THE MOMENT OF CARING:
A MANUSCRIPT FOR REFLECTION ON CARING MOMENTS
IN NURSING PRACTICE

by

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ABSTRACT

The focus of this study was on understanding the caring nature of the nurse-client relationship as reflected in a story of nursing practice. The story was examined and understood using an interpretive approach which emerged over time and reflected the exploratory and intuitive nature of the work.

The processes of reflection, immersion and crystallisation were used to generate an exploratory theoretical work on caring. The method was called 'The Hermeneutic Wave' because it focused on interpreting and understanding textual reflection of experience, and reflected the ebb and flow nature of the processes of interpretation used. These tidal processes involved moving out of the story to conceptualise what was occurring within the story from a general perspective, and then re-layering the conceptualisations back over the story to examine congruity and differences, and to uncover understanding and meaning of practice. These processes were repeated until 'The Moment of Caring: A Manuscript for Reflection on Caring Moments in Nursing Practice' emerged.

The manuscript consists of four phases; Phase One - Readiness to Co-participate, where the nurse and client fulfil expected health related roles and their relationship is characterised as one of apartness where they are relating in regard to their distinct roles; Phase Two - In Relationship, where the nurse and client are in the process of moving from a relationship characterised by apartness to that of oneness where they relate as person-to-person; Phase Three - 'The Moment of Caring', where the nurse and client transcend relating from a position of apartness and relate as one; and Phase Four - Redefining Wholeness, where the nurse's and client's understanding of their shared experience results in growth in
their beings, and where their relationship moves from oneness to apartness in response to this growth.

The manuscript 'The Moment of Caring' provides nurses with a framework for reflection in as well as on nursing practice, offers an emerging exploratory approach to the development of theory from practice, and contributes to the growing body of knowledge of caring within nursing practice in New Zealand and internationally.
ACKNOWLEDGEMENTS

Thank you to my family for giving me the space and time to be creative and to develop my ideas during a long and difficult journey. My journey has been our journey. Thank you for travelling it with me, for sharing the highs and the lows, for your support, your help, your encouragement and belief that one day it would be finished.

To Cheryle Moss my supervisor, thank you for allowing me the freedom to be creative and for trusting my process even when I wasn't sure of what I was doing or what my next step was. Thank you for caring and for your guidance.

To Frances Dower and Peter Hart, thank you for your help with proof reading. My work has benefited greatly from your expertise, questions and suggestions.

I acknowledge the Microsoft Corporation who own the Windows for Work Groups 3.11 Operating System (1985-1993) containing the Microsoft ClipArt Gallery from which the musical feature used to format the leading space of this thesis has been sourced.

Thank you to Reuters Ltd. for granting me permission to reproduce and use their photograph as part of my thesis (see Illustration 10. A Father's Grief, p. 50 and Appendix Two).

And lastly to Phillip, wherever you are, thank you for our shared experience and for teaching me, and continually showing me, more of what caring means in nursing practice.
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PRELUDE
Early Beginnings - When the Words Don't Fit the Music

My study began with my attempt to find and articulate an area or issue of research interest from my nursing practice. The initial phenomenon of interest emerged from processes of reflection and narrative journal writing in exploring thoughts, feelings and experiences from a specific nursing event. In particular I seemed poignantly obsessed with one story. It was a story about my experience caring for a small boy, Phillip, during a short time when he was having a wound dressing changed. Our encounter was emotionally intense and culminated with both of us crying.

As part of my study at that time I re-examined the story, identified an area of research interest from it, developed a preliminary research question related to my area of interest and indicated a methodology that I intended to use to explore the research question. The research question was 'What is the meaning of crying for nurses who are men, who cry in a caring moment?' and the methodology of choice and necessity was phenomenology, specifically Van Manen's approach (1990) simply because I enjoyed writing and felt I could use his process of phenomenological writing to illuminate meaning of the experience.

As I thought more about the research question my ideas changed and I started to wonder whether crying could be seen as a caring intervention in nursing
based on Watson's (1988) notions of transpersonal caring and the art or act of nursing. I read all that I could find on what nurses had written about crying, including a PhD thesis (Betta, 1993) exploring how adult female patients perceived a nurse and nurse-patient relationship after mutual crying occurred.

I started to have second thoughts regarding the whole issue of crying, of using research approaches within phenomenology, and the various data collection and analysis methods that could be used within these approaches to examine this issue. I felt swamped about which research approach to use and uncertain about the whole research topic. I expressed my frustration in trying to fit question with methodology, and the difficulty I was having with this, to a colleague who suggested, 'Go back to your story. Whatever you are interested in doing is in your story.' So back I went to my story.

This revisitation process subsequently became a common step in the whole study as it progressed. My colleague's suggestion and my uncertainty regarding my research question and methodology forced me to re-look at the issue of crying and examine whether it was what I really wanted to explore. My feeling of being bogged down in regard to research methodology, and the subsequent re-examination of the research issue, showed me that though I viewed crying as a singular expression of something that interested me within my story, it wasn't the focus.

When crying occurred in my story it appeared to be the culmination, or the peak, of a shared experience between nurse and client. It was part of a bigger
picture, the peak not the base, a facet not the focus. Crying was like the froth on top of a cappuccino. I realised that it wasn't crying that I wanted to explore, but rather what was going on underneath the froth, and the real issue of interest which emerged was the nurse-client relationship as expressed in the story.

The Method of Composing - A Synopsis

The creation of 'The Moment of Caring: A Manuscript for Reflection on Caring Moments in Nursing Practice' did not follow a predetermined method or prescription but rather emerged over time. On personal reflection and through retelling the journey of how the manuscript came to exist, the process of its creation clearly emerged. Central to its development was nursing practice which was represented textually as a story, and it was from this story that the manuscript emerged and was further refined.

This process can be best described as following an ebb and flow pattern where my thinking and reflection moved from a location of being 'inside' the story, where I was attempting to make sense and understanding of what was going on in my practice of nursing, to one that was located 'outside' the story, where thinking and reflection were more conceptual and theoretical. This process of interpretation and understanding has congruency with aspects of the hermeneutic circle where in order to interpret and therefore have richer understanding of experience, the person or researcher moves "... back and forth between an overall interpretation and an interpretation of significant parts of experience" (Walters,
Various writers also contend that interpretation is influenced by previous understanding and that this prepares and enables the person for interpretation (Annells, 1996, Koch, 1995, Walters, 1994).

I interpreted my story using the processes of immersion, reflection and crystallisation, where I immersed myself in the story, reflected on what was occurring and the meaning contained in it, and intuitively crystallised my ideas about what was happening in the story from an abstract perspective and articulated this abstraction (Crabtree & Miller, 1992, Polit & Hungler, 1997). I re-immersed myself back in the story using the articulated abstraction to guide further reflection of the practice of caring in nursing contained in the story, and this resulted in deeper understanding of the story. I reflected further on this richer understanding and interpretation, and again intuitively crystallised my thoughts and ideas of what I thought was occurring in the story from a more abstract level and articulated this abstraction. Taking this additional abstraction, I then immersed myself back into the story again to further interpret and uncover further meaning and understanding of the practice of caring in nursing which had occurred within the story.

This interpretive strategy is similar to the to-ing and fro-ing between an overall interpretation of an experience and interpreting the specific parts of an experience which an hermeneutic approach claims (Walters, 1994). I moved in an ebb and flow fashion between interpreting and finding meaning in a specific personal nursing experience or the practice of nursing (the story), to a broader interpretation of what was going on from a more abstract perspective where I
attempted to explain what was happening from a broad or global perspective. I moved back into the experience to gain further understanding and back out again to explore what was occurring from an exploratory and abstract position.

Additionally, my interpretation occurred from various positions of previous understandings of experience, and within the context of understanding my twelve years of nursing practice and what has shaped, formed and directed my interpretation and understanding of it.

I have called my method 'The Hermeneutic Wave'. *Hermeneutic*, in that it is about interpreting and understanding textual reflection of experience i.e. the story, and *Wave*, in that this term more accurately describes my perception of my process of interpretation. My interpretation followed a tidal rhythm where my understanding moved on, through moving into and out of the experience, rather than in a circular fashion as the concept of the hermeneutic circle suggests. This process is outlined in Illustration 1.
The Lyrics of the Methodology

This wave forms the basic framework for the presentation of this thesis with each of the chapters of the thesis corresponding with a position on the wave either located inside or outside the story. Apart from the chapter titled 'Phillip's Story - Allegro moderato con affetto' each following chapter includes comments of my thoughts and decisions regarding the manuscript's development providing methodological location behind each of the subsequent parts of the manuscript. These reflections I call the lyrics of the methodology because they form the methodological story of the manuscript and its development. The lyrics also follow the process of the hermeneutic wave and, although the emphasis of the thesis is the outcome of the process, that is 'The Moment of Caring: A Manuscript for Reflection on Caring Moments in Nursing Practice', the process of the
methodology itself can also be viewed as a methodological manuscript, or counterpoint, providing direction and location from which 'The Moment of Caring' emerged.

This thesis therefore presents a framework for reflection on nursing practice 'The Moment of Caring: A Manuscript for Reflection on Caring Moments in Nursing Practice' based on an emerging exploratory methodology.

The Form of the Thesis - Overview of Chapters

The structural design of the thesis broadly follows the structure of a sonata form of musical composition with the sections named Exposition, Development, Recapitulation, and Coda (Arnold, 1983, Bohle, Sabin, Slonimsky, & Thompson, 1985). With the exception of the first section, each section includes lyrics of the methodology which I have called Bridges. The term Bridge is adopted from the same term used in the sonata form of musical composition meaning 'transitory passage' (Bohle et al., 1985, p. 2103), a moving from one theme or part of a theme to another.
EXPOSITION

The Exposition introduces the theme or subject of the manuscript (Bohle et al., 1985, p. 660) which is the nursing practice on which the manuscript is based. This comprises one chapter called 'Phillip's Story - Allegro moderato con affetto'.

Phillip's Story - Allegro moderato con affetto

This study begins with nursing practice. 'Phillip's Story - Allegro moderato con affetto' is located 'inside' the story within the hermeneutic wave. It presents my nursing experience in textual form in the nature of a story as it was remembered. It provides the foundation from which the theoretical development of the manuscript emerged and re-tells my nursing experience as narrative. Each
of the individuals involved in the experience have a specific voice and personality symbolised by the use of different textual fonts and formats whenever they speak.

This section aims at inviting the reader into my nursing experience, to capture a glimpse of my nursing experience, and sets the scene from which further reflection and development of the manuscript takes place.

**DEVELOPMENT**

The Development which is sometimes referred to as 'Free Fantasia' (Bohle et al., p. 567) elaborates, develops and unfolds the theme of the exposition, thus, "The ideas presented in the exposition are used ... as nuclei for the unfolding of the composer's imagination" (p. 2103). This section comprises three chapters, 'Theoretical Positioning - Adagio', 'Theoretical Beginnings - Andante', and 'Re-layering the Framework onto Phillip's Story - A Self-analysis - Andantino'. 
'Theoretical Positioning - *Adagio*'

Illustration 3. Theoretical Positioning - *Adagio*

*Adagio - Slow and leisurely*

'Theoretical Positioning - *Adagio*' is located 'outside' the story where thinking and reflection were perceived to be more exploratory, conceptual and theoretical. This 'outside' thinking begins with an attempt to position myself theoretically in regard to nursing and includes an exploration of how three nursing theories examine the nurse/client relationship. The first nursing theory chosen was Watson's *Nursing: Human science and human care: A theory of nursing* (1988) because I had used it previously to inform my practice and I perceived there to be general congruity between my views and those of the author. I explored and provided my own interpretation of her view of transpersonal caring because I believed it was relevant to understanding Phillip's Story. In addition, I explored aspects of Paterson and Zderad's *Humanistic nursing* (1976) and Kirby and Slevin's *Commitment to care: A philosophical perspective of nursing* (1992, cited in Arets & Slevin, 1995) because as was the case with Watson (1988), they drew
on Martin Buber's (1958) notions of I-It and I-Thou relating and incorporated them into the nursing context. Furthermore, I perceived similarities of ideas between Kirby and Slevin's 1992 and 1995 works (Arets & Slevin, 1995, Kirby & Slevin, 1995) and Watson's theory of nursing (1988). This chapter concludes with the articulation of a rudimentary framework of what I consider a caring moment in nursing to be, which emerged from my initial reflections on my story, and from ideas drawn from Watson's, Paterson and Zderad's, and Kirby and Slevin's previously stated works.

Theoretical Beginnings - *Andante*

'I theoretical Beginnings - *Andante* is also located 'outside' the story. It provides further development of my views of nursing and summarises my initial attempts at articulating my theoretical view of my world of nursing using, as a
broad framework, definitions and descriptions of the concepts of 'Person' and 'Health', two of the key concepts comprising nursing's metaparadigm (Fawcett, 1984). These definitions provide the foundation from which a rudimentary framework for understanding moments of caring occurring in nursing practice is proposed and developed from my reflections on what I perceived was occurring within Phillip's Story.

Re-layering the Framework onto Phillip's Story - A Self-analysis - Andantino

Illustration 5. Re-layering the Framework onto Phillip's Story - A Self-analysis - Andantino

(Andantino - At a moderate pace but not as slow as andante)

'Re-layering the Framework onto Phillip's Story - A Self-analysis - Andantino' is positioned 'inside' the story. It outlines the process of taking the broad framework identified in 'Theoretical Beginnings - Andante', and moving back 'inside' the story, to see whether it provided a broad description of what was going on in my nursing practice and whether there was congruity between the
framework and the story. Being positioned back 'inside' the story I found that there was a general fit between the framework and the story. This makes sense in that the framework itself emerged from my thinking about the story. I also analysed Phillip's Story using the framework which enhanced understanding of and meaning in my nursing practice, and highlighted that there were components of the framework which needed further development and clarification, such as the assumption that the phases within the framework progressed in a linear fashion.

**RECAPITULATION**

In the classic sonata form the third section or Recapitulation is a repetition of the Exposition (Bohle et al., 1985, p. 2103), however according to Bohle et al. (1985, p. 2102) "The Twentieth Century neo-classic sonata is notable for its ... cutting down on repetitions" and modifying the classic sonata form to develop what is termed the "Twentieth Century Sonata". Historically, many composers have modified the classical sonata form, varying the number, structure, and themes within sections (pp. 2100-2103).

Following the examples of some of the twentieth century musical masters who have experimented with the sonata form e.g. Ravel, Prokofieff (p. 2102), I have experimented with the third section by using the term 'Recapitulation' within my modified sonata form in a specific and experimental way. Holding true to the classic sonata form it incorporates a repetition of the exposition but the repetition follows a different form. The theme or essence of the Exposition becomes clearer
and more developed through the combining effects of both the first and second sections. What was embedded in the Exposition now becomes explicit.

Recapitulation in this sense then is used to reflect more than straight repetition of the original theme, it names the process whereby the detail and nature of the original theme becomes more explicit using the processes identified in the Development section. This develops fuller understanding, awareness and explanation of the original theme through exploring aspects related to the original theme. Recapitulation in this work comprises one chapter titled 'Explanation of the Modified Framework - The Moment of Caring: A Manuscript for Reflection on Caring Moments in Nursing Practice'.
Explanation of the Modified Framework - The Moment of Caring: A Manuscript for Reflection on Caring Moments in Nursing Practice - Allegro (tutti)

Illustration 6. Explanation of the Modified Framework - The Moment of Caring:
A Manuscript for Reflection on Caring Moments in Nursing Practice - Allegro (tutti)

(Allegro (tutti) - At a fast pace, all together)

With this new understanding gained from the processes outlined in 'Re-layering the Framework onto Phillip's Story - A Self-analysis - Andantino', I moved back 'outside' the story and modified the diagrammatical representation of the framework and provided further explanation and refinement of the phases within the framework (now renamed a manuscript). I also modified some of the illustrations so that they became a more accurate representation of the manuscript as I saw it. 'The Moment of Caring: A Manuscript for Reflection on Caring Moments in Nursing Practice' is the result of this process.
CODA

The Coda summarises and concludes the thesis, and following Beethoven's example of varying the sonata form, includes some new material (Bohle et al., 1985). This section consists of two chapters, 'The Performance - Playing The Manuscript (Application) - A piacere' and 'Finale - Encore - Vivace'. The final chapter concludes with a personal reflective summary on the manuscript and its development.

The Performance - Playing The Manuscript (Application) - A piacere

![Diagram](image)

Illustration 7. The Performance - Playing The Manuscript (Application) - A piacere

(A piacere - At the performer's pleasure)

'The Performance - Playing The Manuscript (Application) - A piacere' addresses the performance of the manuscript in nursing, that is its application for nursing. This is diagrammatically represented above as being back inside the
story, because it was from the story that the manuscript which is being performed was developed.

**Finale - Encore - Vivace**

*(Vivace - Lively)*

'Finale - Encore - *Vivace'* concludes the study by summarising the key aspects of 'The Moment of Caring: A Manuscript for Reflection on Caring Moments in Nursing Practice' and is followed by the appendices and the table of references.
EXPOSITION
Phillip's Story

Phillip was five years old and had already been in the ward a number of days when I met him. He had been admitted with osteomyelitis of his left hip and had been to the operating theatre the previous day to have his wound drained and where the surgeons had inserted two redivac drains to help with subsequent wound drainage.

During the nursing handover, the morning staff informed us that Phillip's wound had continued to bleed heavily since the previous surgery and that Phillip had returned to theatre that morning to have both redivac drains removed. I remember thinking that this intervention seemed somewhat premature. I didn't
understand why the redivac drains were being removed when Phillip's wound was still bleeding heavily. Were they blocked and not working? If they weren't blocked, what was the rationale for removing them? The morning staff continued to tell us that following the removal of the drains, Phillip's wound had continued to bleed, and that they had already changed his wound dressing once postoperatively. They described how terrible Phillip's behaviour was when they turned him, how he screamed and yelled, how he wouldn't co-operate and how he made their job quite difficult.

At the conclusion of the handover, another nurse was allocated to look after Phillip and, though initially not directly involved, I was aware of subsequent developments and changes in Phillip's condition as the afternoon duty progressed through the various conversations occurring among the nursing staff.

Phillip's wound had continued to bleed and bleed. The nursing and medical staff were concerned because he was losing a lot of blood, his haemoglobin was falling and his blood was just not clotting. The doctors ordered some urgent tests and, following their results, came up with a diagnosis,

"... some sort of haemophilia, we need to give him clotting factor."

The clotting factor eventually arrived and was administered to Phillip. However, by this time there was a blood clot the size of one circular doughnut
lying under the clear transparent dressing on his leg, and concern was raised regarding the likelihood of bleeding that was occurring within Phillip's hip joint.

The nurse who was looking after Phillip decided it was time to change his dressing and this was when I came on the scene. Remembering what I had been told about Phillip during handover and the difficulty the morning staff had when they wanted to turn him to do the dressing, I thought to myself that it probably hurt and if it was me, I would also be reluctant to co-operate.

Phillip's nurse called me.

'Maurice, can you give us a hand?'

'Sure. How can I help?'

'I need someone to help turn Phillip because he is really difficult.'

I found out which room Phillip was in and introduced myself to him.

'Hi. I'm Maurice, one of the nurses who is on this afternoon.'
he asked.

The other nurse piped up,

'Ve are going to have to turn you Phillip and Maurice is here to help.'

Phillip's eyes were incredible. They became saucers in seconds. He looked at the nurse and then at me. His face became flushed and he shook his head. His hands started grabbing at the bed and then came around him as if to somehow protect himself from an approaching threat.
He cried.

He started to sob.

"Well you can't lie there with that blood like that, and in that position. We have to turn you."

I looked into his eyes as if to convey some sympathy and compassion, but all that shone back were these dilated eyes of a wild cornered beast.

He pleaded with the other nurse.
'It's got to be done,' was all she would say.

I just stood by the head of his bed looking at Phillip, this scared, young, helpless boy in his bed. What could I do? In the five minutes I had been with him he had transformed into a trapped animal. He didn't know me or anything about me. I was just another stranger who represented pain to him.

He started to cry and yell even before we touched him.

At this point an enrolled nurse who was also working the afternoon shift came in to help and we were about to roll Phillip over.

I held his hand leaving one hand free and said,
'It'll be okay Phillip. I wish I could say it's not going to hurt but it's going to, and I know you won't like it.'

He looked at me, conscious of what the other two nurses were doing down by his hip.

'Phillip, when it hurts hold onto me. I won't let you go, and when it gets really sore you can hold onto me as tight as you want to. I'll be here. It's going to hurt but I will help you.'

He seemed to relax a little, eyeing me up and down, not too sure of who I was and what I was doing. And then the other nurse touched his leg.

Phillip screamed.
I held his hand and spoke to him in a kind and quiet yet confident way.

