate for her that there did appear to be something amiss, she needed to hear that, and then we talked through strategies she could use to open up dialogue with the father. So it was a matter of giving information, putting that into context, and then working together on some practical problem solving strategies.

The nurse was able to re-frame the situation for Mary who was starting to doubt her own abilities and judgment. In addition to providing knowledge about the child's condition, the nurse presented possible treatment options and coached Mary as she developed skills in problem solving and potential conflict management. The nurse was able to facilitate reflection and understanding that enabled Mary to re-frame the situation so she felt less of a victim and had the confidence to begin dialogue with her partner. As demonstrated in this exemplar and in the paradigm case, sharing accurate and appropriate information with clients can be a very powerful tool as it can enhance thoughtful decision making, and encourage within clients a sense of greater control over this aspect of their lives.

Focusing on the everyday

As the public health nurses moved to the client's rhythm, their focus was on everyday activities and problems encountered in daily living. Much of the content addressed within their coaching sessions related to survival skills - hygiene, diet, maintaining health, organising family life and planning the day. There was an awareness that some families lack not only certain knowledge and skills, but often, their lives have no routine, their children have no boundaries, and their ability to cope and manage is minimal. The participants in this study demonstrated an ability

to present information in and on the client's terms. They did not presume to know a client's level of existing knowledge, and they used a common sense approach that had meaning in people's lives.

The notion of making it real and applicable for clients was not some espoused rhetoric but part of these nurses way of being with clients. For example, one nurse commented that she will often recommend salt and water to treat skin sores rather than an antiseptic lotion, her rationale being that treatment is more likely to occur if she recommends easily accessible, low cost products. Similarly, another nurse described how dietary advice must be culturally and economically relevant. If not, the coaching undertaken may be viewed by clients as demeaning or unrelated to their existence, and they will simply step away from the encounter. Much of the coaching focused on survival skills and health promotion, and these nurses were aware that it is not easy for clients to make changes in areas of their life that are often taken for granted, and are a part of one's identity as a person. The communication skills described in the previous chapter are fundamental to the coaching role. Sensitivity, respect, working at the client's pace, checking that understanding has occurred, and constantly reinforcing the message, were recurring themes within the narratives.

> *Paradigm: It was really basic stuff in many ways, but you can never assume that what may be the norm for you is the same for the people you're working with. Take hand washing as an example. In this family, there was no hand washing in regards to food preparation or toiletting, but they hadn't tied that up with the infections the children were constantly getting. And the bathroom was very dirty and unhygienic, the towels only got washed about once a month, and it was a bit of a vicious cycle for them. So we developed a plan where the mother would wash the towels each week, and then we worked from there when she had that on board. I was always very careful not to dish out the orders, but we would talk around the issues and they would usually come up with ideas for improving things, and that seemed to work well.*

> *Exemplar: I had a mother come and see me at the ear clinic and she was saying how her son always had a runny nose and how sometimes he could hear and sometimes he couldn't, and she was finding this all very distressing. And I knew there was a lot of smoking in the house so I said to her, just imagine how all that smoke is irritating his nose just like your eyes get irritated with it, and then that affects the little tubes to his ears. And suddenly, it all made sense to her. She could see the links between the*

pictures of smoking, the runny nose and the ear problems. And when I saw her down town not long afterwards she said smoking was banned from the house and she was pleased she could do something to help her son. And it really struck me how important it is to give messages in terms that make sense, that they can see and relate to. Building pictures is often the key rather than using lots of words.

As highlighted in the above excerpts, focusing on the everyday also involved opening up new ways of thinking or viewing the world for their clients. In other narratives the nurses described modelling life skills by going shopping with women, devising joint plans to help the available food last the week, and presenting options around setting limits for children's behaviour. There was no visible hierarchy in the coaching undertaken by the public health nurses. The clients concerns became the nurses concerns, and they could and did deal with a broad spectrum of issues, from making lunches, to supporting and educating clients through major health events. A frequently made comment was that the approach must be acceptable to the client and that there is very little to be gained by stating the obvious. As one nurse remarked:

There is no point in telling a mother that her children are at school without lunch, she knows that. And you must not be seen as the heavy but as a resource she can tap into and work with. She doesn't need a lecture about being organised, but may benefit from some good practical suggestions around how to stop the kids eating all the food in a couple of days.

The focus is on the client's world and what makes sense to the people within that world. Focusing on the everyday also emerged within the more formal teaching undertaken, as illustrated in the following exemplar.

Exemplar: I vividly remember a talk on puberty I did with a class of young adolescent boys not so long ago. You never know what will happen in these classes, how the kids will react ... Anyhow, we got to the point where I was showing them what tampons look like, how they absorb water, and they were quite fascinated really, they're so intrigued with how things work at that age. And when I passed around some sanitary pads, one bright spark realised they were stick on's and he proceeded to slap these things on his forehead, his arms, and so forth, and of course, that set everyone off. But some really good discussion was generated and it all seemed so natural and ordinary, and that was good for everyone. So you do need to go with the flow in these situations, but you also need to balance your approach so that the message does in fact get across.

The nurse in this exemplar was flexible in her approach and used the humour that was generated in a positive way to reinforce the message she was conveying about understanding this everyday aspect of life. It is critical nonetheless, and forms a part of what life is all about.

Valuing and supporting change

The coaching undertaken by the public health nurses in this study was purposeful and had a focus that looked beyond the here and now into the future. This encompasses the idea that if changes do occur in a client's behaviour, skill, attitude or knowledge level, the nurse needs to recognise, to value and to support these changes. Coaching is not a discrete entity, a task to be completed, but is part of a continuum that includes goal setting, information sharing, support, encouragement and reinforcement of both the message and the clients progress. These nurses identified 'being there' for the client as a key supportive strategy. This does not imply a situation where the nurse props a client up. Rather, it enables the nurse to reinforce progress made, to be able to say "well done" to clients who often receive very little positive reinforcement in their lives. The aim is to foster self-care within the parameters set by the client. It was also recognised that both client and nurse have a joint responsibility to achieve negotiated outcomes.

> *Paradigm: I think one of the most important things I had to offer that family was that I was someone who could see what was happening, what they were achieving largely through their own efforts. I could say well done and they knew I meant it, that I had been with them over time. And that helped keep up the momentum, it fed their improvement and helped to keep them focussed. Even though they wanted to make the changes, we're talking about a way of life here, and it's not easy. I also made sure I left them with good, clear, useful written information to reinforce and support the coaching.*

This supportive role appeared to be particularly important for the women who often featured as central figures in the narratives of the public health nurses who participated in this study. Many of these women were in abusive relationships, they often lacked support and they existed in generally poor social circumstances. For these women, initiating and maintaining even a small change was hugely significant as it often assisted them to break the cycle of poor self esteem and hopelessness that they were experiencing.

Exemplar: I've just started working with a family where the mother has reached a really low ebb – she's having relationship problems, her kids have all these health issues, there's no routine in anyone's life, money is tight, and she's been coping by leaving the kids to it basically. So we started off by talking about getting some routine into their family life in order to help get things back onto some kind of even keel. And we set a couple of small goals, that she would get up with the kids and give them a good breakfast for the day. And we talked about nutrition and made a list of what she could prepare for breakfast and what she needed to buy from the shop. So she tried that for a week and when I did the next visit she had managed quite well and was feeling very proud of herself, and she had even made another goal for the next week. So my role is both to coach her on issues, and then provide that support and validation of her achievements. We've got a long way to go, that's for sure, but she's heading in the right direction.

The public health nurses were aware that change is a slow process. This is particularly so when dealing with core life issues in situations where relationships may be destructive, resources are stretched and community attitudes are not always supportive. In the paradigm case for example, the nurse spoke of the optimism, hope and pride she felt for this family. She did comment however that it was not always easy for the wider community to see beyond the outward manifestations of poverty to the heart of a family who may be struggling, but who are also determined to change some of their present circumstances. In these situations the nurse's role of supporting and valuing the changes that are occurring is pivotal. Her support can assist a family to maintain and to continue to make, some positive difference to their life, despite seemingly overwhelming problems.

There was recognition that change is relative to a particular situation, that progress is not always visible, and that what may seem simple on the surface can in fact be a significant step for this client. Supporting change was about taking one step at a time and recognising, as one nurse rather ruefully acknowledged, that although every ten steps forward may indeed be followed by eight steps backwards, that is at least two steps in the right direction!

Paradigm: As I said, nothing changes overnight and it didn't for this family. I know for example that the kids have got head lice again, and the older child has runny ears again, but the difference is that this time the parents knew what to do and they did it. I mean, I didn't have to do a home visit about the ears, they brought her into the clinic, and they had already started the dry

mopping and so we got those ears cleared up in a week. So they were getting on top of things much more quickly and more effectively, which was a huge change for this family to make, even though it may seem so basic to other people. They were really dealing with preventing that cycle from taking over again.

The nurse recognises the changes this family has made and places these within a particular context. Knowing the family over time and being there to support the changes assisted the nurse to ascertain what was or wasn't working, to visualise future possibilities, and to gradually decrease her input as the family came to incorporate new knowledge and skills into their life. The contracting process was a practical supportive strategy that included clear goal setting, evaluation of progress, and recognition of achievements made. A circular pattern was also identifiable in the coaching undertaken. The public health nurses constantly checked with their clients that understanding had occurred, they used written material wisely, they rephrased information to clarify points made, and they reinforced their coaching during both incidental and planned encounters with clients.

The participants in this study were also aware that change does not necessarily imply an either or scenario. The nurse who introduced alternative treatment approaches to the family as they continued their traditional coin rubbing to ward off colds, provides one example of the ability to work across two different worlds. This awareness and acceptance of the many dimensions that make up the world of another was ingrained in the practice of these nurses, a central part of the complete whole.

Exemplar: There was a young (cultural group) teenager who was extremely overweight, and he came to see me because he wanted to lose weight. All these people had been telling him about different diets and exercise programmes, and he had become very confused and didn't know who to listen to. And as we talked around the issues it emerged that he was sick of being teased at school, but he also didn't want to miss out on all the big feasts that were important culturally. So we worked out a few strategies together that basically helped balance things out for him. ... And as I worked with Tim, his parents, who had many medical problems, came on board as well, and the eventual outcome was that they all lost weight and felt a lot healthier. And what was so great was that they had made the changes themselves. I had been there for them, but ultimately it was up to them and they felt very happy and positive about the changes.

Within this situation the nurse worked through the potential barriers of age and culture with sensitivity. She came to understand what was important for Tim and integrated this into the coaching undertaken. She used her knowledge wisely, and worked at a pace dictated by the client as together they developed ideas and strategies that were congruent with his view of the world. This exemplar also illustrates how the coaching role often impacts widely. In this situation it facilitated health related changes in Tim's parents, who came to understand and support their son's goals, and it also had a positive impact on Tim's relationships with his peers.