'Hold onto me .......... hold me as tight as you want to or can .......... you’re doing great .......... I know it hurts but I am here for you.'

The nurses counted to three and we turned.

'Hold me tight Phillip ........... I’m right here.'

He gripped my arm and shirt so tight and wouldn't take his eyes off mine. I could see the hurt in his eyes and the pain on his face but he still looked into my eyes.

'I know it’s hurting and wish I could make it stop ......'

I was interrupted,

'I have given him some paracetamol,'

bellowed this seemingly thunderous voice from one of the other nurses.

I continued.
'........... but you are doing really well. When you feel it hurting too much, just hold onto me and it will soon be gone.'

We had him on his side with me still holding his hand and him holding my arm. We did his dressing and changed his sheets. As the other nurses were dressing Phillip's wound, I showed Phillip what they were doing and he watched as the old dressing came off and the wound was cleaned.

He said,

watch out for the stitches!

and the stitches were dutifully watched out for. He then became diverted by the cartoons that were on the television and we had a bit of a talk about them. When the dressing was finished and the linen changed, I told Phillip we were going to turn him back.

The trapped animal returned and he looked at me and started to cry. What could I do for a small boy who was hurting so much and for whom the
anticipation of more pain was just about too much for him to bear? I looked into his eyes, and my eyes welled up, overflowed, and I too started to cry. It seemed as though I felt his hurt, his pain, his fear. I wanted so much to hold him close and say it was going to be all right but couldn't because of the environment. I felt ashamed of my tears. A voice inside my head was saying

'Nurses don't cry...'

'Why not?' my heart resounded.

I looked at him again and said,

'Phillip you did really well before and I want you to listen to me again. It's going to hurt again but only for a very short time. I want you to take a deep breath in and hold onto me so tight that the pain won't seem too bad. You can do it, we can do it together.'

The other nurse counted,

'1 .......... 2 .......... 3.'

'Deep breath and hold on to me.'
He took a deep breath in, looked me in the eye and didn't flinch. He held my arm so tight and we rolled him back to his original position.

We finished the procedure and Phillip let go of me. But as soon as the other nurses went to move his leg he made a grab for me and looked into my eyes.

He held onto me, and the pain wasn't so bad for both of us.

When the others had finished, Phillip let go of my hand and I let go of his. He didn't say much, but he was back to his previous happy self.

I left the room and the enrolled nurse who was there said to me,

"You really helped Maurice. He really needed a man to be strong for him. It was so much better this time than it was the first time. You really made it so much easier for us and for Phillip."

It's extraordinary how something so deep can be really quite spontaneous. The 15 minutes of total time I spent with Phillip was so special, I'll never forget it.

I realised that all the analgesia in the world sometimes is not enough to stop pain; sometimes we need someone to hold onto, someone to be strong for us, someone who will hurt with us and share the tears, fears and pain with us.
I believe that for Phillip I did that. I believe it helped him to understand that things do hurt in the world but that there are people to help carry us through the pain. As long as they are honest and are really there for them, then somehow the reality of pain doesn't seem so big.

I remember a saying which goes

'Some of your best teachers are children.'

It took a child to show me that nurses are able to feel and hurt with their patients, and that they are allowed to cry with them. Phillip also showed me that nurses are allowed to be gentle yet strong. That they don't know it all, and that nursing involves growing, not only in my role as a nurse, but also in my being, as well.
DEVELOPMENT
DEVELOPMENT
Having established that my focus was the nurse-client relationship, I made a conscious decision to set the issues of crying and phenomenology aside, and chose to further explore Watson's (1988) ideas about nursing. Particularly her challenge to view nursing through a new lens and to take off the ‘blinders’ of linearity when viewing the metaparadigm concepts and to view "... new ways of seeing the usual" (Watson, 1988, p. 8).
In an attempt to understand what Watson (1988) was proposing in viewing the usual differently, I explored two different ways of describing and viewing the concept of a forest and wrote the following self-dialogue.

If I am told that a forest consists of a group of growing trees in close proximity occupying a sizeable area of ground, then whenever I see trees that meet this description I can call it a forest. However, if my view of a forest is limited just to this description, I may miss seeing other essential elements which comprise a forest and my knowledge of what a forest actually is and what it consists of may be severely restricted. I may not see these other essential elements because I didn’t know to look for them and therefore I wasn’t looking for or expecting them, and furthermore if I did see them, I wouldn’t recognise them or know what they were.

On the other hand my description of what a forest is could be more comprehensive. The description could be that it is made up of between thirty to fifty trees most of which are growing and are at varying heights, though there are some which are dead or are slowly dying. There is leaf litter on the ground, and there are smaller plants and grasses growing at the bases of the trees stretching toward the light that seems
to be being filtered through the canopy of the leaves. As the sunlight falls, the rays dissect the tributaries of the leaves and reflect off the insects dancing in the brightened airways and off spiders' webs caught between the tree branches. The sound of birds gossiping and snickering as light tries to find them while they play 'hide and seek' among the verdant playground provides the accompaniment to the 'insectful' orchestra as they play the melody of the wood. The shuffling of unnamed creatures as they forage for food among the litter furnishes a vibrating lifebeat to the ambience. The laughing and refreshing chorus of a stream provides an undulating rhythm to the atmosphere.

This description offers a very different view of what a forest is and what it consists of. It includes not only the trees but other elements incorporating sound and movement, and a sense of life. This description will alter how and what I expect to see and experience. This is only one pattern or template of a forest, and it is from a human perspective. Imagine how one of the spiders, the insects or the birds would describe the forest and what they would say it consists of from their perspective? Imagine if you were a small insect on a leaf on the highest branch of the highest tree, what would your perspective be? By thinking about these other
ways of viewing a forest, the possibilities of descriptions and experiences is unlimited and boundless.

This process of writing about a forest helped me to explore the concept by describing two different perspectives and enabled me to explore new understandings and ideas regarding what a forest is. In regard to nursing then, this process of describing the usual from a different perspective encouraged me to explore my views of nursing, and to explore what other nurses have written about nursing, so that I could more clearly articulate my personal description of nursing.

Rudimentary Foundations of Nursing

Fundamentally I perceive nursing to be a giving-receiving process between the nurse and client within the context of health. For me, health is a process of becoming whole. Wholeness cannot be achieved/attained by the person in isolation but through relationships and being in relationship with others. 'Others' are not necessarily limited to the biophysical world and can be seen not only as another person but also a spiritual entity. Watson (1988) refers to these as existential/phenomenological forces or as experiences not constrained by time, space and rational thought.

From my perspective, individuals are a unity comprised of three realms, Body, Mind and Spirit. The Body refers to the biophysical components, Mind
refers to the person's intellect and emotions, and the Spirit is viewed as the metaphysical component.

As Watson, I view the person as a being-in-the-world; one who experiences and perceives meaning through relationships with others and the world, and like Watson I also propose that they consist of three interconnected and inseparable components, that of Body, Mind and Spirit. The Body is a person's biophysical composition which is confined to space and time. It influences and is influenced by the Spirit and the Mind. The Mind, which involves cognitive processes, emotions and conscience where space and time are relative concepts and are able to be transcended, also affects and is affected by the Spirit and the Body. Watson refers to the spirit as the inner self or the essence of a person and refers to the terms of soul, spiritual self, inner-self and geist as all relating to the same phenomenon (p. 46).

Whereas Watson (p. 50) states that "The spirit, inner self, or soul (geist) of a person exists in and for itself", I believe it exists for a purposeful relationship with a particular deity. Although Watson proposes that the destiny of one's spirit is to become more God-like, I believe this only occurs through relationship with the Christian God. That is, as I spend more time thinking, meditating in fellowship with God, I start to take on His characteristics (see discussion on Social Learning Theory, Papalia, Olds, & Duskin, 1995, chapter 1, pp. 28-29). Hence, although I believe the person to be holistic, that is their makeup as an individual entity being more than and different to the sum of the parts, as Watson, I believe that the Spirit
holds greater emphasis, as it is to the health of this component that both Mind and Body direct their energies.

Wholeness, or health, is achieved through processes of joining with another for different moments in time for different reasons. The length of these moments is arbitrary and could be as short as a few minutes, hours or days, or even a lifetime. Through this process there is reciprocal giving and receiving occurring, whether it is physical, emotional, or spiritual. As one helps another, both grow and become more whole, that is, their wholeness becomes more complex or detailed.

Artistic Experience - Artistic Impression: Personal Experience and Interpretation of Watson's Notion of Transpersonal Caring

I also explored Watson's (1988) notion of the art or act of nursing, especially with reference to my interpretation of experiencing another's experience, and then as a nurse re-expressing this in a way that encouraged the other to experience their initial experience more deeply.

Watson's notion of transpersonal caring in part fits with my view. According to her, transpersonal caring involves giving-receiving behaviours and responses between the nurse and client, and reflects each individual's subjective world which is comprised of knowledge from the sciences and the arts. "Transpersonal refers to the intersubjective person-to-person relationship in which the nurse affects and is affected by the person of the other" (p. 58). As both beings participate in the
giving-receiving relationship, both are changed. The process comprises the art or
act of transpersonal caring.

Watson proposes that transpersonal caring begins when the nurse, in caring
for a client, joins with them in their experience. The client expresses a feeling in
various ways and the nurse receives these and experiences them for themself, thus
in a sense comprehending the other's experience. Having realised and sensed the
client's experience, the nurse then expresses them in unique and varying ways
which allow the client to experience them more fully and in a way they have been
longing to do but have been unable to. A sense of freedom is thus felt by both
nurse and client and the essence or spirituality of both are further revealed,
experienced and realised.

Again, my thinking became bogged down with questions relating to
Watson's assumptions regarding one to one relating, and the key question that
kept arising for me was, 'How can I experience another's experience?'

It was during this questioning time that I opened the newspaper one morning
and saw the photograph of the man who had just been told that his wife and two
daughters had been senselessly killed in the Port Arthur massacre, in Tasmania,
Australia, in 1996. The first three words accompanying the photograph simply
stated, "A Father's Grief" (see Illustration 10).
On looking at this picture and reading the scant description, within my spirit, my essence of life, I felt the raw ravage of grief, pain and loss. I experienced grief, devastation, pain, tears, compassion and empathy, because for me it was showing exactly what I imagined it would be like if I had experienced the same or similar circumstance.

How could this be? How could I experience another's experience?

Here was a picture of someone I did not know, he was a total stranger from another circumstance and place. I didn't know who he was, his occupation, what
his name was, what his hobbies or interests were, or what his strengths or weaknesses were.

And yet at a different level, I did know him. I knew what it was like to be in a loving relationship. I knew what it was like to have a young child, to bring forth life and see my child grow. I knew what it was like to see my child in pain and in fear; of wanting to help take their pain away but not knowing what to do or how to do it; of feeling helpless; of the special moments when father and child spend precious time together and share their own secrets; having fun, and tickling and laughing in joy and love. Yes, in a different sense, I knew him because reflected in him was me, my masculinity and my humanity.

Even now when I view this photograph the same emotions which arose then, still come flooding back, in a sense these feelings provide continual validation of the ability to participate in the experience of another. It was as though I was experiencing this father's experience in my own way. It was not the 'same as', but there was a 'sameness' about it. I responded emotionally, cognitively, professionally and personally to the image. I saw similarities related to being a father and a husband and the relationships that make up my family, particularly that of husband to wife and father to child.

It also highlighted to me the sanctity of the whole experience. It was an extremely personal moment for the man and a photograph had captured his grief for the world, and I didn't know if he knew. There was a sharing of experience but I also felt there was violation in the sense of intruding and breaking through the
integrity of another person's wholeness. I struggled with this sense of violation until about four weeks later, when the man was interviewed on television simply because he wanted people to hear his story. For me it was as if he was giving me permission retrospectively to share in his experience of grief.

The example probably falls somewhat short of Watson's actual notion of transpersonal caring, yet for me, the illustration was significant in clarifying what I considered a moment of caring to be. I believed there was a connection between myself and this man and that at some level I felt his feelings, but I was unable to share with him my feelings and expressions in a way which would allow him to express and experience his own more deeply.

Because of this shared experience I was now confident in myself to move on, comfortable with my interpretation of Watson's (1988) view of the art of nursing. I still had questions but the foundation that it was possible to experience another's experience was there.

**Impressions on Nursing**

I decided to explore what other nurse theorists had written in regard to the nurse-client relationship and chose specifically aspects of Watson's *Nursing: Human science and human care* (1988), Paterson and Zderad's *Humanistic nursing* (1976) and Kirby and Slevin's *Commitment to care: A philosophical perspective of nursing* (1992, cited in Arets & Slevin, 1995) particularly because
they drew on Martin Buber's (1958) notions of I-It and I-Thou relating and incorporated them into the nursing context. Additionally, I perceived they had some similarities of ideas with Kirby and Slevin's work clearly associated with Watson's.

Buber's (1958) notions of the 'I-Thou' and 'I-It' relationships are useful in exploring how individuals relate. These words refer to how an individual exists in regard to other individuals or objects. When people are relating, if an individual regards another as an object with specific characteristics then Buber suggests that they are regarding them as I-It. This is because we are experiencing and observing aspects about the person, and in doing so we are in a relationship where the person is considered apart from us. The I-Thou relationship however involves joining to the other as whole-person to whole-person. Buber refers to this as 'bodying out' where during the togetherness, the 'I' is with the 'Thou' and they are in true relationship. Kirby and Slevin (1995) assert that when an individual (the I) starts to think about the other (the Thou) with prior knowledge about the other person, then they are objectifying them and their experiences and they move to the I-It mode.

The nursing theorists Paterson and Zderad (1976) drew on Buber's work for their humanistic theory. Focusing on how the nurse and client interact, they have suggested that both bring with them experiences which influence their meeting together so that ultimately they both become more human (Meleis, 1991). Their view of the nursing relationship derives from Buber's view of I-Thou relating. I-Thou relating is intersubjective and takes place when the nurse and client join
together in a form where each sees the other as unique and offers themself truly to the other in authentic presence. Through this uniting, subjective meaning is conveyed. In I-It relating, the nurse relates to the client more as an external object or a collection of material components with which to act on, or manage, rather than as person-to-person or being-to-being (Laffrey & Brouse, 1989, O'Connor, 1993, Meleis, 1991).

Kirby and Slevin's (1992, cited in Arets & Slevin, 1995) recent conceptual model of nursing also draws on Buber's work, and, like Watson's writing (1988), holds that caring is central to nursing. Their approach is humanistic and also draws on philosophical views as posited by Heidegger and Sartre, as well as nursing contributions from Watson, Roach and Gadow. Their proposed model identifies two key components: the elements of care and the caring relationship. The elements of care address key requirements the nurse needs in order to be in a caring relationship with the client. These elements of authenticity of being, conscience, commitment, presence, compassion, empathy, and empowerment, are essential in order for the nurse to truly care. The caring relationship addresses the context in which the elements or conditions of care apply.

What makes Kirby and Slevin's view of caring in nursing distinct from other views of caring which other health professionals may lay claim to, is in regard to the characteristics of a) the health orientation and b) the therapeutic relationship. Health orientation addresses the unique way nursing provides each of the elements of care in environments which promote health, provide care of the sick and in which they facilitate support for those who are either mentally or physically
disadvantaged. The therapeutic relationship which exists in nursing identifies that
the caring relationship is characteristically directed to the client's health and
well-being.

Nursing then is seen as a caring relationship between the nurse and the
client, where the science of nursing, which encompasses technical knowledge and
skills, and subjectivity are brought together. Drawing on Buber's ideas of I-It and
I-Thou relating, Kirby and Slevin relate these to the nurse-client interaction. They
propose that the nurse enters into a subjective relationship with the client where
he/she connects and responds with them in a non-reflective and non-judgemental
way. The nurse also however, has to move into the I-It way of relating in order to
be able to objectively, reflectively, and judgementally observe, assess and respond
to the cares or needs of the client. This allows the nurse to then care and relate as
'I-Thou' with compassion and sensitivity. Kirby and Slevin's model for care is
245-247).
Illustration 11. Kirby and Slevin's Model for Care

In regard to nursing Kirby and Slevin suggest that if nurses care for clients as un-holistic beings or fragmented entities and clinical factors, then the relationship is that of I-It rather than I-Thou because the person is seen as a set of separated parts. They relate this to nurses who, during moments of contact with clients, objectify and adhere to exclusively scientific and technological interventions essentially confining nursing to I-It relationships. They propose that the nursing relationship flows between the I-It and I-Thou relationship. Where the I-It position enables accurate assessment of a client's condition and the appropriate use of technical nursing intervention, and where I-Thou is essential if the nurse is...
to journey with a client through their experiences and their meaning of illness. They propose that "True excellence in the nursing relationship can be viewed as this capacity for movement between the I-It and I-Thou, of coming in to be and going out to see, as nursing proceeds with a majestic rhythm" (Kirby & Slevin, 1995, p. 66).

In a similar way, Heidegger (1962, cited in Kirby & Slevin, 1995) expresses the states of 'inauthentic being' and 'authentic being'. Inauthentic being refers to situations when individuals relate and behave in ways dictated by their own and other's social expectations and norms. During these moments of connection, relating is superficial and follows expected or customary conventions. Authentic being, however, involves addressing what it means to be authentically, that is existence, apart from personal and social dictates and expectations. When we face the reality of our existence and relate to others in this way, it is as authentic beings who are not constrained by scripted behaviours.

Returning briefly to my story, I believed that Phillip's and my time together reflected such movement as proposed by Kirby and Slevin (1995). During the episode there were times when clearly we were relating as I-It. I-Thou was reflected during the time when we cried. I say this with some hesitation because by referring to it as such and by reflecting on our coming together I am guilty in one sense of objectifying the relationship and therefore it could be argued that the relationship has moved from I-Thou to I-It (p. 65). Similarly, from Heidegger's perspective it could be proposed that Phillip's and my coming together in
relationship initially began with each of us in a state of inauthentic being, with the
crying moment culminating in shared moment of authentic being (p. 67).

In relation to my story, the initial process of getting to know Phillip and
taking part in his dressing change can clearly relate to Kirby and Slevin's notion of
I-It relating, but as the moment of crying occurred, caring occurred. I responded
one-to-one with him and the relationship had moved to I-Thou.

Starting to Compose

Because the photograph (Illustration 10) had had such an impact on me I
thought "Why not view my story as a photograph or musical picture of what was
occurring between the nurse and a client?" Having decided this I reflected on the
story and dwelt in the story as though it was a musical score, trying to explore and
capture the essence or theme of what was going on from a more global or macro
perspective.

I made a conscious decision to not get bogged down in the story's intricate
notation because I thought that delving into the detail too soon would result in an
imbalanced introspection with no reference points on which to explore meaning
and understanding of the experience.

The detail of the story therefore faded into the background, much like
having a panoramic view rather than using the zoom lens, or hearing quadraphonic
sound rather than monophonic. From this global perspective my impression of my
story was that it was about the relating between a nurse and client which
culminated in a special and unique shared experience.

**Rudimentary Framework of the Caring Moment**

Emerging from my thinking and with the aim of understanding what I
considered a moment of caring in nursing to be, I drew on Watson's (1988)
description of transpersonal caring, crystallised my thoughts about the story and
composed a rudimentary framework representing 'the caring moment'
summarising what was occurring between the nurse and client. Both the nurse and
client were represented by individual circles which came together, intersected,
moved away, with each circle carrying a bit of the other and their shared
experience with it.

In this rudimentary framework I have suggested that a moment of caring in
nursing begins with two people, the nurse and the client, represented by the two
circles. The dotted lines surrounding the circles symbolise an holistic entity which
is inseparable from its environment. Each is a complete unit in his/her own right,
yet each is seeking wholeness in the three realms of Body, Mind and Soul.
Wholeness in this context I call health and refers to increasing diversity and
complexity of meaning and understanding of experience, and in the illustrations is
represented by depth, diversity and complexity of pattern. In this sense wholeness
is a continual process of becoming, where there is increasing complexity of
meaning and experience, revealing deeper and increasingly detailed layers of meaning which form the ever evolving mosaic of health/wholeness. Both individuals have their own pattern of being which includes their causal past, their present and imagined future. Both are co-participants and are in a process of receiving and giving, taking on specific or prescribed roles according to their health role i.e. either nurse or client. The relationship between the two is professional and distant (see Illustration 12).

Illustration 12. Rudimentary Framework of The Caring Moment - Phase One

As the relationship develops, the nurse opens self to the other and receives the other as client. The client opens self and receives the other as nurse. They express subjective emotion and give cues through signs and emotional expression (see Illustration 13). The nurse receives and comprehends these cues generally and
provides knowledge and skills of nursing to the client through the utilisation of Watson's (1988) ten carative factors.

Illustration 13. Rudimentary Framework of The Caring Moment - Phase Two

In the next phase the giving-receiving behaviours become more focused. The nurse receives the cues through hearing, sight, touch and intuition, and begins the process of realising the other's emotion. The client remains open and continues to give cues to the nurse and responds to the carative factors.

The process of 'in-tuning' begins. This term is directly taken from music and in this sense I use it to mean accurate correspondence of pitch and intonation or harmony (Hanks, 1979). In the giving-receiving process 'in-tuning' occurs.
'In-tuning' is when the experience of one person is in the process of being realised by another. They become 'in-tune' with each other.

Watson commented during a video interview for the Helene Fuld Health Trust (1989) "I was trying to incorporate that [the concept of spirituality] into the very beautiful moment of a human-to-human caring transaction, that nurses live in their daily life and they know it and they live it, but we don't have it in our language, and we often don't have language for it. That's why I am so interested in integrating ... the use of ... metaphor, into our language to try to get us to see what's happening before our very eyes and nose but we can't see it." Paterson and Zderad (1976) comment that the words we use to describe what we experience are limited by our human ability to express them.

I use the terms 'in-tuning' and 'in-tune' because they describe the phenomenon and process of the two persons coming together and experiencing each other most accurately.

Being 'in-tune' does not necessarily mean that the experience that is felt is identical; it may be, but is more likely to be at a different level. When music is in harmony, there can be many notes, each of which include various layers of tones and pitch yet when put together the chord they make produces sound which is complete in itself, full-bodied, rich, euphonic and at various levels of wholeness from simple to complex. In the nursing relationship this occurs between the nurse and client, where there is a harmonising of experience into a melodious symphony (see Illustration 14).
During the next phase the 'in-tuning' process is then complete. Full realisation of the other's (client's) subjective emotion occurs by the nurse and the caring moment is realised. Once this occurs the nurse then expresses these feelings in a way that enables the client to experience the original feelings more deeply, more richly, more fully, and more harmoniously (see Illustration 15).
As the moment of caring comes to a conclusion, both the nurse and client have deeper understanding and richer meaning/experience of the subjective emotion at a further level of complexity than was first experienced. They begin to leave the moment carrying the shared experience/expression with them (see Illustration 16).
The shared experience/expression becomes part of each individual and the completeness of each becomes more detailed as they have attained a deeper level of wholeness as depicted diagrammatically by change in patterning (see Illustration 17).

Illustration 17. Rudimentary Framework of The Caring Moment - Phase Six

In the final phase both nurse and client are complete, distinct entities in constant interaction with their environment but they are changed, and their patterning and experience of wholeness is more complex. They continue like this until further expression of emotion occurs and there is again a new coming together only this time, they bring with them the new patterning of shared experience into the relationship (see Illustration 18). This whole circular process I refer to as the art of nursing.
Illustration 18. Rudimentary Framework of The Caring Moment - Phase Seven
Theoretical Beginnings

Illustration 19. Theoretical Beginnings - Andante

(Andante - Going at an easy pace)

Bridge

'Theoretical Beginnings - Andante' develops the exploratory ideas and metaparadigmatic concepts introduced in 'Theoretical Positioning - Adagio'. Being informed by what Watson (1988), Paterson and Zderad (1976), and Kirby and Slevin (1992, cited in Arets & Slevin, 1995) had to say about nursing, I then theoretically positioned myself by articulating how I viewed my world of nursing using as a broad framework definitions and descriptions of the concepts of Person and Health, two of the four key concepts comprising nursing's metaparadigm (Fawcett, 1984). These provided the theoretical underpinnings from which the more detailed framework of 'The Moment of Caring' developed.
After initially struggling with the metaparadigmatic framework and finding that I was writing to fit the framework and describing rather narrowly my views of the concepts, I stepped out from this constraining perception of how the concepts could be described and used the metaparadigm as a broader framework on which to articulate my personal ideas about nursing with reference to those specific writings which had informed my thinking.

During this time I also found a doctoral thesis by Euswas (1991) called 'The actualised caring moment: A grounded theory of caring in nursing practice', but chose to postpone reading her work because I wanted to explore my own ideas and not be distracted by another's. Whilst consciously deciding not to read Euswas's work and to develop my own theoretical thinking, it is worth noting that when I did review her theory, there was enough similarity with concepts and illustrations to provide general congruence between our work, providing a sense of reasonableness regarding the processes I had used in the development of the manuscript. I return to her work and discuss this further in the section titled 'The Performance - Playing The Manuscript (Application) - A piacere' (pp. 188-190) within the Coda.

Initial Theoretical Development

In an attempt to develop my ideas, I initially tried to follow established methods of theory structure, construction and presentation, and endeavoured to use the concepts fundamental to the metaparadigm of nursing (Fawcett, 1984)
namely person, health/illness, environment and nursing. These are viewed as forming the basic building blocks or concepts within any theoretical structure of nursing. Though useful in providing a beginning point in the process of examination and articulation of fundamental concepts within the emerging framework, I found that I was trying to squeeze and fit my thinking, and consequently the framework, into what I perceived to be an inflexible structure, the nature of which did not fit with that of the framework's origins. I found its usefulness was more in its springboarding effect. That is, I viewed the metaparadigm more flexibly as one which provided a basic platform from which birthed, bounced and catapulted new and different ideas. Thus, using the metaparadigmatic concepts provided a general structure from which the essence of my view of nursing could be identified and expressed (Walker & Avant, 1995).

I began trying to articulate my view of the concept of health. This became an involved process because I found I was being springboarded between the concepts of person and health. What emerged was, quite simply, the fact that I couldn't articulate them in isolation from each other. Clearly this indicated that my views of these two concepts were not mutually exclusive. I could not have one without the other. Though they are distinct in their description, they require each other for full understanding. I focused almost solely on these two concepts, my views of these concepts emerging through exploratory/discovery processes which reflect the nature of the frameworks' development. These two concepts form the basis of the emerging framework.
Health as Wholeness

My view of health, initially informed by the World Health Organisation definition (1946) and by traditional descriptions attached to the concepts of sickness, illness, and well-being, as they pertain to physiological or psychological functioning, has transformed to become more conceptual. My description of health as wholeness, provides a different view of the concept of health requiring a "... changing of [the] lens to see anew ...", as Watson (1988, p. 8) suggests when she refers to viewing nursing science through a new lens. Taking her approach I provide a new lens for seeing health. My view clearly identifies that spiritual health or wholeness is the ultimate goal of nursing. Health is defined as increasing diversity and complexity of meaning and understanding of experience, and is considered as both an outcome and a process. As outcome it is labelled 'wholeness', and as process it is labelled 'becoming whole'.

As an outcome, I describe health as wholeness in the three components or realms of the person, namely Body, Mind and Spirit. That is, there is increasing diversity and complexity of meaning and understanding of experience as Body (biophysical components and biophysical functioning), as Mind (cognitive processes, emotions, conscience) and as Spirit (the individuals soul or metaphysical essence and his/her relationship and developing likeness with the Christian God.)

The ideal then is to have health of all three components 'all-at-once'. The term 'all-at-once' indicates that this occurs at the same time. This is possible if
using the definition as both outcome and process. As outcome there can be increasing diversity and complexity of meaning and understanding of all three realms simultaneously because by nature of the definition, the outcome is not an end point, only an occurrence at a particular point in time at a particular location in space. Furthermore, because the realms are interconnected this presupposes interrelationships among them. The implication being that as one realm increases in complexity and diversity, it has a direct effect (presupposedly in the same direction) on the other two realms in various ways. It must be noted that perfect wholeness conceptualised as arriving at an end point of completed diversity and complexity of meaning and understanding of experience is, in this temporal and spatially bound reality anyway, unattainable and inconsistent with my definition and its use.

As process, becoming whole identifies that a process is occurring through which there is increasing complexity of meaning and understanding of experience which reveals deeper and increasingly detailed layers of meaning to form an ever evolving mosaic of wholeness. Therefore, individuals may refer to health as the process through which one becomes more whole or as an outcome defined by time and space whereby meaning and understanding of experience have increased and become more complex.

The traditional views of wellness, health/illness are not perceived as better or worse than each other. These terms are mere labels to which individuals have subscribed in order to identify certain circumstances, or a group of criteria, which impact on our living in a value related way. I perceive them as an event, that is a
happening at a particular point or place in time. These labels may be part of the process of becoming more whole if they result in deeper understanding and meaning of experience. If they don't lead to deeper understanding and meaning of experience then they are not perceived as contributing to the wholeness of the individual. For example if deeper meaning and understanding of what it means to have a head cold does not occur from having the head cold, then health is said not to have occurred.

In summary, wholeness and becoming whole occur within the three realms of Body, Mind and Soul, which comprise the person. Wholeness refers to the outcome of the process of becoming whole. Becoming whole refers to the process of increasing diversity and complexity of meaning and understanding of experience, and wholeness refers to the outcome of increasing diversity and complexity of meaning and understanding of experience occurring at a particular point in time at a particular location in space.

Person as Client-Nurse

My view of person forms the core of the two concepts of nurse and client within the framework. My view of the concept of person has clearly been informed by my Christian heritage and current beliefs, and also particularly in nursing by Watson's (1988) articulation of her view of person as a being-in-the-world possessing three spheres of being, mind, body and soul.
Like Watson, I view the person as a spiritual-being-in-the-world consisting of three realms: Body, Mind and Spirit. While Watson refers to these as spheres, I use the term realm rather than sphere to indicate a notion of layering or hierarchy of domain. The three realms are viewed in unification meaning a unified entity comprised of three major domains or interwoven layers.

The realm of Body refers to an individual's biophysical composition confined to space and time. Though the Body influences and is influenced by the Spirit and the Mind, it directs its energy primarily towards health (wholeness) of the Spirit because this holds greater emphasis. This occurs through the process of becoming whole (health).

The realm of Mind involves cognitive processes, emotions and conscience, where space and time are relative concepts and are able to be transcended. Though the Mind influences and is influenced by the Spirit and the Body, it directs its energy primarily towards health (wholeness) of the Spirit because this holds greater emphasis. This occurs through the process of becoming whole (health).

The realm of Spirit is the individual's soul, the metaphysical essence of who and what they are. The Spirit exists for a purposeful relationship with the Christian God. Through the purposeful relationship the individual becomes more God-like. In contrast to Watson, I use this term to mean taking on the likeness of God, not actually becoming a god. This occurs through spending time thinking and meditating in fellowship with God. The Spirit influences and is influenced by
the Body and Mind with the aim of becoming more whole. This also occurs through the process of becoming whole (health).

I view the person as holistic in the sense that the whole is greater than the sum of the realms: however, I propose there are higher level realms which hold/ have more significance. Therefore similarly to Watson the Spirit holds greater emphasis. This is conceptualised in the following atomic illustration.

Illustration 20. The Holistic Person

Persons have a meta-pattern of being, that is, their lives reflect a matrix comprised of the merged patterns of the wholeness of each of the three realms. Pattern in this sense refers to the reflection in life of the level of complexity and diversity of meaning and understanding of experiences which comprise each of the three realms. The meta-pattern therefore is a synthesis of each realm's pattern, that is, it is a holistic matrix from the merging of 'Body-pattern', 'Mind-pattern' and 'Spirit-pattern' into a distinct representation of existence. Because every
individual is at different locations of becoming whole in each of the three realms, it is considered that no meta-pattern of being or holistic matrix is ever completely the same. Different individuals may have similarities of individual realmic patterns, however when they combine with the other realms they are quite distinct. Similarities in realmic pattern occur when there is close similarity between one individual’s past and another individual’s past, or in similarities between individuals’ presents.

The meta-pattern of being is reflected in specific behaviours or cues. I use the term cue interchangeably with behaviour because within 'The Moment of Caring' framework, the behaviours expressed by both the client and nurse serve not only as signals to each other inviting participation and connection, but also as guides for each other to follow in developing the connection within the nurse/client relationship. These behaviours are described as giving-receiving. That is, they are behaviours which enable another to become more whole through the process of giving-receiving. These are not two separate processes but a unity whereby there is not only the giving of one's self to another as well as receiving from another their self, but also inherent within this process of giving, receiving occurs in the form of growth and new patterning. In the nursing context these cues fall into two categories, conscious and unconscious. Conscious giving-receiving behaviours are those cues which the individual exhibits of which they are aware. Conversely then, unconscious giving-receiving behaviours are those cues the individual exhibits of which they are not consciously aware.
Persons are not detached observers or experiencers in the world but are an inseparable part of their observations and experiences which reveal meaning to them. Individuals have and find meaning in their existences. Meaning is not absolute. It is subjective, dynamic, relative and connected to individuals' histories and contexts. This meaning can be shared and interpreted.

In the nursing context the two persons involved in the process of caring are the nurse and the client. The concepts of nurse and client are foundationally the same as they share the identical descriptions and definitions of my view of the concept of person. The differences between them occur within the contexts in which their relationship(s) occur. The assumption is that the location, environment or institution (that is organisation) where their meeting occurs determines the description and roles of both nurse and client based on the organisation's meta-view of health. Though this may be very different to the view of health proposed by this emerging framework, it does not exclude the use of this framework. The framework focuses on the nurse/client relationship and can therefore occur within any organisational context.

Consequently both nurse and client have specific organisational roles to perform. Generally, then, the organisational role the client fulfils revolves around a specific health need or requirement defined within the general boundaries of the medical view of health. The organisational role for the nurse is determined not only by the organisational view of health (generally reflected in the medical model) but also by the educational preparation, international trends and
descriptions of nursing practice generally occurring from both within the profession and from external positions as well.

Bridge

My next process was to try and crystallise my thoughts about what I had just written and how it corresponded to the story. Again I was feeling bogged down because I didn't know how my thinking fitted into a research study and whether what I had written made any sense. So I moved back out of this quagmire and attempted to understand what I had done and where I was going to next by again trying to capture a global sense or theme of direction. This time the musical image was in the form of a poem which textually and conceptually reflected my thoughts at the time.
Expository Opus

In the beginning was the experience.
The experience was about nursing
    and the experience was nursing.
The experience reflected praxis
    and the praxis resonated caring.
The caring was art-science
    and the art-science was lived.
The lived encountering became narrative
    and the narrative became a story.

The story enabled re-membering
    and the re-membering hearted reflection.
The reflection enabled examination
    and the examination yielded understanding.
The understanding provided philosophical exploration
    and the exploration produced theoretical possibility.

The possibility fostered revealing association
    and the association encouraged comparison.
The comparison nurtured artistic collaboration
    and the collaboration unfolded reciprocity.
The reciprocity produced in-tuning
and in-tuning composed harmony.
The harmony sang a melody
and the melody and story combined.
The combining created a song,
and the song became
'The Moment of Caring'.

(Drake, 1998)

Because I had used the method of thinking in global themes, drawing
global thematic representations and then writing these representations to provide
the detail, I did some initial exploration of the poem by filling in some detail on
what the poem meant at that point in time.

'Expository Opus' - As the title, it explains what the poem
is about, namely an attempt to explain in synoptic form the
inception, exploration and development of the composition 'The
Moment of Caring' or my interpretation of what Phillip's Story was
all about (opus being the musical term for a complete musical
work, a term which seems to fit with my languaging).

'In the beginning was the experience' - This reflects the initial
struggle in trying to find an issue of interest to explore and
identification that the starting point of my thinking was an experience of nursing.

'The experience was about nursing' - The experience was based in a nursing environment, in a particular nursing context, and occurred in a hospital and involved a patient. It identified nursing actions, thoughts and feelings that nurses do and live, and therefore reflected for me nursing as a whole, that is 'and the experience was nursing'.

'The experience reflected praxis' - The experience demonstrated practical application of nursing knowledge (in relation to Carper's (1978) ways of knowing) revealing how I saw and experienced caring in the nursing context. The statement 'and the praxis resonated caring' addressed this. What happened was a demonstration of what a caring experience in nursing was for me. It included action, feeling, being, relationship and openness to growth and possibility. Using metaphor, the praxis was like a tidal river that rhythmically ebbed and flowed caring.

'The caring was art-science' - My concept of caring encompassed facets of all paradigms of knowing and was also an expressive, artistic demonstration, creating new knowledge and adding richness and meaning to what was already known.
'The art-science was lived' - The artistic/scientific caring work of art was lived and experienced from my perspective jointly by Phillip and me, through Phillip and me, and for Phillip and me.

'The lived encountering became narrative' - Phillip's and my lived, caring relationship became a remembered text, that is meaningful words.

'and the narrative became a story' - The meaningful words were put together in a way that captured the essence of what had happened and what had been experienced.

'The story enabled re-membering' - The story being a memory was comprised of components (members). As a memory, it was revisited with varying frequency. Every visit required a looking at the whole but also enabled a looking at the components from which the whole was collectively made. Through the revisitation process, the components could be looked at in isolation or in connection with each other or others in varying orders or sequences to help give the story meaning. I refer to this as re-membering, putting the members or components of the story together in various ways to give layers of meaning and understanding to the story and therefore to the experience also.
'and the re-membering hearted reflection' - The re-membering process enabled reflection on the components, their interrelationships, the whole story, and therefore the experience which occurred. Hearted as a verb is deliberately used because I saw it moving beyond the meanings related to superficial encouragement. It added the centredness of what it means to be, that is the heart of who I am in the process of reflection. This process of reflection (that is thinking about the experience and meanings contained within it through various structured and spontaneous approaches) involved not only the mind but the heart, in a sense the essence of life or being.

'The reflection enabled examination' - Through the process of reflection, critical judgement and evaluation of the experience occurred. This was realised concurrently through the use of structured approaches, grounding myself from their perspectives and then using this situatedness to interpret the experience through another lens; and from unconstrained thinking and interpretation, going in and out of the story spontaneously revealing understanding.

'and the examination yielded understanding' - The constant examination of the story enabled a deeper understanding of the story, identifying key elements and their interrelationships.
'The understanding provided philosophical exploration' - Understanding encouraged me to explore identified elements or concepts from other perspectives.

'and the exploration produced theoretical possibility' - Through this exploration of what others had to say from their perspectives about concepts embedded in my experience, I thought about what they said and how they interrelated. This started the very beginnings of the conceptual framework developed from my experience.

'The possibility fostered revealing association' - By moving in and out of what I thought happened in the experience and what others had said about identified issues/concepts philosophically, ideas started to emerge which were similar to those of a number of specific writers. These included Heidegger (1962, cited in Kirby & Slevin, 1995) in relation to phenomenology and authentic/inauthentic being, Watson's (1988) nursing theory 'Human science and human care' and particularly her notion of the art of nursing, Paterson and Zderad's (1976) ideas about I-Thou/I-It relating and humanistic nursing, and Kirby and Slevin's (1995) nursing theory based on Martin Buber's concepts of I-It and I-Thou relating.
'and the association encouraged comparison' - Having explored the association with these writings, I was able to compare what they had to say and how what they had said related to assisting me to understand my experience.

'The comparison nurtured artistic collaboration' - The word nurtured was used deliberately. I used it to describe an encouraging, prompting, supporting, growing, emerging action. This process enabled an exploration of how I could put what writers had said about these concepts together in creative and varying ways. I was using them as the tools so to speak, the paint and paintbrushes, the notes and manuscript; but I was defining and changing the rules so that what was created was an artistic conglomeration of eclectic explanations and descriptions of what the writers had said about the identified concepts. I played with them, joined them together, wholly and partly, changed them, and modified them. Philosophically there may be some incongruity, but as I was the artist, the creator of the work, I took the licence to do this, creating a work of art. The process of playing with illustrations to help me to understand what writers were saying was part of this process.

'and the collaboration unfolded reciprocity' - Like the petals of a flower unfolding to become one of nature's works of art, this creative merging revealed an interchange between what other people had written and what I was creating. That is, this process
gave me insight and understanding as to what others were writing about (i.e. the concepts, etc.) which in turn gave me more insight and understanding as to how and what I was creating.

'The reciprocity produced in-tuning' - Through the process of reciprocity the key term of 'in-tuning' was identified. This term was taken from musical language where it means accurate correspondence of pitch and intonation or harmony (Hanks, 1979). The term clearly describes for me the process of how the experience of one person is in the process of being realised by another. It does not necessarily mean that the experience that is felt is identical, it may be but it is more likely to be at a different level. To explain, when music is in harmony there can be many notes, each of which include various layers of tones and pitch yet when put together the chord they make produces sound which is complete in itself, full-bodied, rich, euphonic and at various levels of wholeness from simple to complex. In the nursing relationship this occurs between the nurse and client where there is a harmonising of experience. That is 'and in-tuning composed harmony.' Composed is deliberately used to signal the continued use of musical language and artistic creativeness. The poem deliberately now uses more musical language to describe the artistic processes and outcomes of the experience, in a sense building up to a crescendo with the work's finale.
'The harmony sang a melody' - Through the in-tuning process there was experiencing of another’s experience. The development of the conceptual framework was starting to clearly take form and direction (that is singing in reference to the word sang), and a clear diagram or, in a musical sense, a manuscript was emerging. The developing melody (conceptual framework) was composed of an organised rhythmical sequence of concepts and their interrelationships with each other. All the melody or framework required was words.