The points discussed within this sub-theme also have relevance within the formal teaching undertaken. This often provided the impetus for ongoing coaching and support to occur. One of the participants commented that you never know when your words will make a difference, and that it is important for public health nurses to be available and visible within the community to follow up on issues. For example, following a series of pre-puberty talks in a school, a group of young girls approached the nurse to facilitate group discussions in order to expand and clarify issues raised in the formal sessions. The nurse also provided additional support and advice to one youngster and her mother as they worked through the multiple issues they were facing about understanding and coping with puberty. Coaching was not limited by time or place, and it extended beyond the classroom walls into the community.

Discussion

Following the format of the previous chapters, this section will relate the findings that have been discussed within this theme of 'moving to the client's rhythm' in relation to some of the findings from Benner's research programme. The teaching-coaching function was an identified domain in Benner's original research, Benner noting that "expert nurses not only offer information, they offer ways of being, ways of coping, and even new possibilities for the patient" (Benner, 1984, p.78). Many of the findings from the present research were similar to the competencies described within this domain.

Benner (1984) described a key aspect of effective patient teaching as the ability to capture a patient's readiness to learn, this sense of timing being a central feature as the public health nurses in my study moved to the client's rhythm. For example, the nurse who had the coaching session over the telephone could have closed the dialogue after arranging follow-up care for the streptococcal throat infections.

However, her recognition that the mother was ready and willing to address a range of issues enabled her to follow the client's lead. She realised that such opportunities must not be overlooked simply because the situation did not reflect routine practice. Familiarity with the client assisted the nurse to judge that time, place and readiness had indeed coalesced into this moment of readiness, while being available for the client made the interaction possible. Flexibility and responsiveness to unanticipated work-load demands were essential as the public health nurses coached in harmony with their clients.

As the nurses in Benner's study elicited and understood the patient's interpretation of their illness, and provided interpretations for the patient, so too did the public health nurses in the present study facilitate and value client choice and ownership. The contracting process was one way in which the nurses gained and valued the client's perspective, with goal setting being based upon the client's interpretation of perceived need. An attitude of respect and acceptance was displayed as the public health nurses re-framed situations to enhance understanding for their clients. As they provided alternative explanations or assisted their clients to view a situation differently, the public health nurses were careful to use appropriate language that was comprehensible, culturally and socially acceptable, and that focused on the practical and the everyday.

Benner related the coaching function to the ability of nurses to open up new ways of coping and being for the patient and their family by making that which is culturally avoided approachable and understandable. The coaching undertaken by the public health nurses in the present study often dealt with assisting families to survive in dire social circumstances. As they opened the door to future possibilities and encouraged a sense of self responsibility and control within their clients, the approach of these nurses favoured the suggestive over the directive, the flexible over the rigid. In the exemplar where the mother had reached a particularly low ebb, the nurse did not attempt to deny the poor social circumstances and multiple demands being faced by this woman. By focusing on small achievable goals she was able to assist the mother to visualise and move towards a more positive future.

An important skill demonstrated by the public health nurses as they 'moved to the client's rhythm' was their ability to support and value changes made over time by their clients. Benner described a similar process within the helping role domain in relation to psychiatric nursing practice. This author noted that in guiding patients through emotional and developmental change the nurse uses many ways to channel patients into ways of being that hold more potential for growth. In the present

study for example, the nurse in the paradigm case worked with the family as previous behaviour patterns were replaced with alternative life skills. These were gradually integrated into their way of being and coping as a family. One measure of success in this situation was the way in which the family assumed increased responsibility for their well-being within the physical and emotional resources that were available to them.

Benner and Wrubel (1989) note that a feature of expert coaching is that the nurse presents information with regard to the patients goals and is not an aloof health care professional who stands outside the patients community and realm of possibility. This emerged clearly in the present study. As the public health nurses coached in harmony and focused on the everyday, client choice and involvement were paramount. Benner and Wrubel also reinforce the skill required to expand the patient's world to include future possibility. The public health nurses in this study were aware that clients can and do break out of the cycle of despair and hopelessness, and that small changes are valuable and often extremely significant. This perspective led them to convey realistic possibilities and options for the future, and to provide timely and appropriate support to their clients.

Benner (1984) highlighted that the competencies described within the teaching-coaching domain were only a fraction of the competencies making up this unique nursing function. Additional competencies identified in the present study included a focus on the everyday and the way formal teaching sessions often provide an impetus or springboard for future coaching. These aspects reflect a community orientation where coaching occurs in a context of people living out their daily existence.

Summary

This theme of 'moving to the client's rhythm' has revealed the skilful coaching that is part of the phenomenon of expert public health nursing practice. The nurse in the paradigm case coached in harmony with the family through supporting and strengthening family roles, and recognising the parent's readiness to learn and to move forward. She focused on everyday life skills and activities, and used her broad knowledge base to assist the family to make life changes that were significant for them. The process continued as she supported and valued the changes they were making, and she was present to reinforce positive achievements and encourage family responsibility for health outcomes. The findings described within this theme

supported many of the competencies that emerged in Benner's earlier work. Additional competencies were also revealed that will expand the nursing knowledge base about the skilful coaching that is embedded within expert nursing practice. As was demonstrated in the exemplars and the paradigm case, wherever and however the coaching role manifested itself, it was like a stone thrown into a pond - the ripples spread from a central core but the ultimate destination is not always known.

CHAPTER SEVEN

Coping with the Dark Side

It's okay to feel shattered or even personally hurt by what you see and hear, but you must be able to move through and beyond that and not get stuck with those feelings. If you can't cope with the lows, you end up being no good for anyone, yourself included.

As the public health nurses in this study used their finely tuned recognition and assessment skills, built and sustained relationships over time and skilfully coached their clients, they also demonstrated an ability to cope with what I have termed the dark side of life. As has been highlighted in the previous chapters, the practice world of these nurses is the community where the often stark reality of life is not cushioned by the protective walls of an institution. Much of their work is with families who are struggling to survive physically, emotionally and socially, they often become involved in intimate scenes of despair, violence, and abuse, and it is not always easy to see a positive outcome for their work. Throughout the narratives, the ability to cope emerged as integral to expert nursing practice, enabling the nurses to both respond to need and to move on without being submerged in the lives of others. There is often a personal toll associated with the work undertaken, and it became evident that the nurses must be able to work through this and come out the other side physically and emotionally intact.

An important means by which the public health nurses in this study coped was by focusing on the child advocacy function of their work. Keeping the child at the centre of a web of care served not only the needs of the child, but also gave meaning to the clinical world of the nurses participating in this study. Using the term 'web of care' conveys a sense of the intricacies surrounding the work of these nurses. As will be described, advocacy has both a monitoring and action function – the nurses sometimes work behind the scenes, while at other times they are central figures in decision making around child protection issues. Although this role is often played out against a background of wider family circumstances that can be quite tragic, the nurses were able to convey an understanding that did not dilute their focus on the child.

These public health nurses had developed diverse strategies for maintaining physical and emotional safety, a crucial issue when working within a context where turmoil

is often the norm, highly charged interactions can occur, and where interventions may not be welcomed. Although this was an area where work is highly contextualised and individual, common threads were apparent. These included collegial support, a sense of optimism, and having realistic expectations around their role. It is also important to acknowledge that public health nursing work is not solely within the shadows. Seeing and appreciating the rainbows is central to effective coping. Coping with the dark side of life was also facilitated through an ethical stance that provided a framework for decision making and that permeated client/nurse interactions.

Following the same format as the previous chapters, the body of this chapter will elaborate upon and support these introductory comments, the theme being addressed under the following sub-themes:

* Keeping the child at the centre of the web

* Maintaining personal safety

* Walking along an ethical path

Although these sub-themes are closely linked, there is not a single paradigm that captures all aspects, and therefore, in contrast to the previous chapters, paradigms will be specific to the sub-theme being discussed. A selection of other exemplars will be used to elaborate and support particular aspects.

Keeping the child at the centre of the web

Child advocacy emerged strongly as a primary function of the public health nurses in this study. As these nurses dealt with highly complex and difficult cases, they would often re-frame the situation to clarify for themselves and others that advocating for and with children was paramount. They viewed themselves as a voice for those who are unable to speak for, or protect themselves, and this provided the driving force in situations where meaning and purpose are often difficult to define. As one nurse noted:

You hear their misery, they're beaten, on the dole, they haven't any money, or they've been ripped off, and you acknowledge all that. But then you have to turn it around and say that we can work on some of these things together, but ultimately, I'm here for your kids.

Many of the narratives illustrative of this sub-theme were heart wrenching. The paradigm case emerged as an instance where the nurse clearly identified advocacy for the children as the reason for remaining involved in the case, and as clarifying for her the role of a public health nurse. This is a complex situation involving a mother, her defacto partner and their five children. The children were generally filthy, suffering from sores, ear problems and nits, their nutritional state was a concern, and the mother had difficulty in setting behavioural limits for her children and in being present as a mother for them. A family group conference has been called to discuss the situation and the public health nurse has been asked to attend.

Paradigm: We had a family group conference and I was asked to go and speak to the rest of the family about the concerns the school and I had about the children. And then, as happens with these processes, social welfare and I were asked to leave while the family discussed the issues and came to their decision. When we came back the family revealed that there was a history of abuse of the mother in her childhood and that as a family they had the resources to deal with that. Other members of the family offered to pick the children up from school and assist the mother to get some sort of routine into all of their lives. And basically we had to leave it like that, it was the family's decision, and my role was to keep an eye on the children at school while we waited to see if the extra support did make a difference.

This monitoring role is closely associated with the skilled assessments undertaken by these nurses and the technique of moving in and out of clients' lives, that have been described in previous chapters. However, the focus within this theme is on the children. The public health nurse in the paradigm case worked in tandem with the school and social welfare to monitor the physical and emotional health of the children, this role being overt because it was part of the agreement reached at the family conference. In other situations this monitoring role may be more covert and the nurse will 'watch from a distance'. In these circumstances the public health nurse could be described as a watch dog for the children. She guards, protects, and makes her presence felt where appropriate, and she is ready to intervene when necessary. One nurse described an unanticipated outcome of this monitoring role being that it often assisted the nurse to form and sustain relationships with families. The nurse in the paradigm case for example, described how the mother accepted the nurse's presence in the life of the family because the focus was clearly on the welfare of the children, rather than on the inadequacies of the mother.

Careful documentation was central to the effectiveness of the monitoring role as this tracks a family's progress over time and also may be used as evidence in child protection cases. In elaborating upon the importance of clear documentation one of the nurses noted that, if the nurse making a referral is angry or emotional, this is what comes through in the written word, not the facts, which might be child safety or an absolutely desperate family situation. These nurses demonstrated an ongoing human concern which is always present, but does not intrude on the skilful gathering and recording of information. A genuine concern for the welfare of children engendered a watchfulness within these nurses that was balanced with an awareness that one must be careful not to form premature conclusions that could be extremely damaging to a family.