'and the melody and story combined' - This statement is really future-focused providing the perceived next methodological step I needed to take. Having drafted the conceptual framework which came out of the story and thus the experience, the framework is to be layered over the story to see if it provides direction and explanation of the story, enabling others to capture and understand the original experience more closely how it was actually realised.

'The combining created a song' - Again this is future-focused on what was yet to occur. It was what I thought might happen. This merging of framework and story, melody and words, would become a song.

'and the song became 'The Moment of Caring.' - I assumed that the outcome of the layering of the framework over the story
and the analysis which would occur from this process would provide a clear framework for reflection on practice. 'The Moment of Caring' then is not only the name of the framework, it also describes the use of the model to explore and understand caring experiences in nursing practice.

In many ways, this poem and explanations were a preview or the grand musical score, of both the process and outcome of the thesis. Although I did not use the poem deliberately as framework for the process and outcome which emerged, and that which emerged did not precisely reflect or fit with my initial explanations about the poem, on reflection it was a composition that suggested that, through the process of to-ing and fro-ing between a nursing experience and thinking about the experience, drawing ideas and then writing to these ideas, something would emerge that was useful for reflection on practice.

Bridge

Having crystallised and articulated my ideas on how I viewed the metaparadigmatic concepts of health and person, I carried these articulations and understandings with me and immersed myself back into the original score, the 'Rudimentary Framework of The Caring Moment'. With the additional understanding and perspectives which these concepts gave me, I reflected on the rudimentary framework holding to the metaparadigmatic concepts as
underpinning assumptions and further developed my original ideas and added detailed notations. Emerging from this process, my ideas crystallised creating 'The Moment of Caring: A Conceptual Framework for Reflection on Nursing Practice'.

The Moment of Caring: A Conceptual Framework for Reflection on Nursing Practice

Phase One - Readiness to Co-Participate

'The Moment of Caring' begins with the two persons - nurse and client. Both are fulfilling expected health related giving-receiving roles as determined by the organisation in which they are contextually located. These roles may be very clearly defined. For example, the client may be a person who has some dysfunction in physiological function and who is admitted for treatment and monitoring of the problem e.g. a client with bacterial pneumonia. This person takes on the role which enables nurses, doctors, physiotherapists and other professionals to examine him/her, and modify his/her living in order to eradicate the bacteria which is causing a health problem. The nurse is a person who has had the necessary theoretical and practical education which entitles them to hold a licence to practice, and who is employed by an organisation because of this qualification to assist in the monitoring and treatment of the client with bacterial pneumonia within prescribed boundaries. These include assisting the client with maintaining normal activities of daily living, medication administration, and
monitoring of vital signs, as well as specific treatments, for example the wound care routine.

Both the nurse and client are giving-receiving cues with each other within the context of their environment. Their relationship is distant and they are relating as beings detached or apart from each other even though they are together in a particular context. What I refer to as a 'Relationship of Apartness' is derived from Buber's notions of I-It relating where the nurse and client view and experience each other as mere objects with specific characteristics or aspects (Arets & Slevin, 1995). The nurse and client are relating as external objects or as collections of material components on which they act, work with or manage rather than as person-to-person or being-to-being (Laffrey & Brouse, 1989, Meleis, 1991, O'Connor, 1993).

The nurse and client are represented by the two patterned circles which represent diagrammatically their individual meta-patterns of being (see Illustration 21, p. 94). The dotted lines surrounding the circles symbolise a holistic entity inseparable from the environment. Both are complete and distinct units yet are seeking wholeness in the three realms of Body, Mind and Spirit. Their relationship is professional and apart, and has the potential to develop into a moment where they can come together. Through the initial giving-receiving behaviours there is developing a readiness to co-participate in a potential moment where they come together.
The nurse expresses conscious cues to the client. These cues relate to the organisational roles of the nurse and reflect a level of knowledge and practice through specific behaviours i.e. smiling, verbal communication, conducting a physical assessment, implementing some treatment and generally reflect the realm of Body. The unconscious cues are those which the nurse is not aware he/she is doing. These may reflect the nurse's value system, professionalism, and aspects of the person through the way they do things. i.e. acceptance of the client, genuine interest in the client, an openness to listen and participate with the client, a non-judgmental attitude, as well as other cues whether originated from the realm of the Mind or Spirit.

The client also expresses conscious cues which reflect the organisationally assigned roles the client is playing and relate to specific behaviour related to their medical condition that is predominantly related to the realm of Body. Unconscious cues expressed are similar to those of the nurse but within the context of the organisational role of the client and may reflect values, beliefs, acceptance, interest etc.

Within the following illustration it is assumed that there are more conscious cues given by the nurse than by the client because of the nurse's specialised theoretical and practical preparation and that he/she is initially more receptive within the organisational context. This does not imply that the nurse is considered better than the client. All it refers to is that because of the nurse's education, he/she has a wider repertoire of skills and behaviours to draw on within the organisational context of the working environment, and that these comprise a
specific aspect of the nurse's meta-pattern of being. In the illustration, this is represented by the more obtuse angle formed by the lines representing conscious and unconscious cues for the nurse (see Illustration 21).

Illustration 21. Phase One - Readiness to Co-Participate

Phase Two - In Relationship

As the relationship develops the nurse opens self to the client and receives the client's self. Likewise the client opens self to the nurse and receives the nurse's self. Both the nurse and client express giving-receiving cues. Within my
framework this occurs when the nurse perceives and receives the conscious and unconscious cues from the client with his/her own behaviour guided by Watson's ten carative factors (1988). The client perceives predominantly conscious cues from the nurse demonstrated though the practice of the ten carative factors. As this occurs there is movement in their relating from one of apartness to one where there is a coming together of the two persons represented in the Phase Two illustration by the two circles coming closer together (see Illustration 22).

Kirby and Slevin's (1992, cited in Arets & Slevin, 1995) use of Buber's I-It and I-Thou relating within their theory provide the basis for describing the movement of the coming together of nurse and client. They propose that the nurse enters into a subjective relationship with the client where he/she connects and responds with the client in a non-reflective and non-judgmental way. The nurse also, however, has to move into the I-It way of relating in order to be able to objectively, reflectively, and judgmentally observe, assess and respond to the cares or needs of the client. This allows the nurse to then care and relate as I-Thou with compassion and sensitivity.

In regard to nursing Kirby and Slevin (1995) suggest that if nurses care for clients as un-holistic beings or as fragmented entities and clinical factors, then the relationship is that of I-It rather than I-Thou because the person is seen as a set of separated parts. This corresponds to Phase One of my model. They relate this to nurses who during moments of contact with clients, objectify and adhere to exclusively scientific and technological interventions essentially confining nursing to I-It relationships. They propose that the nursing relationship flows between the
I-It and I-Thou relationship. The I-It position is necessary to enable accurate assessment of a client's condition and assess appropriate use of technical nursing intervention; the I-Thou position is essential if the nurse is to journey with a client through the client's experiences and meaning of illness. They propound that "True excellence in the nursing relationship can be viewed as this capacity for movement between the I-It and I-Thou, of coming in to be and going out to see, as nursing proceeds with a majestic rhythm" (p. 66).

This coming together of giving-receiving behaviours signals the beginning of the process of 'in-tuning'. This term is directly taken from music and in this sense it means accurate correspondence of pitch and intonation or harmony (Hanks, 1979). In the giving-receiving process 'in-tuning' occurs. 'In-tuning' is when the experience of one person is in the process of being realised by another. They become 'in-tune' to each other.

I use the terms 'in-tuning' and 'in-tune' because they describe the phenomenon and process of the two persons coming together and experiencing each other in the best possible way. Being 'in-tune' does not necessary mean that the experience that is felt is identical, it may be, but is more likely to be at a different level. When music is in harmony, there can be many notes each of which include various layers of tones and pitch yet when put together the chord they make produces sound which is complete in itself, full-bodied, rich, euphonic and at various levels of wholeness from simple to complex. In the nursing relationship this occurs between the nurse and client, where there is a harmonising of
experience into a melodious symphony through the giving-receiving process (see Illustration 22).

**PHASE TWO**

*In relationship*

*(Moving from apartness to oneness)*

Illustration 22. Phase Two - In Relationship

**Phase Three - The Moment of Caring**

This occurs when the 'in-tuning' process is complete. Both nurse and client have come together, transcended their detached way of relating and have in a very real sense come together as one in a moment in time. They are 'in-tune'. This is the
moment of caring where there is a full realisation of the client's subjective experience/emotion by the nurse, the nurse then expresses these feelings in a way that enables the client to experience their original feelings and the meanings contained within them more deeply, more richly, more fully and more harmoniously. Through this process there is merging of the nurse's and the client's meta-patterns of being. The merging of the two meta-patterns of being of both nurse and client in the moment of caring through the process of in-tuning results in increasing diversity and complexity of meaning and understanding of experience (wholeness) (see Illustration 23).

**PHASE THREE**

*The Moment of Caring*

*(Relationship of oneness)*

In the caring moment, the nurse expresses feelings in a way that allows the client to experience the original feelings more deeply more richly and more fully, with more understanding and meaning attached to them. This results in growth of both client and nurse into a more complex level of wholeness (represented by the arrows showing expanding boundaries of conscious and unconscious cues for the client and use of carative factors for the nurse. The cues and carative factors reflect a person's being in the nursing caring moment.

Illustration 23. Phase Three - The Moment of Caring
Phase Four - Redefining Wholeness

During 'The Moment of Caring' both the nurse and client have deeper understanding and richer meaning of experience at a further level of complexity than was first experienced. Thus 'The Moment of Caring' has produced 'becoming whole' as process and 'wholeness' as outcome. As process, 'The Moment of Caring' enables the process of increasing complexity of meaning and understanding of experience to occur, and as outcome, meaning and understanding of experience become more complex and diverse through the shared connectedness of harmonising of an experience at a particular location and place in time.

The process of 'becoming whole' is dynamic and continual and therefore the understanding and meaning of experience change and take on different perspectives for both the nurse and client. It is because of this dynamism that the relationship of oneness moves toward one of apartness. The relationship that began as one of apartness and which progressed to a relationship of oneness through the merging of the nurse's and client's meta-patterns of being through the 'in-tuning' process, now moves to another level of apartness different from where the relationship had originally started. This occurs in direct response to the increasing diversity and complexity of meaning and understanding of the experience of each person. Increasing diversity and complexity of meaning and understanding is not predetermined, and it is therefore wrong to assume that it occurs in a uniform and predictable way and that the unfolding of meaning and understanding occurs in the same ways for all persons involved. The moment of
caring by nature of its occurrence augments the change in the nurse-client relationship from oneness to apartness.

As 'The Moment of Caring' comes to a conclusion, both the nurse and client have deeper understanding and richer meaning of experience at a level of complexity and diversity greater than was first experienced. They commence to leave the moment, carrying the initial shared understanding and meaning of the shared connectedness with them. As each person's wholeness becomes more diverse and complex, it occurs in unique ways. Because each person's wholeness is now increasing in individual ways, meaning and understanding that began through shared connectedness now evolves along its own trajectory, the initial shared connectedness being influenced by and influencing the person's past, present and imagined possibilities, and meaning and understanding continues to change. Therefore the nurse and client also carry with them their own emerging wholeness trajectories birthed in 'The Moment of Caring'.

Because of these processes wholeness is changing and being redefined. This results in change in the individual's meta-patterns of being which is reflected by specific conscious and unconscious giving-receiving behaviours. In the following illustration, shared connectedness of experience is represented by shared patterning, and the individual's evolving wholeness trajectory by new and different patterning (see Illustration 24).
PHASE FOUR

Redefining Wholeness

(relationship moving from oneness to apartness)

As the moment of caring concludes, both nurse and client have deeper understanding and meaning of the subjective emotion and experience than before thus their wholeness is more complete and detailed. Wholeness has occurred as outcome, in that both nurse and client carry with them shared understanding and meaning of the Moment of Caring. The process of becoming whole continues as each person's wholeness trajectory continues to evolve.

Illustration 24. Phase Four - Redefining Wholeness

Phase Five - Complete and More Deeply Whole

The focus of the nurse-client relationship moves from oneness which occurred through 'The Moment of Caring', to one of apartness as the processes of 'becoming whole' continue to evolve and diversify. Both nurse and client are complete, distinct entities in constant interaction with their environment but they
are changed and are changing. Their patterning and experience of wholeness is more complex. They again move to a more distant way of relating and take up the organisationally prescribed roles of nurse and client reflected in their giving-receiving behaviours. These roles and behaviours are the same as those described in Phase One (Readiness to Co-participate) of the framework. Phase Five and Phase One are in fact parts of the same phase viewed from different perspectives within the framework, one viewed from the beginning of the process of relationship and the other from the conclusion. I have also identified them as two separate phases to distinguish that wholeness, meaning and understanding of experience in each phase is at a different level. The transition for the nurse and client from Phase Five to Phase One occurs as the focus of the process of relationship shifts from one of conclusion to one of beginning. They continue to fulfil the organisationally prescribed roles until further expression of emotion occurs and there is again a new coming together, only this time, they bring with them the new patterning of shared experience into the relationship. This whole circular process I refer to as the art of nursing (see Illustration 25).
PHASE FIVE - [PHASE ONE]

Complete and more deeply whole
Awaiting next caring moment to become even more whole
[Fulfilling expected health related giving-receiving roles
Readiness to Co-participate]

(Relationship of apartness)

Nurse

Client

Illustration 25. Phase Five - Complete and More Deeply Whole

Illustration 26 represents the perceived cyclical nature of 'The Moment of Caring' with the potential for progressing from one moment of caring to another.
Illustration 26. The Moment of Caring Framework
Re-layering the Framework back onto Phillip's Story - A self-analysis

Illustration 27. Re-layering the Framework onto Phillip's Story - Andantino

(Andantino - At a moderate pace but not as slow as andante)

Bridge

After being inspired by my thoughts about to-ing and fro-ing between my ideas and the story, I decided to see whether what I had written regarding the nurse-client relationship as diagrammatically represented by the intersecting circles actually fitted with what occurred within the story. It was as though I had added the notes and accidentals to the initial score with my explanation but now I needed to add the depth, the orchestral parts. To add the depth I decided to re-layer the developing framework and my ideas over Phillip's Story. Prior to this re-layering process I felt I first needed to provide some background information regarding Phillip's and my encounter in order to contextually locate the story.
Setting the Scene - Locating the Story

Relevant Personal Nursing Background

I registered in New Zealand as a General and Obstetric Nurse through a three year hospital based nursing programme. When I met Phillip I had completed five years post-registration experience. This experience included thirteen months acute medical nursing, twenty-two months coronary care nursing, seventeen months as a Primary Health Care Practitioner in a remote bush clinic in Ghana, and sixteen months working for the New Zealand Justice Department in one of their prisons as a Registered Nurse.

During this time I completed two post-registration certificated courses through the then Area Health Board - Advanced Medical Nursing Certificate and Coronary Care Nursing Certificate. I had no significant post-registration surgical nursing experience but was employed on a casual basis by the local hospital nursing bureau which exposed me to more acute surgical nursing experience.

During the time that Phillip and I met, I was also completing my undergraduate nursing degree. As part of a nursing practice paper I was completing, I worked one day a week in the intensive care unit as a registered nurse student and this experience exposed me to major trauma and surgical nursing. Additionally I often worked in the intensive care unit for the nursing bureau on a casual basis.
I did not particularly like working with children because my pre-registration hospital paediatric experience was comprised predominantly of caring for children with varying degrees of burns, an experience I found rather negative. My experience in Ghana involved caring for severely malnourished children where there were language difficulties, cultural differences, and limited resources. These challenges affected priorities in the provision of care and the nursing decisions I had to make when caring for these children and their families.

**The Day of Meeting Phillip**

The day I met Phillip I was employed as an experienced registered nurse on a Friday afternoon shift (1430-2300 hours) by the hospital's nursing bureau. My key areas of responsibility as addressed in my job description were: providing nursing care using knowledge and skills from nursing theory, physical and behavioural sciences; interacting effectively with health care consumers, family members and health team members; undertaking teaching and learning activities with health care consumers and colleagues; demonstrating individual responsibility and maintaining accountability in nursing practice; and demonstrating effective management skills in nursing practice and within the health care team (Auckland Area Health Board, 1992).

I was not one of the regular staff working on the paediatric ward and I was an unfamiliar face to the staff and to the children. My skills and knowledge were unknown to them. I was unfamiliar with the particular ward's daily routine but
familiar with the general afternoon shift routine and the ward layout. Although I had trained at the hospital, this was one ward I had never been to as a student and my memory of the ward from what other students had told me about their experiences there was rather negative. Being new meant I initially had a lot of questions to ask particularly in regard to where equipment was stored, the normal ward protocols and ward routines. Apart from the medical staff there were no men working as nurses on the ward either full-time or part-time. I wore a white uniform - white shirt, white trousers, white shoes, and name badge.

In regard to nursing practice, I believe I had well developed assessment skills, good therapeutic communication skills, that I could liaise effectively with other members in the health care team, that I had a significant amount and variety of personal and nursing experiences to draw on, and that I provided safe, professional, personal care to a high standard.

Employing the Novice to Expert framework postulated by Benner (1984), I believed I was a proficient nurse in caring for adult clients in acute medical nursing and coronary care nursing environments. I believed some of this knowledge was transferable to the paediatric area, for example knowledge about medical/cardiovascular problems, management and care of medical/cardiovascular problems and assessment skills. I did not, however, have significant knowledge of surgery (particularly involving children), care of children following surgery, current developmental theories, and basic care of hospitalised children. In this respect I felt I was very much between levels one and two on Benner's model - between a beginner and advanced beginner.
On the afternoon shift I was allocated seven children to care for. Their rooms were located at the far end of the ward furthest away from the nurses' office. All the children were stable either having uncomplicated recovery from surgery a number of days earlier or were being prepared to go home. There was discharge management to organise, medication administration, assessment of vital signs, wound assessment and management/dressing, assistance with meals including help with feeding, assistance with hygiene, elimination and comfort needs, skin assessment and appropriate management for children on bed rest, answering questions from parents/guardians and the children, reading stories, playing with the children, talking and general socialisation. The children were between the ages of six and ten. I also was available to assist other staff as they required.

**Knowledge of Phillip**

The afternoon hand-over that I had received from the morning staff addressed significant information about each of the children in the ward and I made appropriate notes. Following the hand-over my normal routine was to read the integrated notes of the clients I was caring for, check their drug and recording charts, introduce myself and do a brief client assessment as appropriate, checking wounds, drains, redivac bottles, intravenous infusions, luers, catheter bags, mood, etc.
I remembered the hand-over nurse's account of what had happened to Phillip that morning, particularly how his wound had continued to bleed, that the redivac drains were removed, my not knowing the rationale for their removal and wanting to know what assessment findings had been the basis for their removal, questioning in my head had they checked the suction, was the tubing blocked, and thinking 'What's going on here? Something's not right!'

I also remembered the nurse clearly describing how Phillip screamed and yelled when he was turned to have his wound redressed, and her description of him being uncooperative and making the redressing of his wound more difficult for the nurses to complete. I was asked by the afternoon staff caring for Phillip if I could help them when they redressed Phillip's wound later on that evening which I agreed to do.

Throughout the afternoon duty I was aware that Phillip's wound had continued to bleed, that there was a large collection of blood forming under the transparent dressing covering his wound, and that his haemoglobin was falling. I was also aware that he had further blood samples taken and was diagnosed as having a bleeding and clotting disorder for which the medical staff gave clotting factor in an attempt to promote haemostasis. Concern was expressed regarding the bleeding that was occurring in Phillip's hip joint and I remember feeling that there was a sense of heightened anxiety and 'uneasy calm' among the nursing and medical staff in regard to Phillip.
My Perception of Phillip's Background

His Medical History

Phillip was a five year old boy who had been admitted with a medical diagnosis of osteomyelitis of his left hip. He had been in hospital for a number of days and had required surgery to drain his wound. He had two redivac drains inserted to further help with wound drainage. This was Phillip's first hospitalisation and he had no previous known medical problems. His parents (mother more than father) spent some time with him each day but work and family commitments made this at times problematic. He was in a four bedded room with an infant and two other children. He had a television on his bedside locker, some favourite books and toys with him, there were numerous get well cards on the wall at the head of his bed and some snack food on his locker. His bed was by the window and if he pulled himself up by using the lifting bar he could see outside to a flowering garden and grassed area.

Phillip had experienced numerous interactions with nurses, doctors, and other members of the health team since his admission. These meetings had usually involved a number of painful interventions including general physical examinations, examination of his wound, x-rays of his hip, laboratory blood tests, insertion of intravenous cannulae, administration of intravenous antibiotics, intramuscular injections, wound dressings, intervention for problems with bowel elimination because of the location of his wound and bed-rest, and difficulty in turning and changing position.
The Day of Meeting Maurice

Phillip's mother had been with him during the morning but was not able to come in again until that evening. He had no other family support with him for most of the day. Phillip's wound had bled continuously since surgery the preceding day to drain the wound, and he had returned to surgery to have the redivac drains removed. Following their removal his wound continued to bleed throughout the day. Phillip was lying on a disposable drainage sheet and I perceived him to be in pain which was exacerbated by movement.

Phillip had already had his wound redressed once that day and this procedure had been perceived by the nursing staff as being very painful. He was also having to be restrained while health staff were carrying invasive and painful procedures. He had further examinations by doctors, numerous blood tests, was receiving care from a primary nurse and an enrolled nurse who were working the afternoon shift, and had his vital signs frequently measured and recorded. He was receiving oral analgesia and intravenous antibiotics. Phillip was waiting for his mother to return later that evening and he had not been told that his wound would need redressing sometime during the afternoon.
Phillip's Knowledge of Maurice

Phillip had little knowledge of who I was. My perception was that he viewed me as someone in white called a nurse, who represented to him everything that nurses had done or did for him during his hospitalisation. I was also someone whom he had never met before.

Bridge

Having reflected on my perceptions of what Phillip and I were bringing to our encounter and crystallising these thoughts to contextually locate the story, I once again immersed myself back into the story with the contextual perceptions and re-layered the conceptual framework over the story. The conceptual framework was the articulation of what I considered to be occurring within the caring moment from an abstract perspective, and I used the framework as a guide for reflecting on my nursing practice as represented by Phillip's Story. This created a dance or dialogue between abstraction and practice, where the framework - created out of processes of immersion, reflection and crystallisation - became a tool which I used to guide further reflection and understanding of what was occurring between the nurse and client within Phillip's Story. Using the framework as instrument, I immersed myself in the story, and reflected and explored the meaning of nursing practice embedded in the story in order to develop a deeper and richer understanding of what occurred between the nurse and client.
It makes sense now that there would be some congruency between the story and the framework because the framework came out of the story. I suspected that there would be clear linkages but because I had deliberately chosen not to focus on the detail of the story with my initial thoughts, I wanted to answer the question 'Is what I have articulated what is really going on?'

Phase One - Readiness to Co-participate: Fulfilling Expected Health Related Giving-Receiving Roles - A Relationship of Apartness

By the time Phillip and I met, we both brought with us a considerable amount of knowledge which impacted on our meeting and understanding of our experience. The background knowledge listed previously, though not exhaustive, does highlight important aspects of both our 'beings' that we were bringing. I was in the global role of the registered nurse and fulfilling those requirements expected of me by the institution. Phillip's global role was that of being the sick client. He was viewed as having something biophysically wrong which needed correcting. He had a medical diagnosis and was receiving medical intervention, some of which was delegated to the nursing staff, for example administration of intravenous antibiotics. Nurses' practice was based around the medical diagnosis and fulfilling the organisation's expectation to assist other members of the health care team with Phillip's treatment, care and management.

These broad roles are what I would call the beginning component of Phase One. 'Readiness to Co-participate' therefore begins to occur when there is a
meeting of the nurse-being and the client-being. 'Being' in this sense is used to describe the holistic nurse and holistic client, each a complete entity comprised of the three realms. I perceive that the histories which Phillip and I were bringing with us and the knowledge we had of each other comprised the beginning of Phase One. We were in fact meeting, in that each had an encounter with the other; that is, there was an awareness of the other's existence and reason for being at an institutional level, and by acknowledging this, there was a coming together of two beings. The basis of this relationship at this stage was from other individuals' documented and actual narrative (nurses, doctors, other health professionals).

I suggest that many meetings between clients and nurses occur and end at this level. Many nurses and clients are aware of, and meet, the other either as: a brief visual identity which resembles what clients may assume nurses to look like, or the nurse briefly knowing who the client is and what they look like; an audible representation as clients hear other nurses or health professionals refer to a nurse by name, or the clients may in fact hear the nurses voice; or (for nurses especially) they may meet the client as a collection of words written down from the nurses' hand-over and from medical notes.

For Phase One to proceed, there needs to be a moving on from these initial and somewhat distant encounters to a physical coming together of nurse and client where they actually meet at a certain place and at a certain time. Readiness to Co-participate then is said to have occurred when there is a physical meeting of nurse and client as being-to-being at a particular point in time where each has some knowledge of the other as either nurse or client.
Phase One became realised when the initial physical encounter began between Phillip and myself. From my perspective I was thinking about Phillip as a collection of specific characteristics which needed acting on or managing. Phillip's care was dictated by a medical view of health, a medical diagnosis and a medical view of treatment. The ward functioned and the care and treatment of clients generally pivoted around the medical view of the world.

"I found out which room Phillip was in and introduced myself to him.

'Hi. I'm Maurice, one of the nurses who is on this afternoon.'

He asked."

This introduction indicates that Phase One - Readiness to Co-participate is in process. The event which precipitated our meeting was that the nursing staff
caring for Phillip required assistance with redressing his wound. This intervention based on medical treatment initiated a need for Phillip and I to meet. We were both fulfilling our expected roles, I as nurse and Phillip as client, providing each other with conscious and unconscious cues.

My cues included initiating conversations and introducing myself to Phillip as Maurice the person and as Maurice the nurse who was one of the staff working that afternoon. I smiled when I introduced myself and kept focused eye contact with Phillip while doing the brief scan of Phillip and his space in the room, assessing the environment and his health status in the process. I was a tall figure, someone Phillip had to look up to. I was also dressed in a white uniform with a watch, medal, name badge and red epaulettes representing the hospital's traditional view of a nurse. On reflection, unconscious cues would have been those giving-receiving behaviours I was unaware of and these included my facial responses, the use of my body position and body language, and my physical distance from Phillip.

For Phillip I believe the conscious cues included listening and responding to my introduction, eye contact with me throughout our initial exchange of dialogue, lying in bed and receiving intravenous fluids. By asking the question 'Why are you here?' I sensed that he had received me as nurse, that he had some expectation of what nurses do and that I was there to do something either with him, for him, or to him. From the way he asked the question, the volume, tone, pitch and meter of his response, I sensed that he saw this 'acting on' or 'doing for' as unpleasant, undesirable and one that he had little control over. This was likely to have been a
purely unconscious response which I received and processed. Further cues were revealed by both Phillip and myself when ...

"The other nurse piped up,

"We are going to have to turn you Phillip and Maurice is here to help."

My description of Phillip's response to the nurse's comment revealed the various cues he was sending.

"His eyes were incredible. They became saucers in seconds. He looked at the nurse and then at me. His face became flushed and he shook his head. His hands started grabbing at the bed and then came around him as if to somehow protect himself from an approaching threat."
he cried.

He started to sob.

'Well you can't lie there with that blood like that, and in that position. We have to turn you.'"

The unconscious cues I read from Phillip's reaction included his dilated pupils and the opening of his eyes as wide as they would go, his flushed face, shaking of his head, his grabbing hand actions and them moving to encircle his body. These I interpreted as manifestations of the fight/flight response to perceived threats; that of pain, discomfort and lack of control. His cry of "No, no it hurts" I took as a conscious cue, a conscious action again putting words to thoughts and feelings although the tone, pitch, meter and volume of his response were most probably unconscious. I regarded the sobbing as an unconscious cue expressing his unhappiness at what he knew was going to happen, his lack of control over the events and his fear of pain. I believe that Phillip also would have
read my response to the nurse's reply, thus revealing more of who I was. These responses were predominantly unconscious at this stage and related to body posture, body language and facial expression. The main conscious cue I gave was keeping quiet. I remember thinking that I didn't know what to say so I chose not to say anything.

Consciously the nurse's reply also added more rationale and meaning to my initial introduction and supported Phillip's preconceived notion that I was there to do something either with, for, or to him. It added further meaning to Phillip's interpretation of why I was there. This was made even clearer to Phillip with the nurse's second reply. This clearly told Phillip that he was going to have to change his position and that I was included as one of the nurses who was going to have to turn him and cause him discomfort and pain. It also implied that he had no choice about what was going to happen. No matter what Phillip felt or said, his dressing still needed to be changed.

"I looked into his eyes as if to convey some sympathy and compassion, but all that shone back were these dilated eyes of a wild cornered beast."
He pleaded with the other nurse.

'It's got to be done,'

was all she would say."

The unconscious cues included moving closer to Phillip and conveying sympathy and compassion with my presence. The major conscious cue was looking into his eyes with an open and relaxed facial expression. My mind was wanting to convey to him sympathy and compassion. Either I was not expressing my behaviours clearly enough or Phillip was not receiving them. His eyes reflected the unconscious responses (automatic) related to the fight/flight mechanism. Phillip's pleading for the wound to be left alone I perceived initially as an accumulation of unconscious responses expressed in a conscious way. The other nurse's response provided other cues for Phillip about what was going to happen. Though I did not speak, I was included in the other nurse's voice as I had already been introduced as someone who was going to act on Phillip in some way and therefore was someone else who would say 'It's got to be done'. The silence
that followed seemed to summarise the fact that the change of dressing was in fact a fait accompli. Phillip had no choice.

"I just stood by the head of his bed looking at Phillip, this scared, young, helpless boy in his bed. What could I do? In the five minutes I had been with him he had transformed into a trapped animal. He didn't know me or anything about me. I was just another stranger that represented pain to him. He started to cry and yell even before we touched him.

MumMogg. I want my MumMogg!

The cues he provided here I see as mainly unconscious. He was a small boy, he was young, his behaviour demonstrated fear and a lack of control. I don't remember what Phillip actually did at this point in time and what cues he expressed. What I do remember however is my perception and understanding of what was happening, and this memory is represented by what I had seen on television when wild animals have been caught and caged. One minute the animal
is roaming free, existing in its own familiar world having at least some control over its present life experience, only then to be chased, cornered, muzzled, and then confined in a place where it has no control or freedom.

My comments that 'He didn't know me or anything about me' and that 'I was just another stranger that represented pain to him' reflected not only the personal conflict that was going on in my mind regarding my involvement in the situation but also my perception of how Phillip was viewing me. The first statement is both false and true. False because he in fact knew a lot about me. He knew my name, my occupation and that I was going to do something to him. He had also started to know me as a person, perceiving my responses, reactions and behaviour. It is also true, however because there was so much about me he didn't know, particularly in regard to Maurice the person.

The second comment in some ways contradicts the first statement. At one point I say that he doesn't know anything about me and then I say what he does know about me, that I was a stranger and that because of the cues he had received from the other nurse and those that I was giving particularly in regard to my dress and because of his memory of previous experience, he knew that I would somehow be associated with pain. This contradiction demonstrates the difficulty I was having in coming to terms with what was happening and trying to make sense of. The comment also reflects the tension going on in my mind regarding what was happening and what was about to happen, namely, 'How can you expect him to trust you when he doesn't know you and when you're going to hurt him?'
In one way, I sensed I was realising Henderson's notion of getting under the skin of the other and trying to understand and experience it as client (1966).

To me, Phillip's cues of crying and yelling were a mixture of both unconscious and conscious cues which culminated in a cry for protection, love, stability and nurture. I find his cry for his mother interesting. In a real sense it is quite understandable that a child calls out to and for a figure of stability and protection when they are threatened. His comment adds more realism to my memory of him being trapped and confined. Yet it also highlights an interesting sense of unease in that although nursing has its roots in mothering and nurture, here was a nursing experience which I believe was perceived by a client as antithetical to nursing's tradition. Who could Phillip trust? He wanted his mother but she wasn't there, only the nurses.

My perception of this portion of Phillip's and my meeting signalled the initial movement and beginnings of Phase Two of the framework because through all the cues and consequent thinking that was occurring, I was starting to move towards experiencing and understanding what it may have been like for Phillip.

"At this point an enrolled nurse who was also working the afternoon shift came in to help and we were about to roll Phillip over."
This sentence introduces the fourth person, the enrolled nurse who assisted with the dressing. The sentence indicates that Phillip's primary nurse had prepared the necessary equipment for Phillip's wound dressing and that we were ready to turn Phillip so the dressing could be done. Preparation of the dressing equipment had occurred in the time following my initial introduction with Phillip. On reflection, this occurred in Phillip's room and this would have provided very conscious cues to him as to what was about to happen and what he was likely to experience. Not only did he hear what his primary nurse was saying but he was also watching her preparing for the procedure. The statement also implies that acting on Phillip was about to happen, and I see this as important because it required a response from me that moved Phillip's and my relationship clearly into Phase Two of the framework.
Phase Two - In Relationship: Moving from Apartness to Oneness

"I held his hand leaving one hand free and said,

'It'll be okay Phillip. I wish I could say it's not going to hurt but it's going to, and I know you won't like it.'"

The deliberate action of holding one of Phillip's hands (a conscious cue) was in response to his cue (perceived as also conscious) of reaching out to me. He initiated this movement in our relationship and I responded. I regarded his action as an intentional act of seeking help and one in which he was opening more of himself to me. I hoped that my response of holding his hand was saying to him that I received him as Phillip the person, the small boy who was frightened, who was experiencing pain, and who needed someone to trust, protect and be there for him, in many ways being a surrogate parent.

Our relationship at this point moved from perceiving each other predominantly as a collection of fragmented entities and clinical factors (what I consider was happening during Phase One of the framework) (Kirby & Slevin, 1995), through a rhythmical transition where we were beginning to view each other and relate more as being-to-being, that is the holistic relating of the three realms of who Phillip was with the three realms of who I was.
Leaving one hand free was again a deliberate action to convey that Phillip still had choice and control. The words I offered were conscious cues. Their volume, tone, pitch and meter probably reflected more unconscious cues, particularly about myself as a person. They were truthful and reflected not only my understanding of what was about to happen to him, but also my perception of how he would respond, as well as something more of who I was as a person and a willingness to be there for him.

From a nursing philosophy perspective, Watson's ten carative factors (1988) clearly influenced my actions, words and meaning behind what I was doing. Rather than taking the ten carative factors as purely directive and as clear prescriptions for practice, I have used them more in a philosophical sense to guide my thinking about nursing, to ask and explore the critical issues relating to my clients' experiences in the health and nursing contexts, and also to provide a frame of reference from which I identify my positioning in regard to where I come from and how I am in my day to day practice as a nurse. It may be argued that in fact I am using her framework more prescriptively than I acknowledge if my reflection and analysis of my nursing care is directly based on her carative notions, and at one level I admit that this may be true. However rather than using the carative factors merely as directional and instructional, they provide a philosophical grounding to the way I view nursing, reflect, explore, examine, and develop nursing, which must influence the day to day practice of the how of my nursing, that is the nursing care I provide for my clients. Furthermore, I have viewed the carative factors as being interdependent and relational, collectively guiding nursing care and the practice of nursing. They don't occur in isolation although I
perceive that some may be more prominent than others in some nursing
happenings. The story reflects the nursing care which occurred between Phillip
and myself, and thus the narrative reflects various carative factors which have
clearly influenced my practice. Particularly in Phase Two of the framework these
factors include the instillation of faith and hope, the cultivation of sensitivity to
one’s self and to others, the development of a helping-trusting relationship, the
promotion and acceptance of the expression of positive and negative feelings, the
provision for a supportive, protective, and (or) corrective mental, physical,
socio-cultural, and spiritual environment, and assistance with the gratification of
human needs (Watson, 1988).

The holding of the hands and this initial dialogue also signals clearly that
the process of ‘in-tuning’ was beginning. Throughout Phase One both Phillip and I
had responded to the giving-receiving behaviours and now in Phase Two, these
cues began to provide more insight and understanding about what was being
experienced. There was the beginning of an alignment between both our
experiences.

The dialogue and actions which followed Phillip’s reaching out to me
demonstrate the development of our relationship and reflect the ‘in-tuning’
process where there is a coming together and an experiencing of each other in a
greater way. And just as harmony in musical chords consists of layers of tones,
volumes, and notes, the experiencing of the other in the ‘in-tuning’ process can
occur at various layers within the three realms.
"He looked at me, conscious of what the other two nurses were doing down by his hip.

'Phillip, when it hurts hold onto me. I won't let you go, and when it gets really sore you can hold onto me as tight as you want to. I'll be here. It's going to hurt but I will help you.'"

Phillip deliberately looked at me (conscious cue) in response to me holding his hand and my dialogue with him. He was also very conscious of what the other nurses were doing. This probably created some tension for him. On the one hand the nurses were being very active near his leg with preparing the environment for the dressing, and on the other I was there talking to him, focusing on him and what he needed. His action of looking at me I see as progression and development of the 'in-tuning' process. I offered myself as someone to be there just for him and who wouldn't go away. Our focal relating reflected more of the movement occurring during 'in-tuning'. I explained to him what was likely to happen and gave him permission to use my help on his terms, giving in him choice and with it a degree of control.

As the process of 'in-tuning' occurs the unconscious and conscious cues become less distinguishable as separate giving-receiving behaviours and become more unified. This is not surprising when my notions of the Relationship of Apartness moving to the Relationship of Oneness are derived from Buber's
concepts of I-It and I-Thou relating (1958). According to Buber, if an individual is regarded as an object with specific characteristics, then they are being viewed as I-It because the relationship occurs with the person being considered apart from them. When there is a joining to the other as whole-person to whole-person then I-Thou relating occurs. If however in the process of moving from I-It to I-Thou relating we objectify the other in any way, we move back to relating as I-It. Kirby and Slevin (1992, cited in Arets & Slevin, 1995) comment on this and assert that when an individual (the I) begins to think about the other (the Thou) in regards to prior knowledge about the individual, they are objectified and in so doing, relating moves back to I-It. Holding to this notion that objectifying indicates I-It relating, I contend that if the giving-receiving behaviours during Phase Two are viewed as either conscious or unconscious cues, then we are in fact in a process of objectifying them and therefore are not viewing the relationship as I-Thou.

In the diagrammatic representation of Phase Two the cues are indicated as conscious and unconscious merely to illustrate that they both occur. As 'in-tuning' proceeds these cues become merged and unified. In Illustration 22 (p. 97), I have also stated that the client predominantly perceives conscious cues from the nurse reflected in the demonstration of the ten carative factors. At the beginning of Phase Two and the beginning of the process of 'in-tuning' this is true. However as the relating becomes more 'in-tuned', the distinction between conscious and unconscious cues becomes less clear, itself an indicator that 'in-tuning' is occurring.
"He seemed to relax a little, eyeing me up and down, not too sure of who I was and what I was doing. And then the other nurse touched his leg.

Phillip screamed.

Phillip physically appeared to relax. He slumped a little in the bed, and he relaxed his grip on my hand and I responded likewise. I consciously tried to keep eye contact with him. His way of looking me up and down seemed to do two things. Firstly, I sensed it gave him some control and an active part to play in what was happening with and to him, and secondly, it gave him space to breathe, look me over and try to make sense of what was going on.

The touch on his leg seemed the crescendoed conclusion which realised all his potential fears about what was going to happen to him. It seemed to shock both Phillip's and my relating back to a more physical reality, the reminder of
what we were about to do thus objectifying our relating together. This however
was only momentary. Phillip's scream seemed to me to be both a voluntary and
involuntary response. It is interesting to note that the nurse who touched Phillip's
leg did not tell him what she was about to do. I have often wondered what would
have been Phillip's response if he had been prepared for her intervention. And yet
in another way, the touch was purposeful in that it reminded me that we were not
only having to do a painful procedure to Phillip, but also that his fear of pain was
painful in itself and that this would have huge influence on how the dressing
would actually be carried out. When he yelled 'No' he also involuntarily gripped
my hand again and physically stiffened.

"I held his hand and spoke to him in a kind and quiet yet confident
way.

'Hold onto me ............ hold me as tight as
you want to or can ............ you're doing
great ............ I know it hurts but I am here
for you.'

The nurses counted to three and we turned."

I returned Phillip's grip and held his hand firmly. I leaned towards him to
portray a sense of protection. I maintained eye contact and used my voice to try
and help him. My words were focused at Phillip and for Phillip, and were aimed at giving him choice and control, were truthful, acknowledged his pain but also encouraged him as well. By returning his grip the process of 'in-tuning' seemed to restart again. We became focused on each other and the giving-receiving behaviours became more unified.

I had placed my free hand behind his back for support because I was also assisting with the turn. The counting to three by the other nurses indicated to both Phillip and I that we were about to turn him, and again seemed to me to objectify our relating because it reminded me why I was there, what was wrong with Phillip and what I was doing to assist him.

"'Hold me tight Phillip .......... I'm right here.'"