Exemplar: I had a real dilemma to deal with the other day around a story a little girl had written at school which was a bit suggestive in terms of what Mum and Dad were up to at home. By the time I was involved the teacher had taken it upon herself to sit the child down and grill her about what the story meant, asking quite leading questions really. So while I needed to go and see the parents, it was something that couldn't be ignored, I also felt the school had handled it in the wrong way ... When I did the home visit there was quite a simple explanation really and the mother felt really embarrassed, but it certainly showed me how carefully these situations must be handled. It could so easily have gotten right out of control.

The nurse did not avoid dealing with what could have been a serious matter, but neither did she judge a situation prior to ascertaining the facts and assessing the situation carefully. These nurses viewed situations through a human lens not an objective lens. They were ruled by concern, not emotion, and they listened to each client's story carefully to avoid potentially harmful and misguided decision making. They performed a fine balancing act as they dealt with the highs and lows of their work with an attitude of care and sensitivity.

In addition to the monitoring role, there was a very clear action role undertaken by the nurses as they kept the child at the centre of the web. This was not an easy role, encompassing persistence, courage, strength, an awareness of their scope of practice and legislative requirements, fine judgment and skill. Some of the strategies involved in this realm included acting as an intermediary for children, making prompt and unambiguous referrals to other agencies, and ensuring that all possible resources are explored and accessed for the child. Well developed communication skills were essential. At times it was appropriate for the public

health nurse to present reasoned arguments to parents or other agencies, while at other times, a more direct approach was required. Some of the nurses stated that it was sometimes necessary to clearly inform a family that, if they were unwilling to speak to the nurse, social welfare would be called. Balanced judgment supported this decision. Often, immediate action was required, this being demonstrated by the nurse in the paradigm case who spoke out for the rights of the children at a family conference.

> *Paradigm: Things didn't improve greatly for the kids. I mean they weren't being abused, but the situation was really pretty much out of control. They had no routine in their lives, they often didn't know where Mum was or who was looking after them. So I initiated calling another family conference and getting family in from further afield this time. And we had this huge meeting at social welfare to which the Mum didn't turn up. One of the family members said she had been on the booze for months and hadn't turned up because she knew in the back of her mind that she would probably lose the kids. She just didn't know what to do, she couldn't handle it, she was out of control basically. And half the family stood up at this conference and said how they were really supporting her, that things were fine and the children weren't too badly off either. And at one awful stage I thought they were going to leave things as they were. And I stood up at that meeting and let them know in no uncertain terms what these kids had gone through, that they had no routine, no-one to turn to, to care for them, to be responsible for their welfare. And the grandmother who had come from (city) stood up and said she was prepared to take them all and give them a home, and that is what happened.*

This nurse stated that it certainly wasn't easy to stand up in that situation and refute what the family members were saying, but her focus was very clearly on the children and this gave her the courage to advocate on their behalf. Although she was aware of the multiple stressors impacting upon the mother, she did not allow this knowledge to distract her from saying what needed to be said. This situation also demonstrates that the advocacy role does not always lead to a positive outcome for all participants. Nurses realise this in the balancing act that they engage in on a daily basis.

In addition to working on behalf of children, the public health nurses also worked with children in fulfilling their advocacy role. A key strategy was to be visible and accessible for the children both at school and in the community. This encouraged the development of relationships based upon trust and acceptance. Following a

horrific accident one young girl wanted desperately to change schools and she used the nurse as an intermediary with her parents. In another case, when a youngster's mother showed little interest in treating his ear problems the nurse coached an older sibling. Similarly, for the (cultural group) sisters who felt unhappy and out of place at school, the nurse provided support as these young girls worked through the difficulties they encountered in living across two different cultures. The following exemplar demonstrates how the face of advocacy is many sided and spans human emotions and experiences.

> *Exemplar: I had quite a special experience a few months ago with a young boy whose family I had dealt with on and off over the years. He was hanging around outside the clinic and when I asked if he wanted to come in and have a chat, his face lit up. ... After coming to see me a few times he told me he thought he was gay and he just didn't know what to think, who to turn to, whether to feel disgusted with himself or happy, he was so confused and unhappy ... I provided a listening ear and worked with him to access people who were more skilled than I in dealing with all the complex issues around what he called coming out. Initially, he wanted me there at these sessions, which was okay because he felt he needed an advocate, especially in those early days.*

Advocating for and with children provided some clarity of purpose and meaning for the public health nurses in this study. It also assisted them to cope with the dark side.

Maintaining personal safety

The public health nurses demonstrated an awareness of the need to keep themselves physically and emotionally safe. The nature of the work undertaken by these nurses means that there is always the possibility of becoming involved in situations where the threat of physical violence simmers beneath the surface. Integral to the finely tuned assessment skills that have already been described was a constant vigilance around personal safety. Nurses described a process of always being on the alert for potential dangers, of sussing out the environment, and of looking for escape routes. This was very much a balancing act of proceeding with due care, but not being consumed by irrational fears; of acknowledging that although the public health nurse might be held in high regard by a community, this does not guarantee personal safety.

Exemplar: I did a home visit not so long ago where the mother was more than happy for me to come and discuss her daughter's behaviour that was causing quite a bit of concern at school. But when I got there she wanted to talk about it in the lounge where there was a large group of people who had obviously been sitting around drinking for a while, and it took quite a bit of convincing her that we should go somewhere more private. There were a lot of things going through my mind at that time. I mean, it may have ended up as an abuse case and someone in that room might have been involved for all I knew. There was drink and probably dope around and that's always a volatile combination, so I was very aware of my physical safety.

The nurse in this exemplar was consciously on her guard, assessing, reflecting, and questioning. This awareness enabled her to function in a potentially risky situation while maintaining her personal safety. Other strategies used to maintain safety included paired home visits with another nurse, ascertaining where possible who would be present at home when a visit was planned, and ensuring colleagues were aware of the nurse's movements throughout the day. Taking a cautious approach in unknown situations extended to the way in which these nurses responded to referrals. For example, one nurse described receiving a referral from a school about a child who apparently had multiple physical and behavioural issues that needed to be addressed. Her initial interactions with the mother and child focused on the more clearly defined physical aspects, rather than the more potentially complex behavioural issues. The nurse in this situation consciously took a 'softly, softly' approach as she began to establish a foundation on which to build a relationship with this family. This approach was also an important strategy to maintain her safety in circumstances that were relatively unknown.

An ability to think ahead regarding how a situation may develop, and skilful communication, were also essential in maintaining personal safety. The following excerpt was a paradigm for the nurse involved as it taught her an important lesson about personal safety that she was never to forget. Although occurring during her first year as a public health nurse it continues to impact upon her practice.

Paradigm: I had a referral from neighbours who were very concerned about the safety of this little girl who was roaming the streets late at night, sitting on the curb, dressed in nothing but her nightie. ... So I bowled up the path to this house, knocked on the door, and when this woman answered I introduced myself and said I wanted to speak to the parents of this little girl because there was a concern about her safety. Well, everything broke loose at

that point. It turned out they had just recently moved to the area and there had been some problems requiring social welfare involvement in the past. And then the man came out and smashed a beer bottle at my feet, and I could smell the dope on their breath, so I knew I needed to exit the scene quickly. But I was trying to exit at the same time as trying to make an appointment to come back the next day, and that was really the wrong thing to say because they both ended up yelling at me, threatening me, it was all quite scary ... And I often recall that instance because it taught me so much about not barging in like a bull at a gate, finding out a bit of background information first, moving out of a situation at the first sign of potential violence, and not expecting a warm welcome just because I'm a nurse.

As has been highlighted throughout the themes, the practice of these nurses often occurs in situations that are starkly different from their personal lived world, and maintaining physical safety was paramount. Of equal importance was the nurses' ability to maintain emotional safety in the midst of complex situations where it is often difficult to know if the nurse is in fact making a difference to clients' lives.

Exemplar: I've had four really serious child abuse cases this year where the children have been really beaten, and that's taken a huge toll. With one of the kids we went to the play group at (hospital) and that was amazing, it was therapeutic for both of us. We sat down and played with the dough for about an hour or so, and just chatted, and then we got the calico doll and he drew on it for me. And that's how he feels only sometimes (shows doll), that's him happy sometimes, and that's him sad, that's mostly how he feels, and look at that scream, it gives me the creeps to look at it. But that was good for me because it clarified that I needed to talk to someone for myself, and I did, and it's so important you recognise your own needs and do access some help

Listening to this narrative, the pain of both the child and the nurse emerged. The public health nurses in this study could not help but be touched emotionally by the very real sadness and despair they encounter. Being able to find some meaning to their work and the ability to access appropriate support was essential. Finding meaning in their work was a personal journey for the nurses in this study. It included recognising the small changes that do occur as a result of their interventions, keeping children safe, and being able to visualise long term outcomes for their clients. A sense of optimism for the future was a guiding light for many of the participating public health nurses.

Commonly identified supportive strategies included setting professional and personal boundaries, leaving work behind at the end of the day and the ability to prioritise workload demands. These nurses were realistic about having to work in an environment where resources are limited, and they also accepted that clients lead the care in most instances. It was a matter of balancing demands, keeping things in perspective, knowing when to move in and out, realising that the burden does not rest solely with the nurse, and walking a very fine line. The nurses in this study had worked through the process of separating the ideal from the real. They valued the changes that occurred, but they certainly did not expect miracles. Many of these aspects are revealed in the following paradigm which reinforced for the nurse that, although you can make a difference, you do not have control over events or people's lives. There are situations where carefully nurtured changes can be destroyed in a moment of time. The solo mother and her two young children have had extensive input from social agencies over the years because of multiple issues relating to the mother's ability to care for her children.

> *Paradigm: Things gradually went from bad to worse, the children were being beaten and abused verbally, and I had to get social welfare involved and the children were removed ... A neighbour offered to help this woman, and the change was really significant, she was washing her hair, had clean clothes, was like a different person, and after a while when we could all see the effort she was making, the children were returned. And over the past year things have been going from strength to strength with this family. The mother was managing to do her shopping, she had just found a job, the family was still living with this neighbour and were quite stable, the most settled they had been for a long time. And that really impacted on the kids, their school work improved, they were clean and healthy, were socialising well. I mean it took a lot of effort, but things were looking good. And then last week I got a call from the neighbour to say this woman had taken off with her son, she had met some bloke and they had gone to ground. She's moved out of the area so that's a huge disruption for her son, and I feel really sad, because she's moved away from all her support, and we were getting places.*

This excerpt captures the experience of working with clients over long periods of time and the inevitable disappointment that ensues when the situation deteriorates before the nurse's eyes. The nurse coped to some extent by re-framing the situation to acknowledge that the children had at least had a period of stability, and that the mother had been coached and supported in developing life skills that would hopefully continue to be of benefit to her. This process of looking for the good in

a situation was not a matter of viewing the world through rose tinted glasses. Rather, it provided nurses with a mechanism to overcome disappointment and to keep working in difficult circumstances.