He gripped my arm and shirt so tight and wouldn't take his eyes off mine. I could see the hurt in his eyes and the pain on his face but he still looked into my eyes.

'I know it's hurting and wish I could make it stop ....' "
As had occurred when the nurse touched Phillip's leg, the turn also seemed to me to stop the 'in-tuning' process between Phillip and myself. However my initial words for Phillip appeared to restart the process of 'in-tuning' and I wonder whether he had remained open to receiving me throughout the whole turning process. We became focused on each other and the giving-receiving behaviours became more unified. After I had spoken, Phillip responded by gripping my shirt and arm very tightly and he maintained very determined eye contact with me. It was though he was taking me up on my previous offer of being available just for him on his terms, with him choosing and controlling what he wanted or needed from me.

I saw myself somewhat as an anchor for him as he was journeying through a violent storm; strong, dependable, a source of security, safety and stability. Even though his eyes and face reflected pain (unconscious and conscious cues), he held eye contact. It seemed as though he now knew that I was there for him and he was trusting my being to help his being.

I verbally acknowledged his pain and added that I wished I could make it stop. I see this statement as significant because it not only signalled further movement on my part to how we were relating to each other but clearly showed that 'in-tuning' was occurring. What had started off with me offering myself and my help to Phillip and with him accepting my offer, now lead to me responding in a way that reflected a deeper commitment to Phillip's experience, with me wanting to stop his pain and make the situation satisfactory for him if that was at all possible. On reflection, from my perspective it seemed as though our relating
had changed from one of apartness to a developing relationship of oneness. We were becoming 'in-tune'. Even when the nurse interrupted our meeting by explaining that she had given analgesia to Phillip, our relating was at a point that it didn't impact significantly on how we were relating to the extent that the touch on the leg and the count to three had done. I continued to acknowledge his pain, encourage him and be available to help him in any way possible.

"I was interrupted,

'I have given him some paracetamol,'

bellowed this seemingly thunderous voice from one of the other nurses.

I continued,

'......... but you are doing really well. When you feel it hurting too much, just hold onto me and it will soon be gone.'"

Phillip's and my relating by this time had become very close. It seemed to me that we had moved beyond just viewing each other as either nurse or client, to one where we were relating more as person-to-person. The relating transcended
from being apart, to a relationship where it seemed that each was an extension of
the other where we both seemed to move and flow uniformly as one; very much
like two ice skaters performing a single togethersed creative performance.

At this point the dressing and bed linen were changed and followed normal
procedural steps. Phillip didn't cry, complain or cause problems. It was as though
the actual dressing change wasn't causing him fear or pain at all. The fear of
having to be turned in order to do the dressing seemed to be the major stressor for
Phillip. I included Phillip in the dressing procedure, showed him what the nurses
were doing and explained it as best I could to a five year old boy. He even
showed interest by expressing his concern about the sutures and that the nurses
needed to be careful when cleaning around them.

"We had him on his side with me still holding his hand and him
holding my arm. We did his dressing and changed his sheets. As
the other nurses were dressing Phillip's wound, I showed Phillip
what they were doing and he watched as the old dressing came off
and the wound was cleaned.

He said,
and the stitches were dutifully watched out for. He then became
dverted by the cartoons that were on the television and we had a
bit of a talk about them."

Once he was sure that he had been heard and that the nurses had done what
he had told them to do, his focus moved to the cartoons that were playing on
television. Phillip and I had a brief conversation about the cartoons but it was as
though this was a personal space for him to be who he was, and where any further
attempt to communicate through conversation would objectify our relating.

I did not perceive the silence or the completion of the dressing as
interrupting the 'in-tuning' process as had occurred previously when the nurse
touched Phillip's leg and when we turned him. It is only through reflecting on the
events which happened that I assumed the dressing was actually completed
during this time. My focus was Phillip-Maurice relating and not what the other
nurses were doing. This silence was more like a transitional plateau, a pause,
where Phillip was tuning out of what was being done to him, those factors or set
of characteristics which would describe and determine a relationship of apartness or I-It relating. Yet by still holding my hand it seemed an embodied connection, an anchoring and confirmation of our relationship of togetherness where the 'in-tuning' process was rapidly building up to a peak which is what I call 'The Moment of Caring'.

As had happened earlier on in our meeting, I again told Phillip we were going to turn him. As before I cannot remember his exact behaviour, only that I remember seeing a desperate animal being confined in a cage. As he had also done previously he looked at me and started to cry.

"When the dressing was finished and the linen changed, I told Phillip we were going to turn him back. The trapped animal returned and he looked at me and started to cry."

His crying now was different to his previous episodes. This time it was silent, deep and embedded tearing, which seemed to come from his inner being. It was as though it wasn't only his eyes that were crying, but his whole being cried out in ravaged fear and hurt. It seemed to me that I was seeing Phillip as he really was and I didn't know what to do and I felt helpless.

"What could I do for a small boy who was hurting so much and the anticipation of more pain was just about too much for him to bear?"
Phase Three - The Moment of Caring: Relationship of Oneness

"I looked into his eyes, my eyes welled up, overflowed, and I too started to cry. It seemed as though I felt his hurt, his pain, his fear."

Our eyes focused and it was as if we had became one and I shared his tears and he shared mine. This is what I call 'The Moment of Caring'. We had transcended our detached way of relating and were as one in a moment in time. We were 'in-tune'. I believed I had full realisation of Phillip's experience/emotion and I was expressing this in my tears, legitimising and enabling Phillip to experience and understand what he was going through in a deeper, richer, and fuller way. Both Phillip and I were 'becoming whole' which is the process of health. 'The Moment of Caring' represented the unified merging of Phillip's and my meta-patterns of beings. I don't remember the length of the moment, it was as though time had been transcended and took on new meaning.

Phase Four - Redefining Wholeness: Relationship Moving from Oneness to Apartness

Because of the dynamic nature of health (the process of becoming whole), Phillip's and my understanding and meaning of the experience became more diverse and complex resulting in increased diversity and complexity of our
meta-patterns of being. This process revealed harmonised layers of understanding and meaning of the experience. They are harmonised in the sense that the subsequent revelations of understanding and meaning were grounded in the initial experience. This specific experience triggered further understanding of previous events, occurrences, thought patterns (personal histories) which are related to and connected with the grounding experience.

Phillip's and my relating triggered for me a number of specific personal memories which had some similarities with his situation. Some of these related to when I was young and hurting and needing someone to be strong whom I could hold onto, seemingly trivial events on the surface but in retrospect holding significant meaning for me. Some examples include falling off a childhood bike and hurting myself and wanting comfort and not finding it, being involved in a car accident, feeling the hurt and pain and fear of not having anyone familiar to comfort and protect me. On reflection this is why I wrote in the story the following sentence because the events reminded me what I needed when I was young and frightened and in pain.

"I wanted so much to hold him close and say it was going to be all right..."

It is because of the further understanding of these histories and their merging with the understanding and meaning of the experience shared in 'The
Moment of Caring' that the understanding and meaning of experience begins to diverge into individual patterns. Thus the process initiates a change in the relating of the individuals from the Relationship of Oneness to a Relationship of Apartness. This diverging is demonstrated in the story through the dialogue I was having with myself regarding why I couldn't hold Phillip and why I was telling myself that I shouldn't cry. This identifies that some of my history I brought with me to Phillip's and my encounter included issues arising from what I had been taught regarding how nurses relate to clients, and this identified a tension between what I had been taught from a nursing perspective and what my personal experience told me was needed in a nursing encounter.

"... but couldn't because of the environment. I felt ashamed of my tears. A voice inside my head was saying

'Nurses don't cry...'

'Why not?' my heart resounded."

Phillip and I were still relating on a close basis but in response to the consequences of 'The Moment of Caring' we were no longer relating as one. We
both became more aware of the giving-receiving behaviours we were directing at each other. I became aware of the other nurses preparing for the turn and I turned to look at Phillip and explained what we were about to do. These were conscious cues and as previously, the volume, tone, pitch and meter of my words probably reflected more unconscious ones.

"I looked at him again and said,

'Phillip you did really well before and I want you to listen to me again. It's going to hurt again but only for a very short time. I want you to take a deep breath in and hold onto me so tight that the pain won't seem too bad. You can do it, we can do it together.'

The other nurse counted,

'1 ......... 2 ......... 3.'

'Deep breath and hold on to me.'
Throughout the turn Phillip also provided conscious and unconscious cues. These included looking me directly in the eye and holding my arm tight (perceived as conscious cues) to the deep breathing and not flinching (unconscious cues).

"He took a deep breath in, looked me in the eye and didn't flinch. He held my arm so tight and we rolled him back to his original position. We finished the turn and Phillip let go of me."

The actual turn seemed quite mechanical. Phillip knew what he had to do. I knew what I had to do and so did the other nurses. It was as though Phillip's and my relating had become quite objectified. We both had roles to play in the intervention and we both carried them out. This turn represented for me that our relationship was moving to one of apartness and this seemed to be confirmed when symbolically he finally let go of my hand. What he had initiated during the beginning of our meeting and our getting to know each, and what we had both maintained throughout our meeting, Phillip now completed by releasing my hand and thereby releasing me. Our relating was now one of apartness and we were back in Phase Four/One of the framework.

What occurred next I consider demonstrates the uniqueness of each 'Moment of Caring' and that though each phase is essential in order to get to the moment of relating as one, their duration is arbitrary. Because the framework
acknowledges and takes into account the histories of each individual involved in the relating, it encompasses those previously shared experiences between the individuals also. If these were experienced as positive, when the new meeting occurs the persons involved are bringing a shared connection and shared meaning of history of their previous relating which includes familiarity with the other's giving-receiving cues. This appreciation for and identification with each other can act as a catalyst providing mutual trust, openness and thereby a shortcut in the time taken to get to know another, allowing for the possibility for another 'Moment of Caring' to occur. It is possible therefore for Phases Four, One and Two of the Framework to occur and progress almost instantaneously, culminating into another new 'Moment of Caring'. This was my perception of what happened next between Phillip and me.

"But as soon as the other nurses went to move his leg he made a grab for me and looked into my eyes.

He held onto me, and the pain wasn't so bad for both of us."

We initially were relating as apart - Phase Four/One. When the nurse went to move Phillip's leg Phillip grabbed me and looked into my eyes (conscious and unconscious cues). I held him and looked into his eyes (conscious and unconscious cues), he held onto me (Phase Two - the process of moving from apartness to oneness) and another 'Moment of Caring' occurred (Phase Three).
We had again transcended our detached way of relating and were as one in a moment in time. Again our meta-patterns of being were 'in-tune'. I believe I had full realisation of Phillip's experience/emotion informed by our previous meeting and what was happening to him at this point in time, that of fear, pain and the need for protection. By holding Phillip I was expressing my feelings in action in a way that was enabling him to experience and understand what he was going through in a deeper, richer, and fuller way. I perceived that this process created further wholeness in both of us. Both Phillip and I were becoming more whole, that is the process of health.

This time for me the increased diversity and complexity of understanding and meaning of experience and the associated new patterning, focused on the restoration of the associated triggered memories and the freedom to merge personal experiences with my professional role. As the patterning changed, our relationship moved from that of oneness to that of apartness (Phase Four/One) and I became aware that the other nurses had finished moving Phillip's leg. Our relationship of apartness was exemplified by Phillip again letting go of my hand, I releasing his, and him not saying much.

"When the others had finished Phillip let go of my hand and I let go of his. He didn't say much, but he was back to his previous happy self.

I left the room ..."
Before I walked into his room and introduced myself to him at the beginning of our encounter, I heard Phillip laughing and talking with and to the other children in his room. He seemed happy and as though he was having fun. When our meeting had concluded my perception was that he was back in this place. I too was back in my place of being, as Maurice the person and as Maurice the nurse and the associated roles I was required to fulfil. Though we appeared to be back to where we were at the beginning of our relating in regard to our prescribed roles, for me it was different. Because of Phillip's and my meeting I had become more whole and I carried and carry this with me in my personal and professional way of being.

Bridge

Following the re-examination of Phillip's Story with the initial framework I was excited, because I believed that by using it as a tool for reflection and understanding, it had revealed something new, and because of this it meant that I learnt more about the experience that occurred between Phillip and myself. I also had a sense that if I dug deeper, I would reveal something more and have more understanding about what went on between the nurse and the client.

I found the hermeneutic process of reflection on and crystallisation of my thoughts hard work, but enjoyable and fun. What had emerged from a place of abstraction outside of the story, then became the instrument of interpretation and was used to uncover deeper meaning and understanding of practice from inside
the story. This process of moving between inside the story and outside the story, between practice and abstraction through the processes of immersion, reflection and crystallisation reflects the nature and process of the hermeneutic wave.

The hermeneutic process revealed congruity between the framework and the story but also highlighted other issues which I hadn't considered. My personal response was that something else was going on here which I hadn't covered or addressed and I considered this significant because the framework didn't tell the whole story. There were holes or silent bars in the score. The process of re-layering provided more understanding of what was going on in the story. It provided clarity of what I believed nursing to be, what I believed a caring moment in nursing was, and what was happening in my nurse-client relationship.

Furthermore, the process also highlighted other issues and questions related to other individuals involved in the story. For example why the other nurses responded to the situation in particular ways. I always knew these issues were part of the story and they did attract some interest but I deliberately decided not to look at them any further because I believed that if I had done so, then I would have journeyed down different paths and had to leave what it was I was really interested in examining. Furthermore, I believed the resulting work would become too convoluted and involved. If it was too complex I felt I would lose focus, I'd become lost and readers would also become lost. I decided not to explore them, acknowledged that the other nurses' stories were important, but chose to remain focused on the nurse-client relationship as reflected in Phillip and myself.
So putting these issues aside, I explored the other gaps or issues requiring clarification related to the nurse-client relationship between the framework and the story which I believed needed addressing. I was dissatisfied that the framework was not complete and that it didn't tell the full story of how Phillip and I related.

Refinement

Through the process of using the framework, further understanding and meaning of Phillip's and my experience had been realised. The process revealed an interesting pattern that was not first identified when the model was first constructed. Initially I had perceived that all Phases were distinct and unidirectional. Generally the framework (as reflected in the four phases) suggested that the relating of the two persons moved from apartness to oneness and back to apartness again. However from my reflection on the story, it was clear that this relating did not follow the assumed predetermined pattern and that in fact what did happen was that there was more an ebb and flow between the ways of relating. There was a process of 'build-up' occurring between phases Four/One and Two, before Phase Three - 'The Moment of Caring' occurred, similar to the process of labour where contractions become more intense, regular and closer together before culminating with the delivery of the baby.

Kirby and Slevin (1992, cited in Arets & Slevin, 1995) also propose this tidal nature of relating where the nursing relationship flows between the nurse and client relating as I-It and I-Thou. They describe it as the nurse coming in to be
with the client where they enter into a subjective relationship with the client and connect and respond with them in a non-reflective and non-judgemental way (relating as I-Thou), and then go out to see, in order to be able to objectively, reflectively, and judgementally observe, assess and respond to the cares or needs of the client (relating as I-It).
RECAPITULATION

(Allegro (tutti) - At a fast pace, all together)

Bridge

Emerging from my thinking which occurred through the re-layering of the framework back over the story, I again started to consolidate my ideas and visualise globally what was going on in the story. I rearranged and altered the framework holding to my interpretation of Buber's (1958) notions of I-It and I-Thou relating, my assumptions of the two metaparadigmatic concepts of health and person, and taking into account the gaps and areas requiring clarification highlighted through the re-layering process.
My ideas crystallised into a global view of what happened between the nurse and client and I visualised this diagrammatically. I rearranged the framework, much like rearranging a musical score, and turned the framework on its side focusing on the relationship of the nurse and client. Having re-drawn the nurse-client relationship diagrammatically, I again had a structure into which to write the details of my thinking.

Rearranging

The process of re-layering the original framework of reflection over the story from which it emerged clearly identified that the movement from a Relationship of Apartness to a Relationship of Oneness did not progress through a linear pattern as the original framework suggested. The first framework suggested that one moves through Phase One, Phase Two, Phase Three and Phase Four, with Phase Four of the encounter merging into Phase One of the next encounter of relating. However in contrast, the re-layering process revealed that the ways of relating appear to follow an ebb-and-flow pattern.

The nurse and client commence relating from a position of apartness then begin a more global process of coming together characterised by smaller encounters which, as an illustration, could be described as the nurse and client taking one step closer to each other, then moving one or two steps back, before taking a further two or three steps closer and then moving only one step back. This gradual coming together process enables both nurse and client to reveal more of
themselves to each other, and to open and receive more of the other to themselves until the process culminates in an encounter where the nurse and client relate as one, what I describe as 'The Moment of Caring'. This process of moving in and out between the Relationship of Apartness and the Relationship of Oneness I have described as tidal in nature because I view each wave of relating building on the preceding one, figuratively flowing and cresting into a unified peak of relating.

After the shared experience each individual moves off onto their own trajectories of meaning resulting in them moving apart and therefore moving back to a Relationship of Apartness.

This description of how the nurse and client relate as tidal would appear to add support to Kirby and Slevin's (1992, cited in Arets & Slevin, 1995) assertion that the nurse constantly moves between subjectively relating with a client and objectively relating with the client depending on the reason and purpose defining their relationship.

The dynamic nature of this movement between the Relationship of Apartness and the Relationship of Oneness is illustrated in Illustration 29.
Illustration 29. The Moment of Caring Framework (Modified)
Bridge

Following the method of the hermeneutic wave used previously, I re-layered the modified framework back over the story to see if it provided for more reflection and whether there was a clearer fit. This time the process was tinged with a sense of anxiety in that I wondered what else would emerge and what else I would have to write. I immersed myself back in the story using the modified framework as the instrument of reflection. Again I found the process enjoyable and it wasn't too difficult because I was building on content and process which I had already covered. I believed there was greater congruency between Phillip's Story and the modified framework rather than the first framework, and again it revealed more understanding of experience and I was being changed by it. It was as if my own pattern of being was becoming more complex, the process I refer to as health, that is becoming whole. In many senses I was paralleling the story. On one level I was writing about the relationship between the framework and the story but on another I was moving between the story and the framework finding understanding and meaning, and being changed.

The re-layering of the modified framework again showed more areas for development within the framework but this time they were particularly in relation to potential gaps or outcomes. The framework showed what happened in the story but also highlighted other possible scenarios that could occur within the nurse-client relationship, including what would happened if a phase was missed or if the nurse and client never met again. So further possibilities arose and I moved
back out from the story and arranged more variations reflecting the different scenarios. I wrote to these variations again filling in the details with text.

Having immersed myself back into the story and reflected on what was occurring between the nurse and client and the meaning contained in their relating, I moved back out of the story, and crystallised my ideas into an abstract summary of what I believed to be occurring between the nurse and client during a 'Moment of Caring'.

At this point in the writing I chose to stop going back into the story because now the possibilities I was exploring were not grounded in the story. The story highlighted that these other scenarios could exist however I couldn't re-layer the possibilities back over the story because they just weren't there. I had moved past my story into new stories.

**Changing the Name**

The manuscript was complete. I now called the modified framework a manuscript because to me this term represented both a written (word processed) composition and, in regard to the musical context, a framework on which musical notation is written creating musical compositions.
Phase One - Readiness to Co-participate: Fulfilling Expected Health Related Giving-Receiving Roles - Relationship of Apartness

Phase One commences with the nurse and client in a Relationship of Apartness with both fulfilling expected health related giving-receiving roles as determined by the organisation in which they are contextually located (see Illustration 30a point A). Even before there is any physical encounter between the nurse and the client there can be movement from relating purely from a position of apartness to one where there is some coming together of the two individuals. This movement of coming together is indicated when both the nurse and client are aware of the existence of the other and, to varying extents, the roles and functions of the other within the organisation, through various informing processes including the observation of the other, hearing about the other, and reading about the other (see Illustration 30a point B). Following this initial abstract encounter there is a physical coming together of nurse and client where they actually meet at a certain place and at a certain time (see Illustration 30a point C). Readiness to Co-participate then is said to have been initiated when there is a physical meeting of nurse and client at a particular point in time where each has some knowledge of the other as either nurse or client (see Illustration 30a point D).

In some circumstances knowledge of the other's existence and role within the organisation may occur at the same time as their initial physical meeting. An
example would be an emergency when nurse and client physically encounter each other while at the same time they are being informed by and through various other informing processes, i.e. someone describing the client's health history, the nurse being addressed by name, the client observing how the nurse responds and functions (see Illustration 30a point E).