The nurse in the paradigm case identified that her colleagues provided her with much needed support as she dealt with a difficult and complex case, and as she worked through the recent events. The importance of both giving and receiving collegial support was recognised by all the nurses in this study. The former was a definite skill as the nurses heard what their colleagues were saying without becoming embroiled in, or disabled by, the stories. Colleagues often acted as an intermediary with families; they understood and shared the rather black humour that was occasionally used to describe their work; they offered suggestions, validated strategies used, mentored, and shared their collective wisdom. It was recognised that it can take time to learn how to reach out to colleagues, but for safe practice and emotional sanity, it was essential. Case review, where the difference that nurses do make in clients' lives often becomes visible, was also seen as a mechanism of support and satisfaction. Similarly, their formal health promotion role provided an important positive balance to the case management undertaken. Health promotion in schools was variously described as fun, creative and worthwhile. As one of the nurses commented:

The formal teaching helps me get through the rough times ... You get so much positive feedback from the kids, it's a bit like being renewed and invigourated. It helps restore my perspective and sense of worth.

Through maintaining their physical and emotional well-being using a diverse range of strategies, the public health nurses gained strength to cope with the dark side.

Walking along an ethical path

Throughout the narratives the public health nurses demonstrated an ethical stance that was blended in with their day to day behaviour. This provided an ethical lens that impacted upon the finely tuned assessments undertaken, relationships formed and sustained over time, and the coaching role. These nurses demonstrated an ethical maturity, an awareness of the need to ask what is good, what is right for this client in this situation. They were driven by a belief that people have value. In acknowledging that their way was not necessarily the client's, or even the best way, a perspective that is truly client focused became evident. The nurses in this study did not seek to impose their moral voice on the community, and in most instances,

facilitation took precedence over an authoritarian approach. This ethical stance has been revealed in the paradigms and exemplars cited in the preceding themes, and I will refer to these as I discuss how this stance shaped the practice of these nurses and assisted them to cope with the dark side.

The finely tuned assessment skills demonstrated by the public health nurses were based upon the ethical premise that situations are seldom simple and that it is necessary to peel back the layers with care and caution in order to ascertain the full picture. For example, the nurse in the paradigm case for this theme skilfully delved beneath the surface to ensure the physical signs of hyperventilation displayed by the young boy were not viewed in isolation from broader social and emotional considerations. She was careful not to take the situation at face value and was aware that constant vigilance and questioning are pivotal when performing a comprehensive assessment. This conveys the realisation that assessments must be multilevel, broadly based and ongoing. The contextual knowledge she gained provided the background for subsequent decision making and action, and enabled the nurse to provide a clear rationale for her actions. This was also apparent with the nurse who set events in motion that ultimately led to the arrest of the father from the medical centre. Her decision making was based upon an understanding of both the present situation and the circumstances that had led to this moment in time. She stated: "It was terrible, quite ghastly, but it had to happen that way. I knew that was the right thing to do for that little chap".

The theme of watchful journeying encompassed the forming and sustaining of relationships with clients over time, and a common ethical thread was the belief that in most instances the power rests with the client. As the public health nurses waited to be invited into situations, negotiated role boundaries, and balanced their sense of involvement, they reflected an attitude of respect, acceptance, flexibility and optimism. Their acknowledgement that clients lead the care assisted these nurses to find some meaning in situations where success may simply indicate that a situation is not deteriorating. This enabled the nurses to cope through a realisation that responsibility for families who often exist in dire circumstances does not rest entirely with the nurse. As one of the nurses noted when describing a chaotic situation where she felt she made little progress:

(Mum) *just doesn't have the energy or desire to make any longer term goals. So I have to accept that that's how they choose to live, and I get involved as things crop up. And I do make a difference at those times, but it's not over the long term.*

Similarly, skilful coaching was based upon the ethical notion that it is the client who chooses the path to follow. This provided a framework as the nurses supported family roles, accepted client choice, focused on the everyday and fostered self care within a climate of respect. Although the nurse in the paradigm case for this theme acknowledged that smoking cessation could have been an additional objective for the family, she worked with them towards a future of their choosing. She valued the achievements made and did not seek to impose her values and beliefs onto the family. In relation to the advocacy role, a perspective of what is right and good influenced the way these nurses coped with difficult and emotional issues. An attitude of concern, watchfulness and moral courage was evident as they accepted the role of being a voice for those who cannot speak for themselves. Sometimes this ethical stance was a cry from the heart with nurses asking how they could even think of withdrawing from seemingly hopeless situations when to do so would leave children completely vulnerable and at risk.

As became apparent in the narratives and the emergent themes, walking along this ethical path was simultaneously a burden laid upon the public health nurses, and a guiding light. It assisted them to re-frame situations, to accept their personal limitations, to make sense of the senseless, and to cope with the dark side. Although this ethical lens was visible throughout the narratives, the following exemplar captures how it can provide a motivating force, and a guide for the nurse as she works with the human side of people. In this exemplar, a conversation is taking place in the local carpark between the nurse and a young teenage boy who had attended the puberty talks this nurse had given in his primary school days.

Exemplar: He was talking about the video we had shown and how he'd like to see it again, and I thought do you ask the next question or not, so I asked if he had a girl friend and he said yeh and his whole body just relaxed. And he said he wanted information about sex so I gave him this video that talks about what your body looks like. And he's only in his teens, but we had a long talk about contraception and I really encouraged him to think about the relationship he had with this girl, about the legal aspect, and how it wasn't something to be taken lightly. And he came around a couple of weeks later and said they had broken up and that he was glad I had talked about respecting the girl, and that he had really thought about if it was all a wise thing. ... So it's a real dilemma, because if kids are going to have sex in their teens they need protection and information. He had decided I was a safe person to talk to, and if I had turned him away he may never have asked anyone again. So you don't water down your own values, but you have to be

careful not to prejudice your effectiveness by taking too high a moral tone or appearing to be passing judgment.

The nurse was aware of some personal discomfort in this situation and performed an ethical balancing act as she discussed the subject in a sensitive and wise manner. She was careful not to take a high moral tone that may have achieved little, but neither did she merely present the facts, preferring to encourage this young teenager to consider the issues widely and carefully. Her ethical stance helped the nurse to deal with the unexpected and to decide what was right in this particular situation. The public health nurses in this study often found themselves dealing with difficult scenarios where rules provide little guidance and decisions must be based upon ethical sensitivity and a fine judgment call. Decision making certainly did not occur within an ethical void.

Discussion

Following the same format as the previous chapters, this section will discuss the findings described within the theme of 'coping with the dark side' with some of the findings from Benner's research. In Benner's (1984) original research the advocacy role of the nurse was mentioned within the helping role domain, and the domain of monitoring and ensuring the quality of health care practices. Aspects described within these domains included the way nurses work with patients to enhance their ability to control and improve their condition, and the negotiation skills required by nurses as they speak out on behalf of their patients. These aspects can be related to the present research. For example, by working with the young sisters who were struggling to live across two cultures, the nurse assisted them to find some new ways of coping more effectively with the dissonance they were experiencing. In the paradigm case, acting on behalf of the children to ensure that appropriate social, physical and emotional support was available, and speaking for the children at the family conference, demonstrated the many facets involved in taking on the advocacy role.

Benner's description of how nurses will often provide a back-up system to ensure safe care, and the careful detection and documentation that precedes the ability to present a convincing case to physicians, were also evident in the present research. Although providing a back-up system to ensure safe care for children can be considered a rather ambiguous role, it did give some meaning to the monitoring role described in this chapter as part of the advocacy function. Ensuring facts and

not emotions were visible in referrals made, speaking out on behalf of children, and acting as an intermediary when required, highlights that for the public health nurses in this study, their advocacy role was often carefully planned and quite overt. The ability to communicate clearly and convincingly was a key factor in keeping children safe.

In discussing the power of caring, Benner (1984) used the term advocacy power to describe the kind of power that removes obstacles or stands alongside and enables. This was illustrated by the public health nurses as they worked with children and on their behalf. An involved stance that was based upon knowing not only the client but the wider picture, and being there to assume the role, enabled the nurses to use their power wisely and safely for the sake of the children. This power was highly contextual and was based primarily upon a concern for, and commitment to, the well-being of the child.

In their latest work Benner, Tanner and Chesla (1996) describe how involvement and knowing the patient creates the possibility for advocacy, and that having a good clinical grasp is essential to fulfilling this role. In the paradigm case for this sub-theme, the nurse's grasp of the wider picture encouraged her to assume a realistic, contextually based approach. Her confidence in her understanding of the situation set up the possibility for advocacy and for making a balanced case at the family conference. The interconnections that exist between skilled assessment, building relationships over time, and performing the advocacy function with courage, conviction and expertise were also revealed in the present research.

The advocacy function has been a recurring theme in Benner's work, and in my research it emerged strongly as an integral component of the practice of these public health nurses. It was not only part of the essence of their practice, but was a key element in assisting these nurses to cope with the dark side. The pivotal nature of this role may be related to the intimate insights that public health nurses have into chaotic social situations. Too often, they know that they provide the sole protective barrier that helps to ensure the safety of the child. Although this could weigh heavily upon the nurses, they were able to re-frame situations so that the advocacy role became a way to cope. It gave some meaning to their work and helped to make some sense of the dark side.

In considering the sub-theme of maintaining physical and emotional safety in relation to the findings from Benner's research programme, there are some areas of similarity. Within Benner's (1984) discussion of organisational and work-role

competencies, coping strategies were primarily described in terms of meeting multiple patient needs and coping with staff shortages and high turnover. The latter in particular can be considered relatively short-term and work-place focused, while the coping required of the public health nurses in the present study was primarily client focused and continuing. The nature of the social landscape in which their work occurs, and the ongoing demand of meeting multiple client needs, means that coping for these nurses was not delineated in time, but must occur over time. Benner noted that expert nurses recognise the team as an integral part of their own effectiveness, her concept of a therapeutic environment supporting the importance of collegial support. This was identified strongly by the nurses in my study. As the nurses in Benner's study coped with heavy work loads, their rapid assessment skills and ability to prioritise were important factors that also emerged in my study.

Benner and Wrubel (1989) provide an interesting discussion around what they describe as the modern epidemic of burnout. Although the public health nurses in the present study often dealt with situations that, to an outsider, could be considered to be both mind blowing and spirit numbing, their narratives did not convey a sense of extreme disillusionment or alienation. Norbeck (1985, cited by Benner and Wrubel, 1989) found that social support from fellow nurses was the most effective way to reduce distress and burnout because colleagues can provide the insights and perspectives of the insider. Once again, this validates the importance of the collegial support that was identified as a coping strategy in my study. Benner and Wrubel also discuss finding the right level and kind of involvement as a strategy in coping with caregiving. The importance of this was recognised by the public health nurses as they maintained emotional well-being through boundary setting, moving in and out in clients lives and balancing multiple demands. As was described in Chapter Five, these nurses did not view themselves as omnipotent rescuers, but neither did they detach themselves emotionally from situations. Rather, they sought and found a level of involvement that appeared to meet the needs of both the client and the nurse.