Illustration 30a. Phase One - Readiness to Co-participate

Following their initial meeting the nurse and client begin to relate through the expressions of the conscious and unconscious cues reflected in the giving-receiving behaviours (see Illustration 30b point F). Because these behaviours are generally in response to the expected institutional health related roles, the nurse-client relationship still predominantly tends to focus toward a position of apartness. As they relate together the conscious and unconscious cues start to merge and begin to be viewed holistically rather than being categorised as
unconscious cues reflected in the giving-receiving behaviours. Phase Two is said to be truly occurring when the conscious and unconscious cues are progressively viewed more and more holistically rather than categorically, and the relating focuses on relating as being-to-being rather than in response to each individual's expected organisational health related roles and as a collection of fragmented entities and clinical factors. This process is facilitated by the nurse's practice being grounded philosophically and therefore may be described as being guided by Watson's (1985) ten carative factors.

The process of 'in-tuning' is said to have begun as the nurse and client begin to relate as person-to-person and where the giving-receiving cues are no longer categorised as conscious and unconscious. There is still a continual moving between the Relationship of Apartness and the Relationship of Oneness; however, the relationship moves from the position focusing on apartness to that of oneness. As the giving-receiving behaviours are viewed more and more holistically, and as the nurse and client relate more and more as being-to-being, the relationship ebbs from a position leaning towards apartness to that of oneness, never completely flowing back to the position it previously held. This process can be very aptly described as the relationship moving three steps forward (towards the position of oneness) and one step back (to the position of apartness) before there are another three steps forward (closer to the position of oneness) and one step back (further away from the position of apartness) (see Illustration 31 point H).

As the nurse's and client's relationship becomes focused on relating as unified being-to-being (the Relationship of Oneness) the nurse and client reach a
transitional plateau where attempts to objectify their relating by external factors have virtually no impact on their relationship. This transitional plateau again marks another difference from the original proposed framework of analysis in that it identifies the transitional overlap between Phase Two and Phase Three of the manuscript.

This transitional plateau is the beginning of the actual 'Moment of Caring' where the relationship between nurse and client transcends apartness and where each becomes an extension of the other, the two experiencing as one (see Illustration 31 point I).

![Illustration 31. Phase Two - In Relationship](image-url)
Phase Three - The Moment of Caring: Relationship of Oneness

Phase Three - The Moment of Caring: Relationship of Oneness begins as the transitional plateau of Phase Two and is realised when the nurse and client are truly 'in-tuned'. The nurse and client are in a state of readiness and preparation for a collective and unified response to an experience (see Illustration 32 point J) which brings the two of them together as one, transcending detachedness and relating wholly with realisation of the other's experience/emotion. The nurse and client are experiencing as one, that is as a unified 'person-to-person'. The nurse domain of the 'unified person-to-person relating' expresses a response which enables the client domain of the 'unified person-to-person relating' to understand and experience their response to the initiating experience in a deeper, richer, and fuller way (see Illustration 32 point K). The client's meta-pattern of being and the nurse's meta-pattern of being merge creating the 'unified person-to-person relating'.

The concept of time now takes on new meaning and description. This occurs because the characteristic and perception of the attribute of 'duration' applied to the concept of time is transcended. That is, rather than viewing time in relation to quantity of seconds or minutes, the focus moves and becomes whatever the nurse and client need it to be so that a relationship and experience of oneness is realised (see Illustration 32 point L).

The pre-transcendent view of time begins to return while both the nurse's and client's meta-patterns of being are becoming more whole because the
diversity and complexity which characterises this process progresses through individual pathways rather than as a unified relationship (see Illustration 32 point M). This indicates the ending of 'The Moment of Caring' and signals the transition between Phase Three and Phase Four of the manuscript.

Illustration 32. Phase Three - The Moment of Caring

Phase Four - Redefining Wholeness: Relationship Moving from Oneness to Apartness

As the nurse's and client's understanding and meaning of the experience becomes more diverse and complex it results in increased diversity and complexity of their meta-patterns of being. The harmonised layers of understanding and meaning that are realised from this process become a catalyst, triggering further understandings of previous events, occurrences, experiences
and thought patterns (personal histories) related to and connected with the initial experience. These new revelations of understanding merge with the understanding and meaning of the experience shared in 'The Moment of Caring', and thus both the nurse's and client's understanding of the initial experience begin to change and continue to diversify.

Now, however, the focus becomes more personalised rather than shared resulting in the nurse's and client's relationship moving away from oneness back to apartness (see Illustration 33 point N). The actual experience of 'The Moment of Caring' initiates a change in how the nurse and client relate. As the nurse's and client's own understanding and meaning become more and more personalised they begin to view the other in regard to their roles and functions within the organisation rather than viewing the other as an extension of self and relating as person-to-person. When the nurse and client view each other predominantly in regard to their roles and functions they have moved back to the Relationship of Apartness (see Illustration 33 point O). The way of relating, however, never goes back to the position it was at initially at the beginning of their meeting. Though they are relating in regard to their roles and functions, they have experienced a shared encounter and this they carry with them. This results diagrammatically with their relationship still being situated in the arena of the Relationship of Apartness, however positioned closer to the Relationship of Oneness (see Illustration 33 point P) than where it was situated at the beginning of Phase One of the relationship (see Illustration 33 point Q).
Phase Four/One - Transition from Redefining Wholeness to Readiness to Co-participate

Scenario One

The end of Phase Four diagrammatically shows the nurse and client relating in regard to their roles and functions within the arena of the Relationship of Apartness, but their relating position has moved closer in proximity to that of the Relationship of Oneness. Both nurse and client are fulfilling expected health related giving-receiving roles as determined by the organisation in which they are
contextually located and Phase Four merges into Phase One (see Illustration 34a point P).

Both nurse and client are aware of the other's existence because of their shared experience of relating as one and from the continual receiving from various informing processes inherently occurring within the contextually determined health related roles each individual assumes. As both nurse and client continue to relate there are two possible outcomes. Firstly that they continue in their health related giving-receiving roles and maintain a Relationship of Apartness, and secondly that they experience another moment where they are in a Relationship of Oneness or as I describe 'The Moment of Caring'.

Maintaining a Relationship of Apartness may result from a number of possibilities. For example the nurse and client may no longer be able to relate according to the health expected roles i.e. nurse being assigned to care for another client, the client being transferred to another ward, the client being discharged or the nurse being off duty. There is also the possibility that either the nurse or the client (or both) may choose to continue to relate from a position of apartness. If these circumstances occur I then propose that they determine that the relating between nurse and client continues from a position of apartness.

It is important to remember that though the nurse and client may not be together, they continue to carry their shared experience with them and as such, if they do meet again, their relational positioning in regard to Readiness to Co-participate (Phase One of the manuscript) will be different from where it was
when they first met (see Illustration 34a point R). They continue to fulfil expected health related roles but though their relating is still located within the arena of the Relationship of Apartness, their position of relating has changed and is located in proximity closer to that of the Relationship of Oneness (compare points R and Q in Illustration 34a).

Illustration 34a. Phase Four/One - Transition from Redefining Wholeness to Readiness to Co-participate
Phase Four/One, Two and Three, or Phases Four/One-Two-Three

Scenario Two - Two Variations on a Theme

The second possibility is that the nurse and client may also experience another moment of being in a Relationship of Oneness, that is 'The Moment of Caring'. As a generalisation I am proposing that once the nurse and client have shared an experience of relating as one, there is an openness and an enabling for another experience of relating as one to occur. This is not a repetition of the same experience and the same meaning of the initial experience; rather meaning, experience, and meaning of the experience, is new. The processes by which it unfolds or progresses are similar but the experience is different.

This view is consistent with my view of health, health being defined as increasing diversity and complexity of meaning and understanding of experience. After the nurse and client have been in a Relationship of Oneness their understanding of the experience and meaning contained in it becomes more complex and diverse and is reflected in their meta-patterns of being. They are said to be becoming more whole. If they meet again in another Relationship of Oneness their understanding and meaning of the new experience (which contains the incorporation of the old experience) will result in further complexity and diversity. This results in them becoming even more whole and their meta-patterns of being will change.
As an analogy I view this much like tramping along a well used forest track. The first time one goes down the track the individual prepares by studying the directions and acquiring appropriate footwear and supplies before departing. However the next time it is walked, the track is still there, the process of walking, footwear and preparation remain basically the same; but what is seen, heard, felt, touched, the speed of the walk, the weather, the time of day and others who may be accompanying the individual, may all be different and will affect his/her experience of going on a walk through the forest and the meaning it contains. There might be the occasional diversion in the track and the person might stop at times but the basic framework for getting from the start to the finish is there, and there is some familiarity because he/she has been down that track before.

Through the process and analysis of re-layering the initial 'Moment of Caring' framework over Phillip's story, it revealed that when the nurse and client had shared a moment of relating as one, and were currently relating from a position of apartness, they were able to move rapidly in their relating to another moment where they were again in a Relationship of Oneness. The term 'rapidly' inherently has associated with it the concept of time and when using it to describe this transformation I am using it to indicate a concept whereby detailed transitions as described in Phases Four/One, Two and Three of the manuscript appear to be occurring 'all-at-once', that is they are occurring simultaneously and are indistinguishable. If they are occurring 'all-at-once' the concept of time therefore takes on new meaning.
There is consistency, then, between this view that time takes on new meaning and my description of time during Phase Three of the manuscript. In this phase I propose that the meaning of time is transcended and takes on new meaning and description. This transcendence of the meaning of time also then enables Phases Four/One, Two and Three to occur 'all-at-once'. When this occurs, time does not have disorganised meaning but reorganised and differently-organised meaning.

I perceive that once the nurse and client have shared a 'Moment of Caring' that it is possible for them to share another 'Moment of Caring' without having to be aware of going through all the phases and steps within Phases Four/One, Two and Three.

It is possible then for the nurse and client to experience another 'Moment of Caring' by either progressing through each phase of the framework in detail again (see Illustration 34b) or by experiencing another 'Moment of Caring' with Phases Four/One-Two-Three perceived to be occurring 'all-at-once' (see Illustration 34c). If Phases Four/One, Two and Three are perceived as occurring 'all-at-once', the transitional plateau stage which signifies the beginning of 'The Moment of Caring' (as previously described under the heading Phase Three) is now considered part of this simultaneous occurrence and is thus not separately identified in the diagrammatical representation in Illustration 34c.
Illustration 34b. Phases Four/One, Two and Three

Illustration 34c. Phase, Four/One - Two - Three
Phase Four  (revisited) - Redefining Wholeness: Relationship Moving from Oneness to Apartness

Phase Four recurs as previously described. However, at the conclusion of this second occurrence of Phase Four, the nurse and client have moved back to a different position from that at the conclusion of the original Phase Four of the manuscript (see Illustrations 35a & 35b point X). Although they are relating in regard to their roles and functions, they have experienced another shared encounter and carry this with them, and this results in their relationship, though still being situated in the arena of the Relationship of Apartness, being positioned closer to the Relationship of Oneness than it was situated at the beginning of the initial Phase One (see Illustrations 35a & 35b point Q) or the beginning of Phase Four/One of the manuscript (see Illustrations 35a & 35b point P).

As Phase Four/One progresses, the nurse's and client's way of relating may continue from a detached position or they may go through the phases again either separately or 'all-at-once'.
Illustration 35a. Phase Four (revisited) - Redefining Wholeness

Illustration 35b. Phase Four (revisited) - Redefining Wholeness
Harmonisation

The crystallisation of my reflections and ideas as articulated in the manuscript 'The Moment of Caring' reflects the harmonisation of two themes; the interpretation and understanding of Phillip's Story, and the development of the framework for reflection on caring moments in nursing practice.

The two themes emerged accordantly using the interpretive method which I call 'The Hermeneutic Wave'. This interpretive approach involved immersing oneself in the text of practice, reflecting on the text and meaning it contained, and crystallising the reflections and meaning into a synthesised whole which I have called a manuscript for reflection.

I moved in and out of Phillip's Story, immersing myself in its content and the nursing practice it embodied. I reflected on the experience of caring for Phillip and what it meant to me, and crystallised my thoughts and ideas about the experience, and how I viewed and understood caring in my nursing practice.

The process of moving in and out of the story also made it possible to move beyond my personal journey of interpretation and understanding of Phillip's Story, to a position where I explored more abstractly what I believed was occurring within Phillip's Story, within the general context of nursing practice. From this location I explored and developed my ideas of what I considered to be occurring between a nurse and client during the process I refer to as a caring moment in nursing practice.
'The Moment of Caring: A Manuscript for Reflection on Caring Moments in Nursing Practice' therefore encompasses the thematic harmony of the interpretation, understanding and meaning of a personal caring moment in nursing practice, and the development and proposition of an abstract framework for reflection on caring moments in nursing practice. The aim of the manuscript is to function as an instrument which assists nurses to reflect on and explore the meaning and understanding of caring moments within their nursing practice.
CODA
The Performance - Playing the Manuscript (Application)

Illustration 36. The Performance - Playing the Manuscript (Application) - *A piacere*

(*A piacere - At the performer's pleasure*)

**Bridge**

The Performance - Playing the Manuscript (Application) addresses the application of the manuscript for nursing. Though diagrammatically above it is represented as being back inside the story, the term 'story' at this point can be viewed as any experience related to nursing practice within the domains of clinical practice, education, management or research, or any textual representation of any nursing experience to which the manuscript is applied.
Performing the Manuscript in Nursing Practice

Throughout the processes of composing, refining and completing the manuscript as a discrete composition, a number of considerations related to its performance in and for nursing became apparent. I deliberately use the word 'performance' rather than 'application' of the manuscript, because I believe this term is more congruent and in harmony with the global metaphorical images of music I have used in my thinking and methodological processes in the development and composition of the manuscript.

Performing the Manuscript as a Complete Work

The most significant issue raised throughout the processes of manuscript composition regarding the purpose of the manuscript was clearly performing it in nursing practice, or in other words applying the manuscript to nursing practice. While refining the model I was often asked by colleagues what was the purpose of the study. On reflection of my own journey through the manuscript's development and the richness in understanding and meaning I had received of my own practice through use of the manuscript as an instrument for reflection, I saw the possibility that other nurses too may find the manuscript useful for reflection. Thus my reply became clear and without hesitation, 'to provide a theoretical framework for nurses to use either in part or in whole for reflection on practice to reveal more meaning and understanding of their nursing practice'.
The manuscript provides a foundation and frame of reference for nurses to utilise when interpreting their nursing practice. By utilising a framework for reflection, nurses can layer the manuscript over their practice and use it as an instrument to explore their practice, one which may reveal more understanding and meaning of what was occurring in the nurse-client relationship.

The manuscript can be used as a complete work in itself where nurses hold to the rudimentary metaparadigmatic assumptions on which it is based. They can then use the manuscript as an instrument to reveal understanding and meaning of their practice through the processes of layering the manuscript over their practice and interpreting the fit. This utilisation may not only uncover more meaning of practice but would also encourage closer critical examination of the manuscript and reveal areas within it which may require clarification and further development.

Performing Discrete Sections of the Manuscript

Sections or movements within the manuscript may be used independently, much like performing movements within a piano sonata as separate discrete works. Though it may be claimed to detract from the total experience of the complete sonata, there is still worth, value and potential pleasure within the movement that is performed. Nurses may wish to use or refer to specific parts within the manuscript, using it conceptually to focus on personal understanding and enlightenment of nursing practice and nursing knowledge. For example they
may focus solely on examining the developing metaparadigmatic assumptions in relation to themselves or other nursing theoretical works and philosophical positions. They may wish to explore the notion of the giving-receiving behaviours and their role in the nurse-client relationship, or other aspects of the manuscript which they find significant.

**Performance or Musical Licence**

A third consideration in performing the manuscript is personal interpretation. Generally during symphonic performances there is a conductor and the members of the orchestra play their parts according to the conductor's interpretation of the score. The essence of the score doesn't change but the interpretation of how it will be played may be different. If a particular symphonic movement was written to be played at a particular speed or volume, the conductor may change it to fit within the overall impression or atmosphere he or she is wanting to create. These changes may be subtle or dramatic but the general essence of the underlying score and themes contained within it remain unaltered.

Similarly, the performance of the manuscript 'The Moment of Caring' is open to individual interpretation. By using the manuscript as a musical score for reflection on practice, individuals may play, adapt and modify it so as to perform or use it in a way that accommodates and provides for individual preference and nuance but which still holds in essence to its general theme. For example what comprises the giving-receiving behaviours may be viewed differently by some
nurses, individual interpretation of a particular nurse-client interaction may provide contrasting perspectives and meanings, or the metaparadigmatic components of nursing on which the manuscript is based may be modified to fit more congruently with an individual nurse's world view. These modifications viewed as interpreted changes I hold as musical or performance licence by the conductor, where they perform the manuscript with their own flavour yet still hold to the general theme of the original work.

Performing New Manuscripts

I think it is possible that through the process of interpretation of the manuscript there is the potential for additional and discrete manuscripts to be developed. In much the same way as the manuscript 'The Moment of Caring' had roots in works by Watson (1988), Paterson and Zderad (1976), Kirby and Slevin (1992, cited in Arets & Slevin, 1995), and Buber (1958), I see that reading, using, and/or interpreting 'The Moment of Caring' may provide the impetus for further new and eclectic works to be extrapolated from its articulated content and intricacies. Included in these intricacies are the methodological processes used from which the manuscript was developed.
The Process of Manuscript Development as a Manuscript for Theory Development

'The Moment of Caring' evolved through an exploratory, intuitive process which began with nursing practice articulated as a written story, and which then followed a hermeneutic process of moving in and out of the text in order to try to understand and find meaning of my practice. Moving out of the text involved distancing myself from the details of the story to intuitively grasp a global sense of what was occurring within the story and then writing theoretically about the theme or musical picture which emerged. Moving into the text involved layering what I had written over the story and examining the story through new and different lenses. This tidal motion of moving into the story and out of the story characterised the process of the manuscript development.

It is recognised that the following linear representation of the steps involved in the process of the manuscript's development is not definitive. It is included in order to offer some guidance on how the process may be used or considered for the development of other theoretical works. This is not intended to be formulaic but to provide a general overview of how the process occurred.

- Think about an experience.
- Write a story about your experience.
- Leave the details of the story aside and try to get a global theme of what is occurring within the story.
• Articulate this theme, or draw a picture of it.
• Add detail by writing about the theme or what the picture is about.
• Go in to detail.
• Re-layer the theme or picture with the detailed description back over the initial experience.
• Consider if there was a fit? What didn't fit? What was new? Was understanding and meaning enhanced?
• Step back out and re-conceptualise your theme or picture, taking into account your re-layered experience.
• Re-articulate your theme or redraw you picture.
• Fill in the details by writing to the theme or picture.
• Re-layer the modified theme or picture with the detailed description back over the initial experience.
• Explore what further meaning or understanding emerges?

The potential exists for the process outlined in the development of the manuscript 'The Moment of Caring' to be used itself as a manuscript for further theoretical exploration and development to enhance and enrich nursing knowledge. From just 15 minutes of one nurse's practice 'The Moment of Caring' emerged. Taking into account an average work day of 7 1/2 hours and that each nursing work day comprises thirty 15 minute periods, considering the number of nurses world-wide and multiplying this by thirty (the number of 15 minute periods in each day), the amount of untold stories and potential theoretical explorations
and extrapolations are immense. My story and manuscript are just one part in a symphony of nursing practice.

Performance Review and Further Refinement and Development

The manuscript needs to be critiqued and examined alongside other literature on caring in nursing, and tested by practising nurses and nurse scholars in order to provide feedback and refinement, provide validation of the content and claims it proposes, and provide validation of the manuscript as a useful instrument for reflection on caring moments in nursing practice.

The most significant question which I believe needs to be answered through research is, 'Does the manuscript 'The Moment of Caring' as an instrument for reflection reveal meaning and understanding of caring moments in nursing practice?' The manuscript could be used as the tool for analysing stories of caring occurring in nursing practice within a phenomenological study, or even form the theoretical framework in which studies exploring aspects of caring either qualitatively or quantitatively could be positioned. This would aid not only in validating and/or challenging some of the assumptions and propositions made, but also help in refining and clarifying the manuscript as a whole.

To some extent there has been internal critique and validation with the internal process from my own experience of writing, intuiting, layering, re-layering, and developing the manuscript. There is also validation in the sense
that there is a broad sense of congruity with notions proposed by significant writings in nursing which hold that caring is fundamental in nursing practice (Benner & Wrubel, 1989, Kirby & Slevin, 1992 cited in Arets & Slevin, 1995, Leininger, 1984, Paterson & Zderad, 1976, Watson, 1988) and within the New Zealand context, Christensen's Nursing Partnership (1990) and Euswas's (1991) doctoral thesis 'The Actualised Caring Moment: A Grounded Theory of Caring in Nursing Practice'.

'Nursing Partnership'

Christensen's revised model 'Nursing Partnership: A Model for Nursing Practice/Hauora Takirua: He Tauira mo nga Kaupapa Hauora' (1990) focuses on the nurse-client relationship while the client undergoes a health-related experience which is perceived as a journey or passage comprising five components; the Beginning, Entering the Nursing Partnership, Negotiating the Nursing Partnership, Leaving the Nursing Partnership, and Contextual Determinants. In each of the first four components both nurse and client have work to do in order for the client to progress through the passage and achieve the client's health related goals.