As was highlighted by Benner and Wrubel, health care workers are repeatedly exposed to breakdown and tragedy. It is important to acknowledge the pain and the threat in order to come to terms with feelings, and to move on. This was mirrored by the nurses in my study as they described using humour, the support of colleagues and a sense of optimism to find some meaning within the present, to take them into the future with their emotional well-being intact. Being confronted on a daily basis with extreme breakdown in family functioning, witnessing the

effects of poverty and violence, and acknowledging that one person can only accomplish so much can be considered the challenge of caring. Through maintaining their physical and emotional safety the public health nurses demonstrated the courage, conviction and strength to meet this challenge without an untenable personal toll accompanying the process.

The final sub-theme for this chapter discussed how a particular ethical perspective provided a framework for expert public health nursing practice. It permeated nurse/client interactions and assisted these nurses to cope with the dark side. Throughout the narratives, the meanings, feelings and concerns that emerged captured this ethical perspective. Benner, Tanner and Chesla (1996) note that for the practising clinician, ethical and clinical knowledge are inseparable, with ethical principles and notions of the good providing guidance for decision making. These authors use the term ethical comportment to refer to "the embodied, skilled know-how of relating to others in ways that are respectful, responsive, and supportive of their concerns. ... (comportment) encompasses stance, touch, orientation-thoughts and feelings fused with physical presence and action" (Benner, Tanner and Chesla, 1996, p. 233). This definition encapsulates how the ethical stance of the nurses in the present study was not a list of objective criteria that could be clearly articulated, but was more a way of being that encircled, and provided a framework for practice.

Benner, Tanner and Chesla use the term ethical discourse to describe narratives where notions of the good and ethical concerns emerge strongly. The narratives recounted by the nurses in my study could be considered an ethical discourse on expert public health nursing practice within a particular context. They reflected a world view that assisted these nurses to find both purpose for and strength from their work. In elaborating upon the development of ethical expertise, Benner et al. describe emotional attunement, relational ethics and a focus on the strengths of the other as central to expert ethical comportment. Each of these aspects has been highlighted throughout the preceding themes, supporting the statement made by these authors that ethical nursing practice demands the nurse not only act for the right reason but also be in a good or right relationship to the other.

From cumulative research on nursing narratives, Benner, Tanner and Chesla identified two major types of commonly occurring themes: constitutive or sustaining narratives, and narratives of learning. The former type is particularly relevant to the present discussion. The nurse who, through expert timing and skilful coaching, assisted the family to move forward with more highly developed

life skills, and the nurse who supported the mother on her journey towards enhanced self esteem and respect, are but two examples of constitutive narratives. These depicted situations that assisted these nurses to come to some understanding of what it means to be a public health nurse. This understanding was essential to enable the nurses to find meaning in their professional lives and some answers to the question of how, or indeed if, they make a difference. The ethical dimension of expert public health nursing practice requires further study, but within the confines of the present research it provided an orientation or world view that assisted the nurses to cope with the dark side. The way in which this perspective infiltrated their practice supports Benner et al.'s contention that there is a close connection between ethical and clinical expertise.

Summary

'Coping with the dark side' was a central component of the emerging phenomenon of expert public health nursing practice. The exemplars and paradigm cases described in the preceding sub-themes revealed that coping is complex, multifaceted, challenging and essential for safe practice. The clear identification of her role as one of advocacy for the children was important to the nurse in the paradigm case for this sub-theme. This helped her to clarify the purpose and meaning of her continuing involvement in a desperate social situation that could otherwise have proven overwhelming. Maintaining physical and emotional safety required a fine balancing act, integrity, courage and self awareness. These nurses were cognisant of the personal, social and environmental constraints impacting upon their practice, and they had found ways to work safely and effectively within these constraints. The practice world of the participating public health nurses was shown to be circumscribed by an ethical stance that provided guidance, and gave some meaning to their work. Many of the concepts addressed within this theme have been articulated in Benner's research programme. Aspects that seemed to be unique to my research included the vigilance required by the public health nurses as they maintained their personal safety, and the description of advocacy for children as a mechanism to assist these nurses to cope with the dark side of their work.

CHAPTER EIGHT

Discussion

This chapter will provide a summary of the themes which are the outcome of this research that had the aim of describing and understanding expert public health nursing practice. The research findings will be discussed in relation to selected nursing literature, and implications of the findings for nursing practice, education and further research will be explored. Limitations of the research will also be addressed and comments made regarding the value of the study for the researcher.

Summary of the research outcome

In order to describe and understand expert public health nursing practice it has been necessary to break down this complex phenomenon into a number of themes and sub-themes. The various parts making up the whole do not however stand in isolation from each other, being closely interrelated and integrated into nursing practice. Expert public health nursing practice can be considered a tapestry woven from countless threads into an intricate whole that should not be unravelled thread by thread but viewed in its complex entirety.

The identified themes and sub-themes include:

* Delving beneath the surface

    - Recognising that it is seldom simple
    - Seeing the full picture

* Watchful journeying

    - Forming relationships
    - Sustaining relationships over time
    - Closing with care

* Moving to the client's rhythm

  - Coaching in harmony
  - Focusing on the everyday
  - Valuing and supporting change

* Coping with the dark side

  - Keeping the child at the centre of the web
  - Maintaining personal safety
  - Walking along an ethical path

The finely tuned recognition and assessment skills used by the public health nurses as they delved beneath the surface comprised many closely linked and intricate aspects. The recognition that it is seldom simple involved a conscious process of peeling back the layers to reveal the many diverse aspects that make up the client's story. This was a dynamic process which was continuous and based upon an understanding that situations are usually more complex than they appear. By working within a concept of time that encompassed past, present and future, and listening with all their senses, these nurses maintained a watchful vigilance that opened them to understanding the world of the client. The creative use of reflection ensured that the process of sound and reasoned judgment was based upon a stance of continual questioning. Their ability to connect up patterns was a key factor in contextualising the situation and seeing the full picture, while an overarching concern with well-being provided a framework for the nurses' broad assessment.

Watchful journeying meant that the public health nurses walked alongside individuals, families, and schools as they formed, sustained and closed relationships over time. They had to wait to be invited in, a process consistent with their belief that power rested with the client from the outset. Similarly, the process of negotiating boundaries was based on the underlying premise that the nurse's role and interventions must be acceptable to the person(s) within a particular situation. A skilful sense of timing emerged as crucial for ensuring that opportunities to work with clients were not missed, safety not compromised, and outcomes as positive as the situation allowed. The nurses' strategy of moving in and out of clients' lives was closely linked to an understanding that clients lead the care, and was a key element as the nurses balanced their sense of involvement. This measured involvement was very much a conscious process, because the nature of

the work had the potential to submerge the nurses within the chaos and despair of what are often desperate social situations.

The public health nurses in this study possessed an extensive and diverse range of strategies to deal with both the simple and more complex facets of their working life. Their focus was not, however, on tasks to be completed, but on their relationship building skills, including the art of communication, knowing clients over time, monitoring, support and networking. The closure of cases also required skilled clinical judgment because the associated decision making tended to be complex and needed to be addressed with care and expertise. The nurses accepted that there were instances when relationships did not achieve some objective ideal, but they were able to accept and work within these limitations.

The coaching role involved moving to the client's rhythm along the path to enhanced well-being. It was about coaching in harmony, opening doors, learning from clients and having a focus that was both far reaching and broadly based. A fine sense of timing and an attitude of respect and acceptance guided the nurses as they supported family roles and dealt with the everyday issues that are integral to the way an individual finds meaning within their world. Valuing and supporting changes that clients made in their circumstances over time required a sense of optimism and hope that was balanced by an awareness that change is complex and relative to the situation. The more formal aspect of the coaching role also demonstrated this sense of possibility, impacting beyond the encounter into another place and into another time.

Finally, coping with the dark side required skill, knowledge and courage as these public health nurses struggled, at times, to find meaning for their work. As the nurses closely monitored situations, documented progress over time and acted with integrity, they did not lose sight of the child at the centre of the web of care. This advocacy role assisted them to find a purpose for remaining involved in what are often chaotic and depressing scenarios. Maintaining personal physical and emotional safety was central to expert nursing practice, and collegial support was crucial as the nurses worked through a kaleidoscope of feelings to emerge intact on the other side.

An ethical perspective was mirrored in all nurse/client interactions. The notion of imposing on the life of another, of being within their territory and working on their terms meant that the ethical journey was commenced from a starting point of client control that impacted on the nurses' practice. These public health nurses

often dealt with people who were physically, socially and emotionally vulnerable, and a fine sense of balance was essential in deciding when to move in or out, whether to deal with a situation alone or to involve multiple agencies. This overarching ethical umbrella led the nurse to constantly question not only what was happening in a situation, but the more fundamental question of what is good and right.

Throughout the emergence of the themes it became evident that the nurses had a perspective that looked out towards and embraced the community. This was captured in the wide perceptual vision demonstrated by the public health nurses as they focused on well-being in the broadest sense, visualised the big picture, spread the net widely and moved to the client's rhythm. Their world view was client focused and contextually bound, and they had a clear sense of future possibility and movement. A key aspect that shaped their community orientation was the notion of acceptance, both in terms of the nurse being accepted as a social and cultural other, and in the demonstrated, genuine acceptance of a world that is often markedly different from her own. Another common thread was the fine balancing act that these nurses engaged in daily, from decision making around child welfare, to the what, when and how of information sharing, and the degree of involvement that was most appropriate. The practice of these nurses was not based primarily upon rules and regulations. Rather, it was marked by a flexibility that enabled them to remain open to experiences and to use a diverse range of interventional strategies. As one of the participants remarked:
This role is full of opposites ... you're involved in situations, but also apart from them; you teach and you learn; you push and you wait; you're a doer and a listener ... no wonder it's so hard to explain.

Relationship of research outcome and selected nursing literature

In the preceding chapters the findings that emerged in each theme were discussed in relation to Benner's research programme. The following discussion will summarise the main areas of similarity and difference that were identified. The present research supported many of the findings from Benner's work, indicating that key elements of expert nursing practice cross social, cultural and practice boundaries. For example, the concept of intuitive judgment, as described by Benner and Tanner (1989), was a feature of the finely tuned recognition and assessment skills demonstrated by the public health nurses in this study. This was integrated into the broader realm of expert clinical judgment. Benner, Tanner and Chesla

(1996) assert that this includes both conscious deliberate decision making and holistic intuitive responses. Within my study the process of connecting up patterns and constant reflection highlighted that decisions were not based upon whim, while the ability to make intuitive links was essential in situations where it was necessary for the nurse to assess and act simultaneously.

Six of the seven domains of nursing practice that Benner (1984) identified in her original research were apparent in the findings from the present research. The work of the public health nurses was predominantly around skills associated with working with people within relationships rather than the completion of technical tasks. It is therefore not unexpected that the domain of administering and monitoring therapeutic interventions and regimens did not emerge in my study. Although there were similarities in the six domains, the specific competencies within each reflected an orientation that was unique to the present study. This supports Benner's statement that the competencies described in her research were in no way intended as an exhaustive or comprehensive list. For example, within the domain of effective management of rapidly changing situations, Benner focused on physically life threatening crises. In my study the term "social arrest" was used to expand the concept to include a broader focus that included the psychological, the social and the emotional. Similarly within the organisational and work-role domain, coping was described in both studies as an important competency. However, the focus in Benner's work was primarily on workplace demands while the coping required of the public health nurses was predominantly client related and ongoing.

Benner and Wrubel's (1989) work on expert caring adds to the understanding of some of the meanings that emerged in my study. It was in the work of these authors for example that the term 'well-being' was described as a phenomenological definition of health. In the present study a focus on well-being provided the framework for the broad assessment undertaken by the public health nurses. Similarly, Benner and Wrubel's discussion of the importance of eliciting and understanding the client's story, and the role of concern, emerged as central to expert public health nursing practice. These aspects were important as nurses formed and sustained relationships over time. They became attuned to, and prioritised within, particular situations and developed a level of trust with clients that was essential in facilitating and supporting change. In relation to expert coaching, Benner and Wrubel support the inclusion of future possibilities and working within the clients' goals, which were key elements as the public health nurses worked with clients towards enhanced well-being. The collegial support that

was identified in my study as central to coping with the dark side was discussed by Benner and Wrubel in terms of preventing burnout. Finding the right level and kind of involvement was also relevant to the ongoing well-being and safety of the nurses in these studies.

Many of the aspects of expert nursing practice that were elaborated upon in Benner, Tanner and Chesla's (1996) latest work also found resonance in the present research. For example, taking the past, present and future into consideration was a theme within both studies. This was demonstrated in the present study in the way relationships were built upon knowing the client over time. The nurses' coaching role projected future possibilities, and a superb sense of timing permeated all interactions. The narratives of the public health nurses also supported Benner et al.'s assertion that there is no context free 'right' level of involvement. Rather, this required a constant juggling act as the public health nurses moved in and out of clients' lives. The ethical perspective that encircled and provided a framework for the practice of the nurses in my study was captured in Benner et al.'s term of ethical comportment. The findings were also supportive of these authors' contention that ethical and clinical expertise cannot be viewed in isolation from each other, but rather form an integrated whole.

The present research therefore supports the relevance of Benner's research findings beyond the North American acute care setting. This is important in view of the seeming dearth of research that has attempted to validate her research in diverse socio-cultural and practice settings. From a New Zealand perspective, the findings build on the work of Paterson (1989) whose study of the practice world of nurses in an acute setting supported and expanded the domains and competencies as described by Benner (1984). Although Paterson's research did not focus on expert nursing practice, the findings from both studies begin to explicate more clearly the contribution that nurses working in diverse New Zealand practice settings do make to client care.

Although many of the findings from Benner's research programme were supported in the present study, differences were also evident. This suggests that nurses should be cautious about adopting models developed in contexts that are vastly different to the New Zealand nursing scene without careful evaluation of their relevance. It was noticeable that the cultural dimension of practice was not mentioned in Benner's work, and yet in my study it emerged as integral to expert public health nursing practice. This cultural dimension was not an adjunct to the work of these nurses but was embedded in a practice where they were open to

cultural messages but did not attempt to 'be' that cultural other. The concept of well-being was only mentioned in Benner and Wrubel's (1989) work where descriptions of nursing as a caring practice extended beyond the hospital walls. One could hypothesise that an acute care focus tends to engender a more narrowly focused world view, while a community perspective must of necessity be broad.

Other differences could be described in terms of their significance within diverse nursing practice contexts. For example, although many of the competencies within the helping role as described by Benner (1984) were identified in my study, the frequent use of physical touch was not a common strategy. This is in contrast to Benner's findings and could be related to many factors, including socio-cultural norms and a nurse/client relationship that is based upon the premise that clients lead the care in most instances. Similarly, although the advocacy role was described in Benner's research, in the present study this role was strongly identified as pivotal in assisting public health nurses to cope with the dark side of life. Such differences are important to uncover and articulate, as this begins the process of understanding the nuances within the specialties of nursing.

Although the present research did not have the aim of exploring changes that occur during the development of expert nursing practice, this emerged during many of the interviews. In elaborating upon their narratives, the public health nurses often commented that their knowledge and skill base had developed with experience in the field, and that their attitudes and role expectations had also broadened and matured. The public health nurses did not discuss their experience in terms of some static, objective criteria, but as practice that is lived through and from which aspects are taken into the future. This supports Benner's (1984) definition of experience as resulting when preconceived notions are challenged, refined or disconfirmed in actual situations. A strong message from the nurses in my study was that they never stopped learning, through formal education, sharing the wisdom of colleagues, learning from their clients, gaining life experience, being open to situations and acknowledging both personal and professional limitations.

Specific instances of changes occurring in practice were articulated within each of the themes. For example, assessment was described as having developed from a narrow focus on the presenting problem, to encompass the broader complexity of well-being and the ability to assess and act simultaneously. Moving to the client's rhythm had replaced the 'nurse knows best' attitude, and the nurses had developed diverse strategies to balance their sense of involvement with clients. Coping with the dark side was also a developmental process, highlighted in the exemplar from

the previous chapter where the nurse learnt an important lesson about maintaining physical safety as a result of getting it wrong. Within the confines of the aim of the present research, these aspects reflect changes in the four general aspects of performance articulated in the Dreyfus Model of Skill Acquisition and described by Benner, Tanner and Chesla (1992). These include movement from reliance on rules to the use of past experience, a shift from analytic thinking to intuition, a change in perception of situations as comprising equally relevant bits to a complex whole, and passage from detached observer to a position of involvement.

Benner's (1984) description of the relevance of the novice to expert framework to nursing has been supported by other authors. Bostrom and Newton Suter (1992) found that the level of complexity in the patient assignment process was greater among experienced nurses, while Summers (1994) described how the framework can be used to describe research skill development. The nursing clinical career development pathways that have been described by numerous authors (for example, Peach, 1995; Balasco and Black, 1988; Silver, 1986) are based upon the assumption that there is a difference in the beginning and expert levels of nursing practice. My research supports the view that developmental change does occur, and it also clarifies that it is possible to describe some aspects of the phenomenon of expert public health nursing practice. This has the potential to lend some credence and support for the development of clinical career pathways for community nursing, the majority of the available literature having addressed this from an in-patient perspective.

One exception was McMurray's (1992) study that described the difference in practice behaviours and shared meanings between novice and expert community health nurses. This author described the expert as a nurse who, in comparison to the novice, clearly demonstrates superior processes in judging clinical situations. McMurray noted that these processes closely resembled those outlined by Benner and Tanner (1989). As was supported in my study, aspects such as pattern recognition, the ability to prioritise and a sense of timing were relevant. Highly refined communication skills were also identified. These emerged in my study as the public health nurses sustained relationships and skilfully coached their clients. McMurray's work lends support to the contention that expert community health nursing practice has a predominant people rather than task orientation which is reflected in the development of expertise.

Expert nursing practice has been examined by various authors and findings from the present research build on this growing knowledge base. Congruent with my

research, Fenton's (1985) ethnographic study found that some of Benner's (1984) domains were more represented than others and new competencies also emerged. This supports a previous comment that Benner's domains must be contextually validated and extended and not viewed as a ready made, transferrable list. This would limit understanding of the complexity and diversity inherent in nursing practice. Orme and Maggs's (1993) study that examined how expert nurses, midwives and health visitors make decisions, highlighted the importance of flexibility and the recognition that each situation may require a different decision. These aspects were supported in my research where the contextual nature of expert public health nursing practice was a recurring theme, and flexibility was recognised as vital to ensure practice is effective in rapidly changing social situations.

In relation to public health nursing practice, studies have focused on aspects such as nurse/client interactions (Vehvilainen-Julkunen, 1992; Pearson, 1991), and decision making (Lauri et al., 1997), but there is a dearth of research on expert public health nursing practice. The findings from the present research do, however, support aspects articulated in these studies, adding qualitative distinctions that gradually build a composite picture of this area of specialty practice. For example, in both my study and that conducted by Vehvilainen-Julkunen, verbal and nonverbal communication skills were considered essential, with the nurses in both studies being aware that an important nursing role is to support and encourage the client along the journey towards enhanced well-being.

From a New Zealand perspective Pybus's (1993) descriptive study of the work of three public health nurses mirrored the complexity that emerged within my research. There were many areas of similarity in the findings from these studies on public health nursing practice. Examples include the importance of trust in building relationships, of establishing long term goals, of encouraging families in everyday activities, of acknowledging their achievements, and of being available for families. The main emphasis of the work of the nurses in Pybus's study was their interaction with clients rather than the doing of specific tasks. Pybus noted that the complexity of family situations was paralleled in the conceptual framework used by the nurses in her study, which acknowledged the person within a wider social context. This is captured within my research in the concept of well-being that encompassed a client focused, yet broad framework for assessment. Although the aims of the two studies were different, the congruence in findings support the possibility of developing a model of public health nursing practice that encompasses both a unique New Zealand perspective and an understanding of the continuum of practice development within this specialty.

Zerwekh's (1991b) research was the only study found that specifically described expert public health nursing practice, her work culminating in the development of a family caregiving model for public health nursing. There were many areas of similarity in the findings from this author's research and the present study. The findings articulated within the theme of delving beneath the surface supported Zerwekh's (1991c) description of the detecting function of expert public health nurses. The nurses in both studies used all their senses, possessed finely tuned listening skills, recognised patterns and were continually questioning what was occurring. They recognised that situations were seldom simple and used their unique blend of skills to peel back the layers and reveal what was happening. Zerwekh also supported the focus on well-being, noting that the nurse not only pays attention to the patient and family as a whole, but assesses the home and neighbourhood in taking a "wide-angle approach" (Zerwekh, 1991c, p.32).

Many of the aspects described within the theme of watchful journeying were also apparent in Zerwekh's family caregiving model (1991b). The development of trust was identified as a central component in forming relationships, with persistence, validation of family strengths, and the negotiation of boundaries on the client's terms being essential. The process of moving in and out of client's lives, the ability to spread the net widely, skilful communication and a sense of working within and over time were other areas of commonality. Similarly, as the nurses moved to the client's rhythm in fulfilling the coaching role, it was recognised in both studies that looking beyond the present, validating changes, expert timing and flexibility, were integral to expert nursing practice.