The Beginning occurs prior to the partnership commencing and is described as '... a time of adaptation to a changed situation and preparation for an upcoming experience' (p. 186). The client acknowledges that a health concern exists, prepares for possible treatment or intervention, and tries to make sense of what is going on. The nurse maintains a state of preparedness to receive the client by
acquiring and maintaining appropriate knowledge, skills and attitudes in order to practice safely and professionally.

Entering the Nursing Partnership is described as '... the transition experience in which the patient/client comes into contact with nursing' (p.192). The client takes on the role of the client, modifies and reduces the usual social roles and responsibilities they normally fill, and reveals who they are physically, psychologically and socially. The nurse admits and appraises the client in order to determine what is required to initiate the nursing partnership.

The Beginning and Entering the Nursing Partnership phases have broad similarities to Phase One of the manuscript 'The Moment of Caring' where there is the fulfilling of expected health related roles by both nurse and client.

Negotiating the Nursing Partnership begins at the time of entering the Nursing Partnership and continues until the client leaves the health related experience. Both nurse and client need to collaborate in order for the client to progress through the passage and their work comprises specific complementary activities. Not only does the client rely on learned ways of preparing for and enduring experiences related to their current health-related event, he/she also learn new strategies to optimally interact with other health personnel, to endure the associated diagnostic and therapy experiences and to find meaning in the experience. The nurse selects and uses a variety of nursing strategies which assist the client at each stage in their work. Phase Two of the manuscript reflects the
negotiating nature of the relationship and the work that both nurse and client do in order to transcend their relationship of apartness.

Leaving the Nursing Partnership involves the client and nurse undertaking new work associated with preparing the client for the transition out of the Nursing Partnership. The client prepares for the transition by acquiring and maintaining appropriate knowledge and skills necessary to go home, making arrangements for actually going home, ascertaining what he/she needs to do to continue to progress in regard to their health related event, and resuming control of their life. Using specific nursing strategies the nurse tries to smooth the transition of leaving the Nursing Partnership including evaluating that the client has the resources to maintain self-care. There is similarity in relational direction with Phase Four of the manuscript where the nurse and client leave their Relationship of Oneness and move back to a Relationship of Apartness.

As partners, the nurse and client work together within the nursing situation to achieve the client's health related goals while their working together is shaped by influencing contextual factors, the contextual determinants.

Like the Nursing Partnership, 'The Moment of Caring' is focused on the nurse-client relationship, incorporates work (the giving-receiving cues or behaviours) that both client and nurse provide in order to develop their relationship. Throughout the tension created by the giving-receiving behaviours there is an inherent and continuous negotiating of the parameters and direction of
their relationship which culminates in a shared moment of understanding and meaning, only then to be followed by a distancing in their ways of relating.

'The Actualised Caring Moment: A Grounded Theory of Caring in Nursing Practice'

There is significant congruity between the manuscript 'The Moment of Caring' and Euswas's (1991) grounded theory 'The Actualised Caring Moment: A Grounded Theory of Caring in Nursing Practice'.

The purpose of her study '... was to identify and authenticate those aspects of nursing practice that best typify caring' (Euswas, 1993, p. 311). Conducted within the New Zealand nursing context Euswas's findings concluded that caring in nursing practice was comprised of a series of actualised caring moments.

'The actualised caring moment occurs temporarily at a given point in time, at a place of the nurse-patient transpersonal lived experience. It brings a positive outcome for both the nurse and the patient - growth for both and potential healing for the patient. It may occur only once or at many points in the interactions. Sometimes, the circumstances may be such that it does not occur at all' (p. 321). This has clear congruity with Phase Three of my manuscript 'The Moment of Caring' where nurse and client transcend apartness and where each becomes an extension of the other and experience as one.
There is also a clear fit between Euswas's theory of 'The Actualised Caring Moment' and the manuscript 'The Moment of Caring' in relation to description, language, focus, purpose and outcome. What is interesting is that the manuscript developed in theoretical isolation from Euswas's work following a methodology which was emerging and exploratory. I say theoretical isolation because although Euswas's work did not form the basis of the manuscript and in fact wasn't examined until the manuscript had been articulated and completed, on reflection there is a very real sense of connectedness between the two works. Both were responses to the same phenomena, i.e. caring moments occurring in nursing practice in New Zealand, and both inherently held to aspects of spirituality and spiritual beliefs in their development, i.e. 'A Moment of Caring' - Christian, 'The Actualised Caring Moment: A Grounded Theory of Caring in Nursing Practice' - Buddhist.

Furthermore, because Euswas's work was grounded in New Zealand nursing practice, it is not surprising that my nursing practice grounded in the New Zealand context would fit with what was generated through the grounded theory process of theory development in Euswas's study.

There are similarities between Euswas's notions of 'caring preconditions', the 'actual caring process', and the 'situated context' and the phases outlined in the manuscript 'The Moment of Caring'.

Euswas comments that 'caring preconditions' are prerequisite for the caring process and include '... the nurse, who has capacities or qualities of caring, based
on human care value and knowledge, and the patient with a specific health-related problem, who is in need of assistance' (p. 321). This is comparable with Phase One within my manuscript where nurse and client are fulfilling expected health related giving-receiving roles. Additionally, the component of 'situated context', described as '... the set of circumstances in which the nurse and patient meet at a specific time and place in an environment that allows the nurse to practice caring' (p. 321) also is included within Phase One of the manuscript.

The 'actual caring process' is described as '... the continuity of the interactive process between the nurse and the patient' where 'The nurse translates caring into action of helping the patient, and the patient participates in care' (p. 321). At some moment in time during this caring process both nurse and patient actualise their intersubjective connectedness. This is also closely aligned with Phase Two of the manuscript where I propose that client and nurse are in relationship and are moving from relating from a position of apartness to a position of oneness, and Phase Three where the nurse and client are in a relationship of oneness.

There also appears to be an inherent connectedness between the illustrations used in 'The Moment of Caring' and those included in Euswas's work (1991). Taking both the illustrations used by Euswas and those of the manuscript and layering and re-layering them over each other (using the processes developed in the composing of the manuscript), identifies general areas of harmony, different perspectives of related processes, differences in detail and focus, and creates further interactions requiring exploration and examination from which other images relating to caring may emerge.
These similarities I see as reassuring not only because they draw attention to the phenomena of caring moments in nursing practice, but because they also reveal similarities about the essential qualities of the phenomena, therefore elucidating and clarifying the phenomena. This can be likened to the similarities among various musical compositions pertaining to the theme of, for example, 'Music of the Rainforest'. Musical composers create various melodies and works to describe differing views of the rainforest and although each musical work is discrete, and has been composed from unique conditions, there is similarity in sound, tempo and ambience. Because they are responding to the same phenomena, their collective responses imbue essences of what music of the rainforest is, and through their responses the phenomena speak for themselves.
Bridge

'The Moment of Caring: A Manuscript for Reflection on Caring Moments in Nursing Practice' emerged from a story about a nursing encounter between me and a small boy. By using an intuitive and exploratory interpretive approach, a deeper understanding and meaning of my nursing practice was revealed.

A Summary

The Concepts of Person and Health

The meta-paradigmatic concepts of person and health form key foundational assumptions for the manuscript.

The person is viewed as a unified being-in-the-world consisting of three realms, the Body, the Mind, and the Spirit. The realm of Body refers to an individual's biophysical composition confined to space and time. The realm of Mind involves cognitive processes, emotions and conscience, where space and time are relative concepts and are able to be transcended. The realm of Spirit is the individual's soul, the metaphysical essence of who and what they are, and exists for a purposeful relationship with the Christian God. Although the person and therefore the realms are viewed holistically, the realm of Spirit holds greatest significance.
Persons have a meta-pattern of being comprised of the merged patterns of the wholeness of each the three realms. The meta-pattern is the holistic matrix from the merging of 'Body-pattern', 'Mind-pattern' and 'Spirit-pattern' into a distinct representation of existence. The meta-pattern of being is reflected as specific behaviours or cues called giving-receiving behaviours which are signals inviting participation and connection, and which provide guidance for the developing connections within the nurse/client relationship.

Health is viewed as 'wholeness' and 'becoming whole' within the three realms of Body, Mind and Soul. 'Wholeness' refers to the outcome of the process of 'becoming whole'. 'Becoming whole' refers to the process of increasing diversity and complexity of meaning and understanding of experience, and 'wholeness' refers to the outcome of increasing diversity and complexity of meaning and understanding of experience occurring at a particular point in time at a particular location in space.

The Moment of Caring: A Manuscript for Reflection on Caring Moments in Nursing Practice

The manuscript comprises basically four phases; Phase One - Readiness to Co-participate, Phase Two - In Relationship, Phase Three - 'The Moment of Caring', and Phase Four - Redefining Wholeness.
Phase One - Readiness to Co-participate: Fulfilling Expected Health Related Giving-Receiving Roles.

The nurse and the client are each fulfilling clearly defined roles within the organisation in which they are contextually located. Their relationship is distant and apart, what I refer to as a Relationship of Apartness. This may occur prior to a physical meeting of the two individuals through knowledge of the other through integrated medical/nursing notes, overhearing conversations about the other, or by hearing and seeing the other. When the nurse and client are aware of the existence of the other they start to relate.

They initially relate and view each other as objects with specific characteristics. They communicate with each other through conscious and unconscious giving-receiving behaviours. The conscious cues reflect behaviours related to the organisational role each individual is fulfilling, for example knowledge, skills, expertise, and the unconscious cues reflect each individual's values, beliefs and attitudes. As they progress in their relating the cues start to merge and the nurse and client begin to view each other and the giving-receiving behaviours holistically. Their relating moves slowly from a position of apartness to that of oneness. This marks the transition from Phase One to Phase Two.
Phase Two - In Relationship: Moving from Apartness to Oneness.

As the giving-receiving behaviours are viewed more holistically rather than categorically both the nurse and client open self to each other. This process is facilitated by the nurse who is guided by Watson's ten carative factors (1985). As the nurse and client start to relate as person-to-person there is a continual movement in their relationship from a position of apartness to that of oneness. This process is called 'in-tuning'. As they continue to relate the relationship ebbs and flows between apartness and oneness and gradually their relating moves closer to that of oneness. During this tidal movement the nurse's and client's relationship becomes focused on relating as being-to-being and they reach a transitional plateau where attempts to objectify their relating have minimal impact. This transitional plateau marks the beginning of Phase Three.

Phase Three - The Moment of Caring: Relationship of Oneness

The 'in-tuning' process is complete and the nurse and client are said to be 'in-tuned'. The nurse and client are relating and experiencing as one, that is as 'unified person-to-person'. The nurse domain of this 'unified person-to-person relating' expresses a response enabling the client domain of the 'unified person-to-person relating' to experience the initiating experience more fully, more deeply and more richly. The meaning of the concept of time is transcended to become whatever the nurse and client need it to be in realising the relationship and experience of oneness.
As the nurse and client progress in their Relationship of Oneness their meta-patterns of being start to change and become more complex and diverse in response to their shared meaning and understanding of experience. The pre-transcendent view of time returns when the nurse's and client's meta-patterns of being progress through individual trajectories related to each person's past, present and imagined possibilities. This indicates the ending of 'The Moment of Caring' and signals the transition between Phase Three and Phase Four of the manuscript.

Phase Four - Redefining Wholeness: Relationship Moving from Oneness to Apartness.

As the nurse's and client's understanding of the shared experience becomes more diverse and complex their meta-patterns of being become more complex and diverse, and they become more whole. As the nurse's and client's own understanding and meaning become further personalised, they begin to view the other in relationship to their roles and functions within the organisation rather than viewing the other as an extension of self and relating as person-to-person. Thus their relationship moves from a position of oneness to that of apartness where they predominantly view each other according to their organisationally assigned roles and functions.
The nurse and client relate in regard to their roles and functions, however because they have experienced and carry with them a shared encounter, their relationship does not go back to the same Position of Apartness as in Phase One.

Variations

At the conclusion of Phase Four three further possibilities emerge as to ways in which the nurse's and client's relationship may progress. Firstly, the nurse and client continue their relationship from a position of apartness; secondly, they can repeat the process and proceed through all the phases again (see Illustration 37); or thirdly, Phases Four, One and Two may occur 'all-at-once' enabling both nurse and client to experience another 'Moment of Caring' without distinctly having to progress through each phase of the manuscript (see Illustration 38).
Illustration 37. The Moment of Caring: A Manuscript for Reflection on Caring Moments in Nursing Practice (All phases)

Illustration 38. The Moment of Caring: A Manuscript for Reflection on Caring Moments in Nursing Practice (All-at-Once)
Bridge - A Personal Reflective Summary

"Before the song all music came like muted, empty octaves begging a composer's pen. The notes cried silently for paper staves and kept their sound in theory only."

(Miller, 1975, p. 37)

The composition of 'The Moment of Caring: A Manuscript for Reflection on Caring Moments in Nursing Practice' has been a creative process where I as composer have taken the 'music' of my nursing practice and recorded and ordered the 'notes' into a manuscript summarising my revelations of what I consider occurs in a caring moment in nursing practice.

It has been a learning process where I have explored aspects of the caring nature of the nurse-client relationship as embodied in Phillip's Story and therefore my own nursing practice, and aspects of caring in nursing practice in a broader sense.

Watson's works on caring (1985, 1988) provided a significant component of the philosophical background and location from which I explored the phenomenon of caring within the story, and as my understanding of the story and caring in nursing emerged, I drew on and incorporated some of Watson's ideas within the development of the manuscript for reflection of caring moments in nursing
practice. I don't necessarily hold to all that Watson writes on caring, however, her writing has played an integral part in enabling my own understanding of caring in nursing to develop and has provided me with reference points from which my ideas and thinking on caring were birthed.

Watson's work also first introduced me to Buber's notions of I-It and I-Thou relating, two ways of relating which were foundational to the development of the manuscript. My thoughts on these two processes and the subsequent development of my relationships of 'Oneness' and 'Apartness' were clearly influenced by Buber's descriptions of these ways of relating and in particular Watson's (1988), Paterson and Zderad's (1976) and Kirby and Slevin's (1995) use of his ideas. I have enjoyed using other nurses' interpretations of similar concepts to help clarify my own thinking on aspects I consider important to nursing.

Phillip's story has always held a fascination for me and subsequent to this study, I am even more fascinated with the both the richness of meaning of practice the story contains and the interpretive processes I developed and used to uncover and reveal the meaning it holds. I am continuously amazed that so much learning and understanding has come from my one nursing encounter with Phillip, and I am staggered when I consider the potential possibilities all the untold stories of other nurse-client encounters may have in contributing to understanding the complexity of nursing. Unlocking and recording the manuscripts of practice contained within these stories I believe could add rich detail and clarity to the body of knowledge which is nursing knowledge.
By producing a manuscript of the knowledge and understanding of nursing practice contained within these personal stories, there is also the potential to make known different processes for interpreting and therefore understanding nursing practice. These may be new, or may add or clarify existing interpretive strategies currently used in nursing.

I struggled with using established approaches to interpreting narrative data and identified and developed my own approach where I would move in an ebb and flow pattern between making sense and understanding my nursing practice as represented by Phillip's Story, to a location outside of the story where my thinking and reflection was more abstract. I called this process 'The Hermeneutic Wave' because it accurately described the process of interpretation I used, of moving in and out of the narrative data.

Because my process was exploratory and new there were times when I wondered whether it would work. Two of the hardest aspects I found with my study were to trust the process and at times, to patiently wait until the next step was revealed. Throughout the study I have realised that time is arbitrary and that waiting is part of the process of understanding.

I believe the approach of 'The Hermeneutic Wave' has great potential for further development and use in understanding nursing practice, and there is clear evidence from nursing practice that the tidal nature of moving in and out from an object of focus is not an unfamiliar phenomenon for nurses. Examples include the way nurses move in and out of the context of work and personal life, in and out of
specific client contact, and in and out of specific nursing responsibilities. This broad familiarity with the ebb and flow nature of 'The Hermeneutic Wave' suggests to me that nurses will find the concept not that difficult to grasp as a method to assist with understanding practice.

As an interpretive method I believe 'The Hermeneutic Wave' offers support to current interpretive strategies in nursing research but also offers a different way of going about interpreting and understanding practice: one which directs the researcher to step out from the data to think more abstractly and theoretically on what is contained within the data, then to move back into the data with the abstract ideas to understand the data and meaning it contains in a fresh way. This process can be repeated infinitely with each phase of moving in and out of the data adding more layers of understanding and meaning using the processes of immersion, reflection and crystallisation.

These processes involve the researcher totally immersing self in the textual data, reflecting on the data and intuitively crystallising their ideas about the data (Polit & Hungler, 1997). They form the steps of interpretation within each phase of 'The Hermeneutic Wave', that is from a location either within or outside of the story. The way I have adopted and used them within the framework of 'The Hermeneutic Wave' is just one of many different possible ways of utilisation, which has given me the freedom to explore and understand my own nursing practice and to concurrently develop an abstract framework which theoretically encapsulates what I consider occurs within a caring moment in nursing practice.
"The Moment of Caring: A Manuscript for Reflection on Caring Moments in Nursing Practice" is my response to Watson's challenge to view nursing through a new lens and to develop different "... [new] ways of seeing the usual" (Watson, 1988, p. 8). I offer the manuscript to all nurses for them to play as they so wish.
Commentary Related to Phillip and Phillip's Story

This story was written in response to a nursing encounter I experienced while caring for a young boy in a paediatric ward at a large metropolitan hospital. I wrote the story immediately after completing the afternoon duty.

It is my story of the experience, and I have titled it 'Phillip's Story' because it is about a boy I call Phillip. Phillip is an actual person though this is not his true name, nor is the age I have given his exact age. Phillip's medical diagnosis and interventions given to treat his medical condition are all accurate, as is the length of Phillip's and my encounter, that of fifteen minutes.

The events and dialogue within the story capture the essence of what I remember occurring between Phillip and myself, and what unfolded during our meeting as truthfully as I can recall. Apart from minor grammatical and typographical corrections, the story has remained essentially unchanged from when I first wrote it.
Commentary Related to Illustration 10. A Father's Grief

Illustration 10 A Father's Grief, is a reproduction of a photograph accompanying a newspaper article that discussed aspects of the massacre at Port Arthur, Tasmania, Australia, in the New Zealand Herald on April 16, 1996. My response to the photograph played a significant part in the development of my ideas concerning experiencing another person's experience, as outlined in the chapter titled 'Theoretical Positioning - Adagio' of this work.

I contacted the offices of the New Zealand Herald seeking permission to include the photograph within the thesis, only to be informed that Reuters Ltd. owned copyright, whom I contacted. I explained the significance of the photograph, what I wanted to use it for, and asked for permission to include the photograph in the thesis, which they gave me (see a copy of Reuters Ltd. e-mail on page 207 of the thesis).

Although newspapers are considered public domain and thousands of individuals had already seen the photograph, and, the man in the photograph gave an interview on national television some weeks later telling his story, I still wanted to contact him to seek his permission to include the photograph in my work.

Following a suggestion from my thesis supervisor, I contacted a Senior Lecturer at the Tasmanian School of Nursing, Faculty of Health Science, University of Tasmania, who had worked in varying capacities with nurses
involved in events related to the massacre, asking whether the lecturer knew the
name of the man in the photograph and how I might contact him. The lecturer
gave me the man’s name and occupation, and also explained that he had since
moved to another state in Australia, and was creating a new life for himself with a
new partner. The lecturer did not know a contact address, however, suggested that
if I wrote to him via his professional organisation explaining the purposes of my
letter, the organisation might forward the letter to him.

At this point in my correspondence, I decided not to pursue contacting the
man any further. I understood he was making a new life for himself, in a new
place, with new people, and I felt that at this stage, I did not want to compound or
cause any further stress to him related to the events of his past.

His horrific and devastating experience has impacted this work and my life
significantly.
Hello Maurice,

As per our telephone conversation, regarding a Reuter picture taken by one of our journalists of a man sitting in a car and who had been told his family and children had been killed in the Port Arthur massacre in Tasmania.

I can confirm that you have permission from our photographer to use this picture, and as it is for academic use, not for commercial resale, there will be no charge for this. A Reuters credit would be appreciated.

Thanks and regards,

Simon

-- Any views expressed in this message are those of the individual sender, except where the sender specifically states them to be the views of Reuters Ltd.
REFERENCES


[Editorial Note - The format of the above reference follows advice from the UNITEC Institute of Technology Reference Librarians. Although the text names an Editor-in-Chief (Oscar Thompson), he has been deceased for a number of years, and other editors have added to his work in subsequent editions.]