Although the nurses in Zerwekh's (1991a) research perceived themselves as making a difference, they also identified the growing hardships that restricted their practice. This was described by the author as 'the nurse preserving sphere', and was discussed in the present research within the theme of coping with the dark side. In both studies the nurses described how recognising the small changes that occur in clients' lives was important in terms of validating their work. The nurses in Zerwekh's study also described increasing levels of concern for their physical and psychosocial well-being, and they used coping strategies similar to those disclosed by the nurses in my study. For example, their identified need to balance their client mix had parallels in my study as the nurses described their health promotion role as an important positive balance to the dark side of their work.

Although many similarities were apparent in the expert public health nursing practice across these diverse social and political contexts, the cultural dimension of

care did not emerge in Zerwekh's work. Once again, this highlights both the care required when generalising research findings to different settings, and a unique New Zealand perspective that is integral to expert practice. Other differences were related to areas of focus and client characteristics. For example, the work of the nurses in Zerwekh's research focused on maternal/child clients. Their teaching role therefore had a strong orientation towards parenting skills, while in my study the more diverse client group encouraged a broader and more flexible approach. Nevertheless, a sense of looking beyond the present, ascertaining readiness to learn and goal setting were shared strategies. In describing saving children as a forceful competency, Zerwekh noted that nurses will often struggle with divided loyalties as they endeavour to stand by both the vulnerable child and the vulnerable parent. This did not emerge as a particular dilemma within my study. The clear and constant focus on the child meant that advocacy for the nurses in my study spanned all interactions, and was not only apparent during times of great peril for children.

In relating the research outcome from the present study to selected research from the nursing literature, the findings have been placed within the wider arena of nursing knowledge development. As has been highlighted, the present research has supported and lent credence to many concepts described by various authors who have addressed the complex phenomena of both expert nursing practice and public health nursing practice. The findings have also expanded upon some ideas, and discovered aspects that have not previously been articulated. As the body of knowledge continues to develop in this manner, implications for nursing practice and education emerge, as do suggestions for research that will add further strands to this complex tapestry that is expert public health nursing practice.

Implications for nursing practice

Through articulating aspects of the phenomenon of expert public health nursing practice, the findings from the present research provide some support for the development of a clinical career pathway for public health nurses. The majority of the literature describes such pathways in relation to acute in-patient settings, but this research indicates the concept of expert nursing practice has relevance in a community nursing context. The present political and social environment in New Zealand indicates an increasing focus on community based health care, while developments occurring within the profession demonstrate a trend towards advanced education that retains a clinical focus. Clinical career pathways for

community based nurses can be viewed as one strategy for supporting these trends, because they provide a framework for the development and recognition of expert nursing practice. As was highlighted in this research however, there are significant differences between a perspective that has a community orientation compared to an institutional focus, and this must be reflected in the nursing competencies developed for the practice setting.

It became obvious that the practice of the nurses in the present study had a predominant focus on relationship building skills rather than specific tasks to complete. This provides a challenge for those attempting to articulate expert public health nursing practice and, as a corollary, to measure the outcomes of that practice. For example, the ability to walk alongside families and to balance a sense of involvement, are not usually described in position descriptions or easily quantified in a clinical audit. These aspects were however integral to the practice of the nurses in this study, indicating that new means of measuring nursing effectiveness are necessary. The themes emerging in this study could form components of a position description for those nurses who demonstrate expert public health nursing practice. Portfolio development that continued to address the themes could then provide a basis for performance review and evaluation. When considering skill mix requirements, the independent nature of public health nursing practice would indicate that proficient and expert levels of practice should predominate. The ability to describe these levels of practice therefore assumes even greater importance.

The narratives shared by the nurses in this study support Benner, Tanner and Chesla's (1996) contention that narratives give access to practice as well as particular experiences, that they reveal everyday knowledge, and that they communicate concerns and meanings. In describing instances when they made a difference, the public health nurses spoke with insight about the ordinary, the struggles and the small victories, and built a picture of a complex and intricate nursing world. Narratives provide one way to articulate nursing practice and they could therefore be integrated into performance appraisal and peer review systems, as well as providing a qualitative measure of client outcome. Through presenting narratives in diverse forums the subtleties of expert practice can be shared, and clinical learning enhanced. The narratives of hope, of caring and courage, and of ethical concerns that have been described in this study, revealed a vibrant tradition of expert public health nursing practice. Sharing such narratives can empower nursing colleagues, and perhaps facilitate understanding in other health professionals about the difference that expert nursing practice can make to client

outcome. It is possible that wider implications also exist in terms of explaining to policy makers why public health nursing is integral to the health agenda.

The findings from this research also have implications for organisational structures and processes. For example, continuity of care was important for the nurses as they built relationships based upon trust and knowing clients over time, and this impacts upon workload assignments. Collegial support was identified as a key factor in assisting the public health nurses to cope with the dark side of their work. Therefore, systems for clinical supervision, peer support groups, and access to individual counselling would be beneficial. Nurses must not be naive about the realities of going into situations which are potentially volatile, and policies to maximise their physical safety are essential. Training in managing challenging behaviours is one mechanism that could help ensure that caring for the vulnerable does not incur an intolerable personal sacrifice. Maintaining a balance between case management and the health promotion role was described as an important factor in helping to preserve the emotional well-being of the nurses in my study. This should be taken into consideration when public health nursing roles are changed to respond to contractual obligations.

Benner (1984) raised questions concerning the increasing trend towards excessive formalisation of nursing in policies and standards, and to this could be added the current focus on evidence-based practice and guideline development. The nature of expert public health nursing practice described in this research revealed that practice is contextual and flexible, that clinical judgment does include intuitive elements, and that pre-planning is not always possible. This indicates a need for caution and careful evaluation of systems before they are implemented across practice settings. A potential for the future is that documentation systems incorporate both quantitative and qualitative dimensions, that computerised charting sits alongside narrative accounts, and that clinical audits ensure that cognisance is taken of clinical judgment and interpretations.

Implications for nursing education

The findings that have emerged in this study have implications for nursing education offered in both clinical practice settings and through tertiary institutions. Benner (1984) described how expert practitioners can benefit from describing practice that illustrates expertise or breakdown, and this can be facilitated by encouraging processes such as reflective journalling, and the inclusion of narratives

in portfolio development. The independent nature of public health nursing practice means that learning through directly observing role models is more limited than in hospital settings. Presenting a picture of what expert public health nursing practice looks like through sharing narratives, therefore, assumes an important role in terms of professional development and learning for the nursing team. Benner (1984) and Orme and Maggs (1993) contend that very few educational programmes are developed to meet the needs of nurses who demonstrate expert nursing practice. One way to facilitate this for public health nursing could be to use the descriptions and understandings of expert practice that have emerged in my study as a basis for in-service education programmes. These would be derived from practice, and possible content could include strategies to cope with the dark side, ethical decision making, and relationship building skills.

The development and support of expert practice can be facilitated through post graduate nursing programmes that integrate practice, theory and research. There is a dearth of postgraduate education available in New Zealand that has a community nursing orientation. Through articulating some of the essence of expert public health nursing practice, the present study could provide background for curriculum development. McMurray (1992) makes the point that educational processes that prepare nurses for expert community health nursing practice must be progressive in terms of recognising the complex nature of the role, with content areas including skilled communication and the study of societal trends. Postgraduate education that maintains a clinical focus should be a collaborative endeavour between educational and practice settings, and build on the knowledge and skills gained during undergraduate study and subsequent clinical experience.

Fenton (1992) supports the potential links between research findings and education. This author used data from a study of the expert practice of clinical nurse specialists as a basis for describing curriculum development at the master's level. The aim was to develop a curriculum that was based on clinical practice and that ensured graduates had a firm clinical and theoretical grasp of the role. The findings from my research not only have implications in terms of educational content, but the teaching/learning strategies would need to take cognisance of a practice that is highly contextual and complex. Evaluative strategies would need to reflect both objective and intuitive responses and capture the nuances embedded in a practice that is relationship rather than task oriented.

Implications for nursing research

In order to extend, clarify, modify or perhaps refute the findings that have emerged in this research, further studies of expert public health nursing practice in a variety of New Zealand community health nursing contexts would be required. Regional variation in terms of rural/urban mix, cultural composition and scope of the position is apparent, and replicating the study in diverse settings would provide multiple perspectives on this phenomenon. In the present environment, where the work of nursing is coming under increasing scrutiny, it becomes important for nurses to clearly articulate what they do indeed have to offer in relation to client outcome. It would also be relevant to conduct research that explored expert practice within diverse community nursing groups. This would indicate if the themes identified in the present research were specific to public health nursing practice or were generic across community nursing. The concept of the development of practice from novice to expert has not been studied extensively from a community nursing perspective. Research that examined the novice to expert framework in relation to community nursing would therefore add to the body of knowledge that has validated and extended this aspect of Benner's work. The relative influences of various experiential and educational factors on the development of expert practice would be a related area of interest.

Each theme that has been described in the present research could also be examined in more depth. For example, observations of formal and informal coaching sessions would be a useful strategy to more fully explore an aspect of practice that was identified as being simultaneously simple and complex. Similarly, the ethical dimension requires further study to capture the complexities inherent within this realm, while further descriptions of how relationships with clients change over time, would deepen understanding of the skills required. If expert public health nursing practice is to be facilitated and supported in practice environments, further exploration of how nurses cope with the dark side of their work is also essential.

As the nurses in the present study shared their narratives, their language was resonant with emotion, understanding, humour, integrity and humanity. It was interesting to discover that many of the phrases used by the nurses in my study were echoed by the nurses in Zerwekh's (1991) work. One example was the use of sensory images such as "feeling uneasy" to describe aspects of the finely tuned assessments undertaken by the nurses in these studies. This raises questions regarding the relationship between language and practice - is the language generic for nursing or is it specific to a particular specialty, and if so, what are the

implications for professional communication? Describing and understanding the meaning of the language used by public health nurses would begin to answer some of these questions.

In order to describe and understand the phenomenon of expert public health nursing practice in greater depth, a range of research methods could be used. Participant observation, group interviews, multiple researchers and written narratives would extend the verbal narrative technique used in this study. Incorporating the client's viewpoint as described by Pybus (1993), and extending the narrative interviews to include the family, would reveal differences and commonalities between nurse/client perceptions. This would add a unique perspective to the nursing body of knowledge. Butterworth and Bishop (1995) used a Delphi approach to obtain consensus on the characteristics of optimum practice, and the findings from the present research could form the basis of a similar strategy to obtain a consensual view on expert public health nursing practice.

Limitations of the study

The small sample size of eight public health nurses working in a particular socio-economic and cultural environment is one limitation of the present study. This limits generalisations that can be made from the findings. As articulated in Chapter Three however, the reader plays an important role in judging the textual evidence and interpretations made by the researcher, against the reader's own knowledge of the subject. The reader is therefore invited to transfer findings that are considered relevant into their own context, and reflect upon them, or even replicate the study in diverse settings. The various strategies that were described in Chapter Three to address issues of rigour should also be recognised as having the intent of ensuring credibility of the research findings while acknowledging limitations. Other limitations relate to only one practice setting being accessed and the use of narrative interviewing as the sole data collection method.

It is also recognised that phenomenology is a complex and multi-faceted methodology, and the full complexity cannot emerge in a study that is limited by time and academic constraints. Nevertheless, the phenomenological perspective enabled the researcher to be continually looking for the essence of the phenomenon being explored, with the process of moving between the whole and parts of the data guiding analysis within the concept of the hermeneutical circle. Being aware of Van Manen's (1990) caution that lived life is always more complex than any

explanation can reveal and that final descriptions are in fact unattainable, also assisted the researcher to work within the study's limitations. As already described, a small study does have the potential to impact upon nursing practice and education, and to stimulate ideas for further research.

Value of the study for the researcher

The personal pre-understandings taken into this study that were articulated in Chapter Three were both confirmed and challenged throughout the research process. As was anticipated, data analysis revealed themes that supported concepts described in Benner's research programme and the writings of other researchers. The identified themes also expanded the existing body of knowledge on expert nursing practice by providing a perspective that was unique to a particular New Zealand community nursing context. Although the participants in this study showed some initial reticence in sharing narratives about making a difference, this appeared to be related to a lack of familiarity with this method rather than an attitude that devalued their contribution. It was gratifying to discover that this group of nurses recognised that if nurses do not describe their practice and the contribution they make to client care, others with minimal knowledge or insight will do this on their behalf, and perhaps get it wrong. Many of the nurses noted that participating in the research gave them an opportunity to articulate a practice that is often difficult to clearly describe, encouraging a reflection that was both personally and professionally beneficial. This supported my perception that narratives are a useful tool for making visible aspects of expert nursing practice that would otherwise remain hidden from those both within and outside the nursing profession.

There was a personal and academic challenge in the development of skills throughout this research process. I have also gained some understanding of an area of specialty nursing practice that has not been a part of my background clinical experience. I was left with an admiration for both the public health nurses who participated in this study and many of the clients for whom they care. Each group demonstrated a commitment to surviving and growing in a complex and unpredictable world.

Conclusion

The aim of this research was to describe and understand expert public health nursing practice and, despite the acknowledged limitations and constraints, a portrait has emerged of a complex and multi-faceted phenomenon. The expert public health nursing practice described in the preceding chapters reflects a tapestry in which seemingly opposite strands are woven into a harmonious whole. As researcher and reader we have shared narratives of complex judgments and simple skills, of broad and focused assessment, of intuitive and planned interventions, of despair and optimism.

The selection of Heideggerian phenomenology as the research methodology offered a valuable way to access and understand the practice world of the research participants. Through identification and description of emergent themes that were supported by paradigms and exemplars, it was possible to highlight some of the aspects making up the essence of a practice that has traditionally been poorly understood. As the political rhetoric looks increasingly towards community-based services as a panacea for the health care system, it becomes imperative that we understand, support and educate nurses to practise in these settings. The research findings from this study, through supporting previous research and extending the nursing knowledge base from a New Zealand perspective, is a beginning step in this direction.

APPENDIX 1

Information Sheet for Research Participants

'EXPERT PRACTICE'

INFORMATION SHEET

My name is Leonie Gallaher. As part of my Master of Arts degree, I plan to conduct a research project which has as its aim the description and understanding of expert public health nursing practice.

My present position as Nursing Service Adviser, Community Health Services, Auckland Healthcare, has focused my attention on the complex specialty of public health nursing.

My interest in the topic of expert nursing practice arose from the work of Patricia Benner, whose landmark book, *From Novice to Expert* (1984), provided a framework for describing the clinical practice world of nurses.

Much of the research on expert nursing practice has been conducted in acute care settings. My proposed study focuses on community nursing within a New Zealand context and the findings therefore have potential to increase the knowledge base surrounding this topic.

You have been identified by your colleagues as a nurse who demonstrates 'expert' public health nursing practice, and I would therefore like to invite you to participate in this research project.

You are under no obligation to consent to participate.

If you consent to participate, your involvement will consist of one or two tape recorded interviews, each interview lasting approximately one hour. These interviews will be conducted at a time and place selected by you.

Prior to coming to the interview/s I will ask you to make brief notes about your recent nursing practice when you felt you made a difference to client outcome or which stood out for you in some other way.

At the interview I will ask you to tell your narrative (story) using everyday language, and including as much detail as you are able to give. The interviews will be fairly unstructured, any questions relating directly to the story told.

If possible, it would be helpful if a decision regarding participation could be made within two weeks of receiving the information sheet. You are however under no obligation to make a decision within this timeframe.

Your rights as a participant in this study are:

° You are under no obligation to answer questions, and may request that the tape recorder be turned off at any time.

° You have the right to withdraw from the study at any time.

° Confidentiality will be maintained by:

   - Tape recorded interviews being transcribed by the researcher.

   - You will have the option of having the audio tapes returned to you, archived, or destroyed on completion of the research.

   - During the research, tapes and transcriptions will be kept in a locked filing cabinet at the researcher's home.

° To ensure anonymity and privacy of research participants interview transcripts will be coded, and no identifying names of participants, institutions, places, or third parties will be used in the final report.

° Information given during the interviews is confidential, and will only be used for the purpose of the research report and any publications or presentations arising from the research.

° All participants will have access, on request, to a summary of the research report.

° Both my supervisor and I will be available to answer any questions you may have about the study at any time during your participation.

   - My thesis supervisor is: Dr Jan Rodgers, Department of Nursing and Midwifery, Massey University, Palmerston North.

   - My contact address/phone (business) is: 2 Owens Road, Epsom, phone: 630-1999.

If you have any queries or concerns regarding your rights as a participant in this research you may contact The Health Advocates Trust, phone: 638-9638.

APPENDIX 2

Consent form for research participants

CONSENT FORM

Title of Project   :   'Expert (Nursing) Practice'

Principal Investigator: Leonie Gallaher (RGON; BA, Nursing)

Name of Participant   :

English	I wish to have an interpreter	Yes	No
Maori	E hiahia ana ahau ki tetahi tangata		
	hei korero Maori ki ahau	Ae	Kao
Samoan	Oute mana'o e iai se fa'amatala upu	Ioe	Leai
Tongan	'Oku fiema'u ha fakatonulea	Io	Ikai
Cook			
Island	Ka inangaro au i tetai tangata uri reo	Ae	Kare
Niuean	Fia manako au ke fakaaoga e tagata		
	fakahokohoko vagahau	E	Nakai

I have heard and understood an explanation of the research project I have been invited to take part in.

I have been given, and I have read, a written explanation of what is asked of me, and I have had an opportunity to ask questions and to have them answered.

I understand that I may withdraw from the project at any time and that, if I do, I will not be affected in any way.

I understand that my consent to take part does not alter my legal rights.

I consent to take part as a participant in this research.

Signed: ....,................. (Participant)   Date: ....

APPENDIX 3

Interview probes

(Adapted from the background questions used in the research conducted by Benner, Tanner, and Chesla, 1996)

INTERVIEW PROBES / QUESTIONS

* Why did you think / do that?

* Can you talk a little more about that?

* What was going through your mind at that time?

* Is that a common occurrence?

* What was your central concern or priority in this situation?

    - what led you to identify this as the priority?
    - did your priorities change during the episode - if so, how?

* What were your major expectations in this situation?

    - did anything take you by surprise in the situation?
    - what were you watching out for?
    - what were you ruling out?

* What helps you in these situations?

    - how have you learnt how to deal with such situations?
    - have you cared for similar clients / been involved in similar situations?
    - did any particular prior cases come to mind when you were working with this client?
    - what were the do's and don'ts that you were concerned about in this situation?
    - do you have some 'self-checks' you routinely use?

* How did you feel at the time / when the situation was all over?

* Do you regard a particular level of involvement as optimal for client care?

APPENDIX 4

Domains and competencies of nursing practice as described in *'From Novice to Expert'* (Benner, 1984)

DOMAIN: THE HELPING ROLE

* The healing relationship: creating a climate for and establishing a commitment to healing
* Providing comfort measures and preserving personhood in the face of pain and extreme breakdown
* Presencing: being with a patient
* Maximising the patient's participation and control in his or her own recovery
* Interpreting kinds of pain and selecting appropriate strategies for pain management and control
* Providing comfort and communication through touch
* Providing emotional and informational support to patients' families
* Guiding a patient through emotional and developmental change: Providing new options, closing off old ones: Channeling, teaching, mediating – acting as a psychological and cultural mediator, using goals therapeutically, working to build and maintain a therapeutic community.

DOMAIN: THE TEACHING-COACHING FUNCTION

* Timing: capturing a patient's readiness to learn
* Assisting patients to integrate the implications of illness and recovery into their lifestyles
* Eliciting and understanding the patient's interpretation of his or her illness
* Providing an interpretation of the patient's condition and giving a rationale for procedures
* The coaching function: making culturally avoided aspects of an illness approachable and understandable

DOMAIN: THE DIAGNOSTIC AND MONITORING FUNCTION

* Detection and documentation of significant changes in a patient's condition
* Providing an early warning signal: anticipating breakdown and deterioration prior to explicit confirming diagnostic signs
* Anticipating problems: future think
* Understanding the particular demands and experiences of an illness: anticipating patient care needs
* Assessing the patient's potential for wellness and for responding to various treatment strategies

DOMAIN: EFFECTIVE MANAGEMENT OF RAPIDLY CHANGING SITUATIONS

* Skilled performance in extreme life-threatening emergencies: rapid grasp of a problem
* Contingency management: rapid matching of demands and resources in emergency situations
* Identifying and managing a patient crisis until physician assistance is available

DOMAIN: ADMINISTERING AND MONITORING THERAPEUTIC INTERVENTIONS AND REGIMENS

* Starting and maintaining intravenous therapy with minimal risks and complications
* Administering medications accurately and safely: monitoring untoward effects, reactions, therapeutic responses, toxicity, and incompatibilities
* Combating the hazards of immobility: preventing and intervening with skin breakdown, ambulating and exercising patients to maximise mobility and rehabilitation, preventing respiratory complications
* Creating a wound management strategy that fosters healing, comfort, and appropriate drainage

DOMAIN: MONITORING AND ENSURING THE QUALITY OF HEALTH CARE
PRACTICES

* Providing a backup system to ensure safe medical and nursing care
* Assessing what can be safely omitted from or added to medical orders
* Getting appropriate and timely responses from physicians

DOMAIN: ORGANIZATIONAL AND WORK-ROLE COMPETENCIES

* Co-ordinating, ordering, and meeting multiple patient needs and requests: setting
priorities
* Building and maintaining a therapeutic team to provide optimum therapy
* Coping with staff shortages and high turnover: contingency planning; anticipating
and preventing periods of extreme work overload within a shift; using and
maintaining team spirit, gaining social support from other nurses; maintaining a
caring attitude toward patients even in absence of close and frequent contact;
maintaining a flexible stance toward patients, technology, and bureaucracy

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